

THE NEED FOR DATABASE ON CORONIAL INFORMATION SYSTEM IN MALAYSIA

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ABSTRACT

Establishing a databank is an important component of a coronial system. The databank is to collect, store and retrieve data or detailed information in relation to death investigations, coronial inquests and verdicts in the coronial system. Information regarding previous coronial cases that were stored, in the databank should be made available to the coroners. The coroners may conduct research to enhance their knowledge and skills in relation to the coronial proceedings. In addition, the responsible organization shall use the information to prepare annual reports on death investigations in the coronial system. The annual reports should be made available to the general public. A major improvement to the Malaysian coronial system is necessary. One of the steps required as part of the task of reforming the current coronial inquest in Malaysia is the establishment of a systematic, comprehensive and accessible database on Sudden Death Records (SDRs) and coronial inquest proceedings. Such a database will facilitate access to adequate and comprehensive data which will be of value to coroners and others involved in administering the coronial inquest system, as well as to scholars and researchers. Thus, Malaysia is able to meet the best practice standards with regards to coronial information or death investigation.

Keywords: *database, information, coronial reports, death investigation.*

INTRODUCTION

A databank is an important component of a coronial system. It is to collect, store and retrieve data or detailed information in relation to death investigations, coronial inquests and verdicts in the coronial system. Information regarding previous coronial cases that is stored in the databank should be made available to the coroners. Therefore, a website should be established, so that the information is easily accessible. The best method of collection of such information is by using a database system (computerise or computer data storage). The coronial information stored or uploaded to the database can be accessed, retrieved, protected and transmitted easily.

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The reports that could be generated from a comprehensive database would provide very useful information for monitoring trends in death investigations and inquest proceedings; identifying and addressing hazards within the community; and assisting with injury and death prevention. These reports would also be useful in criminology studies.

THE NATIONAL CORONIAL INFORMATION SYSTEM

A unique feature of the coronial system in Australia is the establishment of the National Coroners Information System (NCIS) (J.O. Smith, personal communication, November 11, 2011). The NCIS is a national internet based data storage and retrieval system for Australian coronial cases. Information about every death reported to an Australian coroner since July 2000 (but, for Queensland since January 2001) is stored within the system. It provides a valuable hazard identification and death prevention tool for coroners and research agencies. The primary role of the NCIS is to assist coroners in their role as death investigators, by providing them with the ability to review similar previous coronial cases (C. Jones, personal communication, November 11, 2011).

Freckelton and Ranson (2006), emphasise that the NCIS is the first potential database for informing ‘precedent-informed decision-making’ by coroners established in Australia. It has the potential to improve the quality of decision-making by coroners. Smith (2009), has pointed out that the NCIS is unique and Australia is the envy of other countries including the United States, Canada, New Zealand, the Netherlands, the United Kingdom, Sweden and other Asian Pacific countries.

The NCIS is an effective and efficient access point to data in relation to coronial deaths information in the state and territory jurisdictions in Australia (J.O. Smith, personal communication, November 11, 2011). Dr Tim Driscoll claims that the NCIS is the most innovative and comprehensive initiative in the world. In 2002 the Victorian Attorney General described the NCIS as a world first in providing an internet accessible database of coronial information across Australia. He noted that coronial data is a rich source of information about the causes of preventable deaths in this country (C. Jones, personal communication, November 11, 2011).

