Coroner's Inquests in South Carolina: A Unique, Impartial, and Public Opportunity to Seek Justice

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Coroner’s Inquests in South Carolina: A Unique, Impartial, and Public Opportunity to Seek Justice

Marshall Crane

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I. Introduction

In South Carolina, county coroners are given the authority to hold inquests into unexplained deaths.1 During these quasi-judicial hearings coroners can summon a jury and witnesses, and effectively strip the accused of many constitutional rights given at a criminal trial such as having counsel present and the right to cross-examine.2 Medical examiners and systems that immediately turn over all investigative aspects to the prosecution have replaced coroner’s inquests and coroners in many states.3 However, coroner’s inquests provide the unique opportunity of having a neutral party show evidence surrounding a death to the public in order to ascertain cause of death. These inquests have been

2. See State v. Griffin, 98 S.C. 105, 111, 82 S.E. 254, 255 (1914) (holding that coroner’s inquests are merely preliminary proceedings during which the accused is not entitled to representation by counsel or cross-examination).

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effective in cases with high levels of public concern and media attention, as well as self-defense killings and officer involved shootings. Thus, South Carolina should take advantage of the current law enabling coroner’s inquests by holding more inquests to add transparency to a critical stage of the justice system. Part II of this Note will provide background into the coroner’s position and coroner’s inquests. Part III will examine the current state of coroner’s inquests, as well as the concerns that process raises in South Carolina. Part IV will survey coroner’s inquest procedures in other Fourth Circuit jurisdictions, and also look at Missouri and Nevada’s procedures. Part V addresses possible reform and remedies that South Carolina should enact to its coroner’s inquest procedures.

II. BACKGROUND

A coroner is “[a] public official whose duty is to investigate the causes and circumstances of any death that occurs suddenly, suspiciously, or violently.”4 Coroner’s duties vary depending on different states’ statutory delegations,5 but coroners are generally responsible for determining the cause of death and whether any criminal responsibility attaches to the death in certain situations.6 A coroner has the authority to hold an inquest to determine the cause of death.7 Coroner’s inquests are “[a]n inquiry by a coroner or medical examiner, sometimes with the aid of a jury, into the manner of death of a person who has died under suspicious circumstances, or who has died in prison.”8 The purpose of an inquest is to determine if fault for the deceased attaches to a criminal act, to timely obtain evidence—both to prevent the guilty from escaping and to establish the foundation for possible further criminal prosecution—and to exclude possible causes of death.9 The coroner generally has discretion regarding whether to hold an inquest when there is a suspicious or problematic death.10 “[A]n inquest is for the purpose of protecting the public interest. It is

10. See, e.g., Potter v. City, 516 S.W.2d 597, 598 (Ark. 1974) (quoting Clark Cnty. v. Callaway, 12 S.W. 756, 756 (Ark. 1890) (per curiam)) (“The [coroner’s] authority is to be exercised within the limits of a sound discretion . . . .”); Commonwealth ex rel. Czako v. Maroney, 194 A.2d 867, 868 (Pa. 1963) (“Generally speaking, whether or not an inquest should be held is within the exercise of a reasonable discretion by the coroner.”); Fishbeck v. State, 225 S.W.2d 854, 858 (Tex. Crim. App. 1948) (stating that the Justice of the Peace acting as coroner had the authority to order a second inquest in order to complete an inconclusive first inquest); Pierson v. Galveston Cnty., 131 S.W.2d 27, 30 (Tex. App. 1939) (quoting 13 Am. Jur. Coroners § 6 (1938)) (“Generally speaking,
not for the protection of an offender and is definitely not a necessary ingredient of due process. A defendant in a murder case has no cause to complain that an inquest was not conducted. He has suffered no prejudice.”

Coroner’s inquests are investigatory and are thus executive functions, however, in actuality they operate as judicial hearings. Further, an inquest does not serve as a criminal trial or part of any criminal proceeding. Rather, the purpose of a coroner’s inquest is to aid in determining whether a criminal act was the cause of death.