Currently, the NCIS is providing a vital source of quality data accessible, in a timely manner, in the Australian coronial system. According to Dr Jones, information in NCIS undergoes a quality assurance review by the NCIS officers. There is a potential for coronial information to contribute to a reduction in preventable death and injury in Australia. Lightfoot describes the NCIS as a ‘preventing tool’

to reduce future injury and death because the coronial information is reported annually (Lightfoot, J., 2005). All information relating to coronial deaths in Australia is collected and stored very systematically in the NCIS. Documents are attached directly into the local case management system and uploaded into NCIS every night via a secured and encrypted process. The NCIS contains data that can be divided into two categories as follow:

Data from Coronial File

The data from coronial files contains data fields and full text reports. The data fields include: name,* date of notification of death, age, sex, date of birth*, place of usual residence,* period of residence in Australia, country of birth, employment status, usual occupation, the time of incident if a work-related occupation or industry, marital status, indigenous identification, time/location of incident, activity at time of incident, intent (both suspected at time death reported and final), mechanism of injury (primary, secondary and tertiary), object or substance involved (primary, secondary and tertiary), medical cause of death and vehicle type, driver/passenger, context and user where the death is related to a motor vehicle accident. The full text reports include police narrative of circumstances,* autopsy report,* toxicology report* and finding* (National Coroners Information System, 2007).

However, the words and phrases which marked (above) with an asterisk (*) are the only type of information that are available to users who wish to view coronial findings, autopsy reports or any other full text documents on the system (National Coroners Information System, 2007). Other information such as transcripts of inquests, photographic evidence, and expert's report or witness statements is not contained in the NCIS system. A summary of de-identified NCIS statistics by jurisdiction is available on NCIS web page as "Operational Statistics" (National Coroners Information System, 2007).

The states and territories are duty bound to provide the coronial information data to the NCIS. The coronial statute of states and territories in Australia provide for such obligation. The Victorian Institute of Forensic Medicine (VIFM) have a licence agreement which permits the transfer of such information for storage and dissemination via the NCIS (C. Jones, personal communication, November 11, 2011). This information or data will be uploaded to the NCIS on a regular basis (mostly every night) by coronial clerks of the coroners' offices (National Coroners Information System, 2007). The information that is contained in coronial file is used as the basis for their data entry. The coronial information which is transferred to the NCIS is subject to State and Federal privacy legislation.

Data from External Sources

The NCIS also contains data from external sources such as, ICD-10 codes provided by the Australian Bureau of Statistics, and codes pertaining to work related deaths from Safe Work Australia. The International Classification of Diseases and Health Related Problems (Tenth Revision) (ICD-10) is the classification system used by the ABS to code cause of death. The extensive nature of ICD enables classification of causes of death at various levels of detail. The underlying cause of death is coded, as are a maximum of 20 multiple causes. Safe Work Australia (and its previous iterations) assigns a variety of codes to deaths which are work related according to the Safe Work Australia definition (National Coroners Information System, 2007).

Meanwhile, the Safe Work Australia definition of a work-related death is “fatalities resulting from an injury sustained in the course of work activity, commuting to and from work, and as a result of someone else’s work activity.” Specifically excluded are deaths of those who die of iatrogenic injuries; due to natural causes or diseases, while working overseas or from self-inflicted injuries (National Coroners Information System, 2007).

The databank in NCIS is not accessible by every person (excluding third party users).² Only a death investigator who is assisting the coroner (such as a police officer, pathologist or scientist) can access NCIS data without any charges (fees). Third party users must pay a fee (National Coroners Information System, 2007). The third party user is required to submit an application form to the NCIS, which will be referred to the Victorian Department of Justice Research Ethics Committee for approval, and this process is assisted by the NCIS team. If a death investigator intends to access information from the NCIS, they should obtain appropriate authorisation from the State or Chief Coroner (National Coroners Information System, 2007).

The NCIS is an important source of information on coronial inquests for the government and non-profit organisations in Australia. For example, the Royal Life Saving Australia has reported that their annual reports on drowning was based on 5 year average figure, obtained from the NCIS’s data (Royal Life Saving Australia, 2008). Similarly, Safe Work Australia used NCIS’s data in their Work Related Traumatic Injury Fatalities Report (National Coroners Information System, 2011)

² Note: A Third Party is an Australian individual or organisation with a role or interest in public health and safety or with a statutorily mandated statistical role. This includes Commonwealth, State and Territory government departments and agencies, University research centres, and other research organisations/agencies with a role or interest in public health and safety or death and injury surveillance. Commercial and media organisations are not currently eligible for third party access to the NCIS.

and the Australia Institute of Criminology also prepared their report in Deaths in Australia: National Deaths in Custody Program based on the statistical data provided by NCIS.