III. SOUTH CAROLINA

In 1276, England implemented an act that gave coroners authority to make an inquiry into a sudden or violent death. On April 9, 1706, the South Carolina General Assembly passed a similar statute. Today, the statute authorizing South Carolina coroners to hold inquests is found in S.C. Code § 17-7-20. The essential purpose of an inquest is to allow a coroner “to ascertain the cause of death.”

Before a coroner deems an inquest necessary, the coroner must conduct a preliminary investigation to determine if an inquest or investigation is advisable. The coroner must go to the body and examine the witnesses who will most likely be able to explain the cause of death. If the coroner knows or is informed of a body of a person who died a sudden or violent death who has already been buried, the coroner may order that the body be disinterred to determine whether an inquest is deemed necessary. The coroner must then gather written testimony from witnesses and determine if the death was the fault of another living person. The coroner has the authority to gather evidence of a crime and preserve such evidence for future trial. If the coroner decides that a living person is likely to blame for the death, the coroner must summon a jury

the determination of the question whether an inquest shall be held rests, within certain limitations, in the sound discretion of the coroner.”

15. Id. (citing Act of April 9, 1706, 2 S.C. Stat. 269) (establishing the office and duties of the coroner).
19. Id.
20. Id. § 17-7-520.
21. Id. § 17-7-20.
and conduct a formal inquest.\textsuperscript{23} If, however, the coroner believes the death was not the fault of another living person the coroner must issue a burial permit and there will be no further inquiry.\textsuperscript{24}

The purpose of a coroner’s inquest is to show the cause of death, as well as exclude other possible causes of death.\textsuperscript{25} Judgments from coroner’s inquests are not binding.\textsuperscript{26} Coroner’s inquests serve as a mere judicial tool for preliminary investigation, not a trial involving judicial merit.\textsuperscript{27} Inquests must be publically held.\textsuperscript{28} Witnesses and the accused have no right to counsel at an inquest.\textsuperscript{29} For example, the South Carolina Supreme Court held that the denial of the appearance of counsel prevents the appearance of a full investigation, which could tend to incriminate a suspect.\textsuperscript{30} Additionally, suspects have no right to cross-examine witnesses at coroner’s inquests.\textsuperscript{31}

To start the inquest process, a coroner must get a warrant to summon a jury of fourteen people within a ten mile radius to appear at the time and place specified in the warrant.\textsuperscript{32} There are no restrictions or requirement regarding where the inquest should occur. Traditionally, at common law, the coroner would summon the jury to the location of the body; however, today, coroners typically hold inquests in courtrooms.\textsuperscript{33} All citizens that are subject to jury duty in circuit court are also subject to serve as jurors for their county at a coroner’s inquest.\textsuperscript{34} After summoning the jury, the coroner must swear in six jurors, appoint a foreman, and administer separate oaths to the jurors and the foreman.\textsuperscript{35} The coroner may issue warrants and summon witnesses for the inquest.\textsuperscript{36} The coroner may also examine any person present concerning the death in front of the jury.\textsuperscript{37} The coroner must take the testimony of all witnesses in writing, and the witnesses must also sign the writing.\textsuperscript{38} Any witness that does not appear or testify will be indicted at the next court of general sessions for the county.\textsuperscript{39}

\begin{thebibliography}{99}
\bibitem{23} S.C. CODE ANN. § 17-7-20 (2014).
\bibitem{24} Id.
\bibitem{25} See Gray v. S. Pac. Co., 68 P.2d 1011, 1014 (Cal. Dist. Ct. App. 1937) (per curiam) (quoting Kingsley v. Forsyth, 257 N.W. 95, 98 (Minn. 1934)).
\bibitem{26} See Smalls v. State, 28 S.E. 981, 982 (Ga. 1897).
\bibitem{27} State v. Griffin, 98 S.C. 105, 111, 82 S.E. 254, 255 (1914).
\bibitem{29} Griffin, 98 S.C. at 111, 82 S.E. at 255.
\bibitem{30} Id.
\bibitem{31} Id.
\bibitem{32} S.C. CODE ANN. § 17-7-100 (2014).
\bibitem{34} S.C. CODE ANN. § 17-7-90 (2014).
\bibitem{35} Id. § 17-7-140; see also 1972 S.C. Op. Att’y Gen., 1972 WL 20462 (June 5, 1972) (opining that the coroner’s inquest must commence with a six man jury).
\bibitem{36} S.C. CODE ANN. § 17-7-170 (2014).
\bibitem{37} Id.
\bibitem{38} Id. § 17-7-230.
\bibitem{39} Id. § 17-7-180.
\end{thebibliography}
Thus, anyone who disregards a coroner’s summons or refuses to testify, as well as anyone who willfully disturbs or impedes the proceedings of a coroner’s inquest jury, may be held in contempt by the coroner initiating the inquest proceedings.\(^{40}\)