NATIONAL DEATHS IN CUSTODY PROGRAM (NDICP)

'Deaths in custody' is one important focal point of the coronial system. The phrase 'deaths in custody' has been defined in many different ways in the coronial system. Generally, 'deaths in custody' refers to deaths that occur in prisons; or detention centres; or lock-ups; while a person in police custody or during an encounter with police; or in other care centres such as psychiatric centres or mental hospitals. Most of the Commonwealth jurisdictions have established a mandatory provision to compel the coroner to hold an inquest where a death occurs in custody. The main objective of this provision is to determine the cause of the deceased as well as to identify if there is any foul play on part of the prison, police or others. The coroner is also empowered to make recommendations to the relevant authorities in order to prevent such deaths. Therefore, a special organisation or institution should be established to oversee and conduct thorough research in order to prevent the uncontrolled deaths in custody.

It is noted that the National Deaths in Custody Program (NDICP) was established to monitor the extent and nature of deaths in custody in Australia. The NDICP is a valuable program which enables continued monitoring of all deaths in custody across Australia and identification of changing trends (Joudo, 2009). The NDICP (formerly known as the National Deaths in Custody Monitoring and Research Program) was established in 1992 to monitor the extent and nature of deaths in police, prison and juvenile custody. This program is administered by the Australian Institute of Criminology (AIC). To date, the AIC has collected and disseminated data on deaths that has occurred in police, prison and juvenile custody since 1980 (Collins & Ali, 2003).

The statistics on all deaths and coronial records were made available to the public in Australia. William³ used the records from the AIC to examine deaths in custody between 1980 and 1989. He compared the statistics on deaths that occurred between 1990 and 1999 in Australia in his study (Williams, 2001). Based on the information, William also observed and identified significant differences between deaths of Indigenous and Non-Indigenous persons in custody according to age distributions, gender and causes of deaths in every state and territory in Australia. He managed to conduct a comprehensive study and trend analysis

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of deaths in custody by Indigenous status in Australia. Such studies are made possible by the existence of comprehensive databank, including for the specific issue of deaths in custody.

The Collection and Analysis of Comprehensive Data

Comprehensive data collection in relation to coronial inquest matters is essential in order to assist coroners by providing information on previous cases that are similar in nature to current investigations or coronial inquest proceedings (C. Jones, personal communication, November 11, 2011). The establishment of a national databank provides a mechanism for furnishing adequate and comprehensive data in relation to all deaths subjected to coronial investigation.

Data of this nature also allows ongoing evaluation of a coronial system, including trends in relation to deaths that are subject to the coroner's jurisdiction, spanning investigations, inquest proceedings and verdicts over time. Comprehensive data also facilitates demographic analysis, and can assist the state or government with injury and death prevention policies and strategies more broadly (Williams, 2001).

Australia's National Coroners Information System (NCIS) provides an excellent model. It is the best organisation for collecting, storing and retrieving information on coronial death inquests in the world (National Coroners Information System, 2007). The NCIS has pioneered the setting of procedures for collecting data and statistics of reportable deaths from all Australian jurisdictions. In addition, the National Deaths in Custody Program (NDICP) plays an important role in collecting data and statistics on deaths in custody in Australia, which, in turn facilitates monitoring of the extent and nature of deaths in police, prison and juvenile detention custody.

For the purpose of this article, these two institutions i.e. the NCIS and the NDICP together, are set as the best practice bench mark in order to evaluate the coronial inquest system, especially on the collection of coronial information in Malaysia.