After a coroner conducts the inquest, the jury is charged with the duty to declare whether the deceased came to their death by mischance and accident or by felony.\(^{41}\) The jury must then decide:

1. If by felony, whether by his own or another’s;
2. If by felony, whether by the act of God or of man;
3. If by another’s felony, who were principals and who accessories, who threatened him of life, or murder, and with what instrument he was struck or wounded; and
4. If by mischance or accident, by the act of God or man, whether by hurt, fall, stroke, drowning or otherwise.\(^{42}\)

The jury’s verdict must be unanimous.\(^{43}\) The jury can also find that another person killed the deceased, but that the death was not willful, or that the death was a suicide, an accident, or that the cause of death remains unknown.\(^{44}\)

In the event the jury finds that there was a willful killing at the hands of another person, the coroner must then issue a warrant to the sheriff for the arrest of the person implicated by such finding.\(^{45}\) Sheriffs and jailors are required to receive and keep all persons committed by the coroner.\(^{46}\)

The coroner must file the original inquisition and evidence with the clerk of court of general sessions for the county in which the coroner presides within ten days after the finding.\(^{47}\) Every county coroner must keep a book with a copy of all inquests and evidence taken before the jury, and that book is public property that must be turned over to the successor to the coroner’s office.\(^{48}\)

Richland County Coroner Gary Watts has been in his current office for over twelve years.\(^{49}\) Previously, Watts was the deputy coroner for fifteen years.\(^{50}\) During Watts’ time as the Richland County Coroner he has held only five

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40. Id. §§ 17-7-180, -190.
41. Id. § 17-7-150.
45. Id. § 17-7-610.
46. Id. § 17-7-640.
47. Id. § 17-7-310.
48. Id. § 17-7-330.
50. Id.
inquests, all of which were cases with high levels of public interest.\textsuperscript{51} Watts believes that coroner’s inquests promote transparency and serve as an effective tool to allow the public to see evidence in highly scrutinized and publicized cases.\textsuperscript{52}

In September 2013, Watts held an inquest into the shooting of a twenty-one year old by two Columbia police officers.\textsuperscript{53} After the Trayvon Martin case, but before the Ferguson events, this case garnered much media attention since a young African American male was shot over ten times—with most of those shots in his back—by two white male police officers.\textsuperscript{54} Watts assembled a jury of three men and three women, three African Americans and three Caucasians, with the jurors’ ages ranging between thirty and sixty.\textsuperscript{55} Watts held the inquest at the Richland County Courthouse, and it was open to the public. Watts called eighteen witnesses, and the inquest lasted over a day and a half.\textsuperscript{56} Watts had two Richland County Solicitors, Joanna McDuffie and Daniel Coble, question the witnesses.\textsuperscript{57} A model of the chain link fence the suspect attempted to climb, as well as a diagram and demonstration with string to show the trajectory of the shots fired from the police officers to the fleeing suspect and the trajectory of the shots fired from the armed suspect toward the police officers were used in order to establish that the officers were justified in shooting the armed and fleeing suspect.\textsuperscript{58} The jury took less than an hour to return a verdict.\textsuperscript{59} Coroner Watts, Solicitor McDuffie, and then-Police Chief Ruben Santiago agreed with the jury’s verdict and no criminal charges were pressed against the officers. Santiago was pleased with the outcome and the usage of a coroner’s inquest in such a public case. “The public has a right to know exactly how this happened,”\textsuperscript{60} Santiago said.

In July 2005, Coroner Watts also held an inquest into the suicide of a Richland County inmate.\textsuperscript{61} Inmate Antonio Richburg hung himself in his jail cell; however, his family believed his death was due to the fact that he had not been receiving his medicine.\textsuperscript{62} The family’s questions, coupled with public concern over the quality of healthcare at the jail, led Watts to summon a jury and hold an inquest.\textsuperscript{63} Witnesses who worked at the jail testified that Richburg did

\textsuperscript{51} Id.
\textsuperscript{52} Id.
\textsuperscript{53} Id.
\textsuperscript{55} Id.
\textsuperscript{56} Id.
\textsuperscript{57} Id.
\textsuperscript{58} Id.
\textsuperscript{59} Id.
\textsuperscript{60} Id.
\textsuperscript{61} \textit{Coroner’s Inquest Jury Finds Alvin S. Glenn Inmate Died From Neglect}, \textsc{WISTV.com} (July 15, 2005), http://www.wistv.com/story/3601153/coroners-inquest-jury-finds-alvin-s-glenn-inmate-died-from-neglect.
\textsuperscript{62} Id.
\textsuperscript{63} See id.
not receive his medication for eight days prior to hanging himself. 64 Ultimately, the jury found that the death was due to “a lack in the standard of care given to Richburg.” 65 Prison Health Services, the company responsible for providing healthcare to the Alvin S. Glenn Detention Center, has been sued twice in relation to the deaths of mentally ill inmates. 66

In April 2012, Chesterfield County held a coroner’s inquest into the death of a thirty-four-year-old Army veteran. 67 The jury deliberated for about fifteen minutes before coming to the verdict that the man committed suicide. 68 The verdict was consistent with the coroner’s initial investigation and autopsy; however, the deceased’s mother believed there was more to the case than suicide. 69

In July 2012, Charleston County held an inquest into the death of a two-year-old child who was mauled by dogs. 70 The jury found that the death was an accident and no criminal fault attached to the parents or supervisors. 71 In October 2012, Charleston County held another coroner’s inquest into the death of a two-year-old child. 72 The jury found that the little girl died at the hands of her teenage baby sitter, which led to a criminal prosecution. 73 Prior to these inquests, Charleston County had not utilized a coroner’s inquest since a case involving a plane crash in 2008. 74

Before surveying other states’ inquest procedures, it is important to note that in South Carolina counties of 100,000 or more people may implement a medical examiner system by establishing a Medical Examiner Commission (MEC). 75 The Commission must appoint a medical examiner for the respective county and that examiner may employ as many deputy medical examiners as believed necessary under the approval of the Commission. 76 In counties with a coroner and a medical examiner, “(1) the coroner has the ultimate responsibility for carrying out the duties required by this article; [and] (2) the medical examiner's

64. Id.
65. Id.
66. Id.
68. Id.
69. Id.
73. Id.
74. Rare Coroner’s Inquest Set in S.C. Mauling Death, supra note 70.
76. Id. § 17-5-230, -240.
duties must be specified in an annual written contract between the county
governing body and the medical examiner.\textsuperscript{77}

\textbf{A. Concerns About South Carolina Coroner’s Inquests}

A major concern with coroner’s inquests in South Carolina is whether the accused should be afforded the right to counsel at coroner’s inquests. In \textit{State v. Griffin}\textsuperscript{78} the court found that “[t]he only object which a suspected person could have in appearing by counsel would be to prevent a full investigation in so far as it might tend to incriminate him, and thus defeat the purpose of the inquest.”\textsuperscript{79} The court reiterated that the purpose of a coroner’s inquest is merely a preliminary investigation and not a trial.\textsuperscript{80}

Another concern is whether coroners should be afforded the authority to compel witnesses and the accused to testify. Currently, coroners have the authority to essentially hold witnesses or the accused in contempt of court if they do not cooperate with inquest procedures.\textsuperscript{81} While coroners are executive officers—and arguably should have these and similar privileges to efficiently investigate—they do not have to go through the same checks as other executive officers in exercising these privileges. For example, police officers cannot issue warrants and need judicial agents in the form of either a judge or magistrate to issue them.\textsuperscript{82} Similarly, holding individuals in contempt of court is a judicial privilege afforded to coroners with no judicial check in place to limit this power.\textsuperscript{83}