FRAMEWORK OF COMPARISON

Comparison of Malaysian Coronial Information with the National Coronial Information System (NCIS)

A high quality databank is an important component of a functioning coronial system. The databank administered by the NCIS offers comprehensive,⁴ reliable,

⁴ Dr Tim Driscoll (Elmatom Pty Ltd, November 2003) observed that the NCIS is most innovative and comprehensive initiative anywhere in the world to make use of Coroners' information, and should underpin all major research initiatives into fatal injury in Australia.

relevant and valid data as a true reflection of reportable death investigations. The data is stored in an IBM Informix Relational Database. IBM Excalibur data blade is used to index and search across reports in Portable Document Format (PDF) that is stored in the database. Custom in-house written C programs are used to upload and validate data which is sent to NCIS by the various jurisdictions (C. Jones, personal communication, November 11, 2011). The data is monitored closely by the NCIS Quality Team to ensure all information is reviewed, edited and audited. The collection of statistical data in relation to death inquests in Malaysia is inadequate. In Malaysia data regarding deaths is registered by the National Registration Department of Malaysia (NRDM). The NRDM is responsible for collecting and registering all births and deaths in Malaysia. Its role is enshrined in the Births and Deaths Registration Act (1957).⁵ The records of all deaths subject to Chapter XXXII of Criminal Procedure Code (Revised-1999) (CPC) are registered by the NRDM. However, no analysis on the coronial deaths conducted by the NRDM. They only provide general information on causes of deaths in Malaysia on their web-site (Department of Statistics Malaysia). The NRDM plays no significant role in the coronial system, in contrast to the NCIS or NDICP in Australia.

In Australia the NCIS is the sole collecting agent of data on reportable deaths. Information is collected from every state and territory in Australia. To date, the NCIS has compiled and stored data on almost 200,000 reportable deaths (National Coroners Information System, 2011). The NCIS offers an excellent collection of useful information that can be relied upon for trend and pattern analysis on Australian coronial deaths (National Coroners Information System, 2011). The information (operational statistics) (National Coroners Information System, 2007) as presented in Table 1 and 2 below are published in the NCIS annual reports and available on their website (Smith, 2009).

Table 1: NCIS, Australia Operational Statistics: Case status by year (2000 - Jun 2015)

Year	Closed Cases	Open Cases	Total Cases	% Closed Cases
2000	8265	30	8295	99.6%
2001	18440	256	18696	98.6%
2002	17956	380	18336	97.9%
2003	18037	440	18477	97.6%
2004	18851	458	19309	97.6%
2005	18333	125	18458	99.3%
2006	17267	329	17596	98.1%

⁵ This act has been revised in 1983.

Table 1: NCIS, Australia Operational Statistics: Case status by year (2000 - Jun 2015) (Cont.)

Year	Closed Cases	Open Cases	Total Cases	% Closed Cases
2007	19149	520	19669	97.4%
2008	21273	617	21890	97.2%
2009	21514	851	22365	96.2%
2010	19963	794	20757	96.2%
2011	19388	1374	20762	93.4%
2012	19271	1507	20778	92.7%
2013	15860	5332	21192	74.8%
2014	11504	10120	21624	53.2%
2015	1541	9232	10773	14.3%
Grand Total	266612	32365	298977	89%

Source: National Coronial Information System.

Table 2: NCIS, Australia Operational Statistics: Case status by jurisdiction (2000-April 2012)

State	Closed Cases	Open Cases	Total Cases	% Closed
Australia Capitol Territory	4689	129	4818	97.3%
New South Wales	70927	8826	79753	88.9%
Northern Territory	4277	355	4632	92.3%
Queensland	38888	3439	42327	91.9%
Southern Australia	37374	1694	39068	95.7%
Tasmania	6494	587	7081	91.7%
Victoria	56935	15294	72229	78.8%
Western Australia	23985	2041	26026	92.2%
New Zealand	23043	-	23043	100.0%
TOTAL	266612	32365	298977	89.2%

Source: National Coronial Information System

The operational statistics and annual reports are very useful resources for researchers and students seeking to conduct in-depth analysis and evaluation of coronial matters (C. Jones, personal communication, November 11, 2011).