A separation of powers argument, as well as a lack of checks and balances argument inherently arises within the current practice of coroner’s inquests. Individual county coroners are representatives of the judicial branch of government.\textsuperscript{84} Although courts and statutes continually claim that inquests are not judicial in nature, inquests often have characteristics similar to judicial processes.\textsuperscript{85} Today, almost all inquests are performed in courtrooms.\textsuperscript{86} Witnesses and jurors take oaths administered by a coroner and follow courtroom procedures.\textsuperscript{87} The current South Carolina statute allows coroners to examine all witnesses and accused persons, charge the jury with instructions for deliberation,

\textsuperscript{77} Id. § 17-5-510.
\textsuperscript{78} 98 S.C. 105, 82 S.E. 254 (1914).
\textsuperscript{79} Id. at 111, 82 S.E. at 255.
\textsuperscript{80} Id.
\textsuperscript{81} S.C. CODE ANN. § 17-7-180 to -190 (2014).
\textsuperscript{82} Id. § 44-53-1400 (Supp. 2014).
\textsuperscript{83} Id. § 14-1-150 (1976).
\textsuperscript{84} S.C. CONST. art. V, § 24.
\textsuperscript{85} State v. Griffin, 98 S.C. 105, 111, 82 S.E. 254, 255 (1914) (stating that inquests fall within the constitutional provision mandating that all courts be public).
\textsuperscript{86} Interview with The Honorable Gary Watts, supra note 49.
\textsuperscript{87} S.C. CODE ANN. § 17-7-140, -220 (2014).
and hold uncooperative witnesses in contempt. Thus, the coroner essentially has the authority to be both the prosecutor and judge in a coroner’s inquest.

Another aspect of a coroner’s inquest that is reminiscent of judicial procedure is the ability to summon a jury. Aside from the separation of powers issue, the lack of safeguards in a coroner’s jury selection process is even more troublesome. There are no restrictions other than the requirement that a juror must reside within ten miles of the county of where the body is found, nor are there guidelines in place that set parameters regarding how a coroner should decide who should be summoned for the fourteen person jury required for a coroner’s inquest. Theoretically, the coroner could assemble a jury of his six best friends and fellow country club members if he wished to do so. Additionally, a coroner may continue to use the same jurors for each inquest he conducts and there are no procedural requirements for how the coroner should whittle down the jury to six people. Nor are there any requirements that the coroner strive to remove certain backgrounds, prejudices, or biases that are commonly addressed in the traditional voir dire process. The voir dire process is commonly used to determine the competency of a potential juror:

Questions are then asked to find out whether any individuals on the panel have any personal interest in the case or know of any reason why they cannot render an impartial verdict. The court also wants to know whether any member of the panel is related to or personally acquainted with the parties, their lawyers, or the witnesses who will appear during trial. Other questions will determine whether any panel members have a prejudice or a feeling that might influence them in rendering a verdict.

In stark contrast, the accused has no opportunity or input in the jury selection process during a coroner’s inquest.

One last concern is why coroner’s inquests are necessary at all? County solicitors are under no duty to honor the jury holdings in a coroner’s inquest, nor are solicitors required to proceed with a criminal prosecution against those found guilty by the jury. The coroner may directly submit an indictment to a grand jury; however, the coroner’s inquest verdict is not binding on the solicitor or the grand jury. If a grand jury finds the charges should go forward it can true

88. Id. § 17-7-150, -170, -190.
89. Id. § 17-7-100.
90. Interview with The Honorable Gary Watts, supra note 49. While this was a practical issue in the early twentieth century, obviously the author is not implying that Mr. Watts ever took such advantage of his power.
93. Id.
bill the charges, but the solicitor may still dismiss the case with no particular deference to the coroner’s inquest findings or the grand jury’s verdict. Richland County Solicitor McDuffie has dismissed all criminal charges against an accused person, although a coroner’s inquest found the accused criminally responsible for the deceased. This begs the question—if the solicitor may prosecute a crime as they see fit, why are coroner’s inquests even available? This is the approach that Virginia, West Virginia, and Maryland to some extent, have adopted by eliminating coroner’s inquests and immediately turning all investigation and prosecution over to police and prosecutors.

IV. SURVEY OF OTHER STATES’ CORONER’S INQUESTS

A. Fourth Circuit States

1. Virginia

In 1946, the Commonwealth of Virginia became one of the first states to abolish the office of the coroner. In 1950, Virginia established an Office of the Chief Medical Examiner as a division within the Virginia Department of Health. Virginia’s General Assembly appoints one Chief Medical Examiner who then appoints four assistant medical examiners at each of the district offices, as well as appointing local medical examiners as needed.

Medical examiners conduct medicolegal investigations—a legal case requiring medical expertise when brought by the police for examination—for deaths in their jurisdictions. These examiners are called to testify to their

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94. See State v. Charles, 183 S.C. 188, 199, 190 S.E. 466, 470 (1937) (“In our opinion, the county solicitor, in the light of our cases, and by long practice, was within his rights in entering a nolle prosequi upon the indictment, without the consent of the court.”).
95. See S.C. CONST. art. I, § 11 (“No person may be held to answer for any crime the jurisdiction over which is not within the magistrate's court, unless on a presentment or indictment of a grand jury of the county where the crime has been committed.”). A "true-billed" indictment means that two-thirds of the grand jury believes there is probable cause for the state to continue with the charges.
96. Interview with Joanna McDuffie, Assistant Solicitor, supra note 92.
97. Id.
98. See infra Part IV.A.
100. VA. CODE ANN. § 32.1-277 (Supp. 2014).
findings frequently in civil and criminal cases. Unlike South Carolina, Virginia medical examiners do not have the option of a formal coroner’s inquest or the ability to summon a jury. If further investigation is required for an unexplained or suspicious death, that investigation is solely left to the discretion of law enforcement and the prosecution.

One of the goals of the Office of the Chief Medical Examiner is to promote public safety. To that end, the Office of the Chief Medical Examiner creates fatality review teams and conducts surveillance to try and reduce violent deaths. The current fatality review teams in place in Virginia are the Child Fatality Review team, the Family and Intimate Partner Fatality Review team, and the Maternal Mortality Review team. These different fatality review teams are composed of sixteen members that are chaired by the Chief Medical Examiner and they focus on children, families, and adults respectively. Each team has a clause that establishes its purpose, similar to that of the State Child Fatality Review Team’s stated purpose:

The Team shall (i) develop and revise as necessary operating procedures for the review of child deaths, including identification of cases to be reviewed and procedures for coordination among the agencies and professionals involved, (ii) improve the identification, data collection, and record keeping of the causes of child death, (iii) recommend components for prevention and education programs, (iv) recommend training to improve the investigation of child deaths, and (v) provide technical assistance, upon request, to any local child fatality teams that may be established.

These teams have individual members from various state and local agencies and law enforcement offices. The collaborative efforts of these individual actors and agencies made Virginia a demonstration site for the National Violent Death Reporting System.

105. Id. § 32.1-283.5.
109. Id. § 32.1-283.1.
110. Id.
111. Office of the Chief Medical Examiner, Va. Dep’t of Health, http://www.vdh.state.va.us/medExam/AboutMedExaminer.htm (last updated Nov. 25, 2013). The Office of the Chief Medical Examiner also focuses extensively on public health, an important matter but rather irrelevant to this Note.
2. *West Virginia*

West Virginia, similar to Virginia, has an Office of the Chief Medical Examiner.\(^{112}\) The director of the State Division of Health appoints the Chief Medical Examiner to a five-year term.\(^{113}\) The Chief Medical Examiner appoints a medical examiner for each county to serve a three-year term under the Chief Medical Examiner’s supervision.\(^{114}\) However, West Virginia also has a statute that mandates county commissions to appoint a county coroner “from time to time.”\(^{115}\) This statute is largely irrelevant today since county commissions have, for the most part, not taken advantage of this statute and there are practically no coroners in West Virginia since most counties utilize the medical examiner system.\(^{116}\)

Medical examiners, upon notification of death, make an inquiry into the cause and manner of death.\(^{117}\) The medical examiner’s findings should then be sent in writing, with one copy sent to the Chief Medical Examiner and another copy sent to the prosecuting attorney of the county in which the death occurred.\(^{118}\) During the medical examiner’s investigation, he may employ qualified pathologists, toxicologists, and obtain additional services and facilities to aid the investigation.\(^{119}\) However, West Virginia provides no coroner’s inquest power to medical examiners in attempting to ascertain cause of death.