In Malaysia, there is no specific or centralised databank that collects and stores deaths covered by Chapter XXXII of the CPC. Nor is a database maintained by the Magistrate's Court. Sudden Death Reports (SDRs) are recorded manually in a register book kept by the Registrar of subordinate courts. The details of SDRs are recorded by clerical staff at the Magistrate's Court. These records on SDRs and inquest proceedings are kept in a filing cabinet. The Magistrates are unable to utilise information on previous cases in order to review deaths of a similar nature that may be relevant to coronial proceedings before them. In the absence of a system for collecting and storing data on reportable deaths in Malaysia, hence trend and pattern analysis is not possible.

SDR data were collected for the purpose of this research from Palace of Justice, Putrajaya and this statistical data were gathered from the register book at Magistrate's Courts, which took almost 6 months to complete. This painstaking work was because there is no portal, computerised or online database system for collecting data in relation to SDRs and inquest proceedings under the current system. The registration system for SDRs and coronial inquest proceeding's in Malaysia is out-dated. The Malaysian data collection and storage system is not efficient, less accessible and lacks integrity compared to the NCIS system in Australia.

The NCIS has established a very systematic method for collecting coronial data. The NCIS is using the latest software to update and enhance the speed of the database program (C. Jones, personal communication, November 11, 2011). The data on 'closed cases' is updated every four months (National Coroners Information System, 2012). The NCIS also provides manual (i.e. the Data Dictionary (National Coronial Information System, 2010) and the NCIS Coding Manual and User Guide (National Coronial Information System, 2010) to those who are responsible for entering, using and analysing the information in the database (National Coronial Information System, 2010).

Interview respondents⁶ during my PhD research suggested that there should be a database for collecting statistical data on SDRs and inquest proceedings in Malaysia. Section 341 of the CPC requires the Registrar⁷ to take charge of all proceedings transmitted by the Public Prosecutor under Chapter XXXII of the CPC. The Registrar is responsible for keeping a proper index or records

⁶ Respondents representing the various stakeholder populations that are involved in the coronial inquest process were selected. The respondent categories were Magistrates who act as Coroners, Deputy Public Prosecutors, Lawyers, Police Officers and Forensic Pathologists - all of whom play a role in death inquiries in Malaysia. The interview questions were open-ended. Therefore, the respondents were given the opportunity to present their views and opinions based on their role and experiences in the coronial process.

⁷ According to Section 2 of the Criminal Procedure Code, Revised -1999 (Malaysia), the word 'Registrar' means the Chief Registrar, Deputy Registrar or any Assistant Registrar of the Federal Court, of the Court of Appeal or of the High Court.

of inquest proceedings. In practice, however, it appears that there is no proper database for SDRs and inquest proceedings of the sort established by the NCIS in Australia.

Comparison of Malaysian Data Collection of Sudden Death Reports (SDRS) With the National Deaths in Custody Program (NDICP)

In 1992 another mechanism relevant to the coronial system was introduced in Australia. The National Deaths in Custody Program (NDICP) monitors the extent and nature of deaths in police, prison and juvenile custody. This program is administered by the Australian Institute of Criminology (AIC). To date, the AIC have collected and disseminated data on deaths that has occurred in police, prison and juvenile custody since 1980 (Collins & Ali, 2003). According to Lyneham, from the AIC, the next NDCIP annual report will covers all deaths in custody in the last 20 years and will be made available to the public via the AIC website.⁸ In Malaysia currently there is no such program established to collect and publish data pertaining to deaths in custody.

NDCIP data has proven to be a valuable resource for researchers. For example, William's 2001 study comparing deaths in custody between 1980 and 1989 and custodial deaths between 1990 and 1999 identified significant differences between the deaths of Indigenous and non-Indigenous persons in custody, as well as age, gender and geographical differences (Williams, 2001).

FINDINGS

No Specific and Centralised Mechanism to Collect Data in Relation to Sudden Death Reports and Inquests in Malaysia

There is no specific and centralised mechanism for collecting data on coronial matters in Malaysia. Therefore, comprehensive statistical data on coronial matters is not available in Malaysia. The difficulties that was encountered when attempting to collect statistical data from separate agencies in Malaysia highlights the fact that no specific institution is responsible for collecting statistical data on SDRs and inquests in a systematic way. The Royal Malaysia Police (RMP) maintains statistical data on deaths in police custody, the Attorney General Chambers (ACG) collects data on SDRs that are referred to their office, the Chief Registrar Office (CRO) records the SDRs that are submitted to the Magistrate's Court, and the Malaysian Prison Department (MPD) keeps records of deaths in prison. Record-

⁸ Letter from Mathew Lyneham to Professor Luke McNamara, 13 July 2012.

keeping is not consistent across these agencies and is sometimes incomplete. It is not easily accessible. If a national databank was established to collect and store relevant statistical data, it would prove very useful information for examining, comparing and analysing the trends and patterns in relation to deaths that are subject to coronial inquest.

Limitation on Access to Data on SDRs

The current Malaysia coronial system limits access to data on deaths and SDRs covered by Chapter XXXII of the CPC. Records are not available to the public. This impedes thorough evaluative research and analysis, and is one of the reasons why the Malaysian coronial system has been subjected to so little scholarly attention. Exceptions include the *Report of the Royal Commission to Enhance the Operation and Management of the Royal Malaysian Police* (2004) (Digital library, 2004). However, there are articles on deaths in police custody by Rajen Devaraj (Devaraj, 2006) and (Charles Hector, 2011).

This lack of scrutiny is at odds with concerns that have publicly expressed about the coronial system (particularly in relation to custodial deaths). In Malaysia, minimal analysis of coronial deaths has been conducted even though concerns about custodial deaths have been raised in Parliament, in the media and by the NGOs.

In contrast, in Australia, since July 2009 data, from the NCIS has contributed to more than 30 academic or research papers published in Australia (Smith, 2011). Information relating to reportable deaths in Australia from the NCIS has benefited a range of people including coroners, experts and forensic pathologists. It has facilitates monitoring and analysis of trends and patterns in relation to reportable deaths, providing a basis for planning strategies to prevent such deaths in the future.

RECOMMENDATION

Establishing a Database for Collecting Information on Coronial Cases in Malaysia

It is noted that there is no proper, centralised and systematic data collection mechanism of coronial inquests established in Malaysia. Therefore, data in relation to SDRs, inquests and verdicts for this research project were provided in a piecemeal fashion by the relevant Malaysian authorities. Malaysia should establish a systematic and centralised mechanism for collecting data pertaining to SDRs, inquests, post-mortem examinations and verdicts in the coronial system.

Coronial information should be gathered and stored in a national database similar to the National Coronial Information System (NCIS) and the National Death in Custody Program (NDCIP).

Developing a Databank in the Coronial System in Malaysia

Malaysia should follow the method of collection of data on coronial cases that are employed by the NCIS (referred to as the best databank in the world by many scholars in this field). All relevant details - the deceased, the place, date, time, the summary of incident, the medical information, details of the family members, the reporting information, the witness statements, the post mortem reports and other relevant documents - should be collected and stored in the database.

The details should be keyed-in or uploaded into the database (via online means) using a standard form. A special form should be used for collecting data on coronial inquest in Malaysia.⁹ Entry of the coronial information and details of the investigation into the database should be performed by the district Coroner's office (coronial case management official or coronial clerk) locally and on a daily basis. Full text documents should either be attached to the information by the district Coroner's Courts, or transferred directly to the databank from the originating agency (such as post-mortem reports from the Forensic Pathologist Department at the Government Hospital, police reports, sketch plans, photographs, witness statements from the Royal Malaysia Police, and chemist reports from the Chemistry Department of Malaysia).