Generally, the Chief Medical Examiner and his subordinates directly report their findings to the director of the State Division of Health that originally appointed the Chief Medical Examiner

> “in all matters except that the chief medical examiner shall operate with independent authority for the purposes of: (1) The performance of death investigations conducted pursuant to section eight . . . of this article; (2) The establishment of cause and manner of death; and (3) The formulation of conclusions, opinions or testimony in judicial proceedings.”\(^{120}\)

In 2012, the West Virginia Supreme Court of Appeals held that the mandatory admission of an autopsy report or other testimonial document into evidence in a criminal action where the performing analyst does not appear at

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113. *Id.* § 61-12-3(c).
114. *Id.* § 61-12-7(a).
115. *Id.* § 61-12-14.
116. *See id.* § 61-12-3. The West Virginia Code still utilizes the term “coroners,” but follows it with “or medical examiners.” *Id.*
117. *Id.* § 61-12-8(a).
118. *Id.* § 61-12-8(b).
119. *Id.* § 61-12-6.
120. *Id.* § 61-12-3(d)(1)–(3).
trial was unconstitutional. The decision rendered section 61–12–13—a statute automatically entering all investigation reports, autopsies, and records as evidence—unconstitutional.

3. Maryland

Maryland, like Virginia and West Virginia, also utilizes a medical examiner system instead of a coroner system, and has the Office of the Chief Medical Examiner in a division of the Department of Health and Mental Hygiene. Aside from this office’s public health roles, which are similar to Virginia’s, it also has the medicolegal responsibility of determining the cause and manner of death.

In 1982, Maryland’s General Assembly created a State Postmortem Examiners Commission inside the Department of Health and Mental Hygiene. The Commission consists of the Baltimore City Commissioner of Health, the heads of the Pathology Departments at the Johns Hopkins School of Medicine and the University of Maryland School of Medicine, the Secretary of State Police, and a representative of the Department of Health and Mental Hygiene of the Secretary’s choosing. The Commission employs a chief medical examiner, one or more deputy chief medical examiners for each county, assistant medical examiners, as well as various toxicologists, physicians, and forensic investigators.

Medical examiners are charged with investigating the death of anybody in their jurisdiction if the death occurs by violence, suicide, casualty, suddenly, or in any suspicious or unusual manner. The medical examiner or the investigator shall investigate fully the essential facts concerning the medical cause of death and, before leaving the premises, reduce these facts and the names and addresses of witnesses to writing, which shall be filed in the medical examiner’s office. If the medical examiner can establish the cause of death “to a reasonable degree of medical certainty,” the medical examiner must file a report with the medical examiners’ office. The Office of the Chief Medical

121. See State v. Kennedy, 735 S.E.2d 905, 912, 917 (W. Va. 2012) (discussing whether or not the admission of an autopsy report violated the confrontation clause).
122. Id. at 917. Although this ruling does not directly relate to findings from inquests because they are not available to medical examiners, this echoes the nonbinding effect of South Carolina coroner’s inquests. The prosecution must still establish the medical examiner’s findings that are not presumed credible or admissible.
124. Id. § 5-309(a).
125. Id. § 5-302.
126. Id. § 5-303.
127. Id. § 5-305.
128. Id. § 5-309(a)(1).
129. Id. § 5-309(c).
130. Id. § 5-310(a).
Examiner keeps records on each medical examiner’s case including: “(i) the name, if known, of the deceased; (ii) the place where the body was found; (iii) the date, cause, and manner of death; and (iv) all other available information about the death.”\(^{131}\) If the medical examiner believes further investigation is warranted, he turns the investigation over to the State’s Attorney for the county by delivering a copy of his report for that death.\(^{132}\)

Unlike West Virginia and Virginia, Maryland medical examiners “may administer oaths, take affidavits, and make examinations as to any matter within the medical examiner’s jurisdiction.”\(^{133}\) This last clause provides medical examiners with the authority to examine people who witnessed the death, although they do not have the ability to summon a jury or hold any sort of formal inquest.