A databank should be developed in Malaysia modelled on the NCIS. The NCIS uses the IBM Informix Relational Database as a Database (backend), where all the coronial data and reports are stored. IBM Excalibur data blade enables the coronial officials to index and search across reports in Portable Document Format (PDF) that are stored in the database.

Malaysia should use the national and international compatible coding scheme for coding purposes. Data items should be defined based on the definitions outlined in the National Health Data Dictionary (National Coroners Information System, 2010).

The NCIS uses the National Health Data Dictionary (NHDD) and the International Classification of External Causes of Injury (ICECI) for the coding of data items (National Coroners Information System, 2012). Malaysia should also establish a similar database and coding system (J.O. Smith, personal communication, November 11, 2011).¹⁰

⁹ This form should be similar to the Police Report of Death to a Coroner (Queensland).

¹⁰ During the course of interview for this study, Professor Dr Joan Ozanne-Smith, Director of the NCIS responded

Ensuring the Reliability of Database

Data and information entered in the new national databank should be monitored and audited by a Quality Assurance Team at the national databank. In circumstances where the documentation is not supported by the databank's coding, or the documentation is not available to the Quality Assurance Team to review, the case should be referred to the appropriate jurisdiction for further assessment and updating. The data stored in the coronial databank would be reliable and consistent across the jurisdictions because it is audited by the Quality Assurance Team. The new database should be established with the latest software to update and enhance the speed of the database program to ensure the reliability of data.

Frequent and scheduled quality review on the data entry and case closure is also necessary to ensure the quality and integrity of coronial information in the national database. The coronial information and details in the new database should be updated every month. However, to avoid inherent differences in data collection between the states of Malaysia, the recommended new comprehensive statute should contain a legislative provision governing data collection.

Benefits of the Databank in the Coronial System in Malaysia

Once coronial data is collected it is viable to analyse and report on deaths in custody, the status of investigations, post-mortem reports, as well as demographic and case closure rates. Government agencies, scholars, academics and researchers will be able to use the reliable data for quality and effective research. The databank will also facilitate ongoing evaluation of the coronial system in Malaysia. Adequacies in the coronial process can be determined based on the statistics of demographical deaths reports and analysis of investigations. Measures can then be taken to solve coronial problems based on the coronial data/information analysis. Countries like the USA (especially in the states of Florida and Mississippi), the United Kingdom, Japan, Taiwan and Singapore have expressed interest in using the NCIS's data collection method (J.O. Smith, personal communication, November 11, 2011).

CONCLUSION

A databank modelled on the NCIS in Australia would be a major improvement to the Malaysian coronial system. One of the steps required as part of the task of reforming the current coronial inquest in Malaysia is the establishment of a

positively to a suggestion that the NCIS might play a role in training the coronial officials from Malaysia. Of course, there would need to be an official request from the Malaysian Government directed to the relevant agency in Australia.

comprehensive and accessible database on SDRs and coronial inquest proceedings. Such a database will facilitate access to adequate and comprehensive data which will be of value to coroners and others involved in administering the coronial inquest system, as well as to scholars and researchers.

The establishment of a new national databank in Malaysia will provide a mechanism for furnishing adequate and comprehensive data regarding all deaths that are subjected to coronial investigation. The trends in relation to deaths that are subject to the coroner's jurisdiction, spanning investigations, inquest proceedings and verdicts over time. Comprehensive data also facilitates demographic analysis, and can assist the state or government with injury and death prevention policies and strategies more broadly.

As a result, the new establishment of database should assist Malaysia in meeting the best practice standards with regards to coronial information or death investigation, as stated in this article.

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