4. North Carolina

North Carolina has also switched to a medical examiner system; however, it still allows counties to elect coroners, and the statutes pertaining to and authorizing coroners to conduct inquests still remain good law.\(^{134}\) Of the 100 counties, roughly only five to twelve still elect coroners.\(^{135}\) The North Carolina Department of Public Health created the Office of the Chief Medical Examiner to perform postmortem medicolegal examinations.\(^{136}\) The Chief Medical Examiner appoints one or more medical examiners per county to serve three-year terms.\(^{137}\)

Under the medical examiner system, the medical examiner must complete a certificate of death, including the means of death.\(^{138}\) However, the Chief Medical Examiner has the authority to amend a medical examiner’s death certificate.\(^{139}\) Both the Chief and county medical examiners have the ability to subpoena “for the attendance of persons and for the production of documents as may be required by their investigation.”\(^{140}\) Further, reports and materials of a medical examiner’s investigation may be received as evidence in any North Carolina court or judicial proceeding.\(^{141}\)

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131. \textit{Id.} § 5-311(a).
132. \textit{Id.} § 5-311(c).
133. \textit{Id.} § 5-312.
135. \textit{See In North Carolina, the Office of Coroner is on its Last Legs, STAR NEWS ONLINE} (Mar. 30, 2012, 12:30 AM), http://www.starnewsonline.com/article/20120330/ARTICLES/12/0329596 (commenting that it is difficult to find out the exact number of counties that still have coroners).
137. \textit{Id.} § 130A-382.
138. \textit{Id.} § 130A-385(b).
139. \textit{Id.} § 130A-385(c).
140. \textit{Id.} § 130A-386.
141. \textit{Id.} § 130A-392.
As stated earlier, North Carolina allows individual counties to abolish or utilize the coroner system at the county’s discretion.\textsuperscript{142} North Carolina’s coroner statute authorizes counties to elect a coroner every four years.\textsuperscript{143} The coroner is tasked with the duty to make a careful investigation and inquiry into when and by what means the deceased came to his death, as well as filing a written report with the medical examiner and the district attorney of the superior court.\textsuperscript{144} If the coroner is not satisfied by his personal investigation and inquiry he may summon a jury.\textsuperscript{145} The coroner must follow the rules of North Carolina General Statute § 9–5,\textsuperscript{146} which sets forth the procedure for selecting a jury and summoning fifteen jurors.\textsuperscript{147} Jurors may be excused if serving would be an undue hardship, they would not be able to remain impartial, or if they are otherwise unqualified.\textsuperscript{148} If the remaining pool of jurors is below six jurors, the coroner shall continue summoning jurors until he has six jurors fit for the case.\textsuperscript{149} If the coroner at any time, either in front of the jury or in his preliminary investigation, finds a person or persons culpable in the death he may and has the authority to issue a warrant, commit a person to jail, and to fix bail for the accused.\textsuperscript{150} The accused is allowed to have counsel present with him, examine witnesses, cross-examine witnesses, and be entitled to a full and complete hearing during an inquest.\textsuperscript{151} Likewise, counsel for the family of the deceased, the solicitor from the coroner’s district, or anyone the coroner designates may participate in the coroner’s inquest and examine and cross-examine witnesses.\textsuperscript{152} The time and location of the inquest is left to the coroner’s discretion, and does not have to follow the common law tradition of summoning the jury to the body immediately.\textsuperscript{153} A court stenographer takes down the testimony and proceedings of the coroner’s inquest, and the witnesses sign their testimony.\textsuperscript{154} The coroner files copies of the inquest transcripts with the medical examiner and the district attorney of the superior court.\textsuperscript{155} The coroner’s inquest takes the place of any other preliminary hearing, but the accused has the right to have a judge review the action of the coroner in fixing or denying bail.\textsuperscript{156}

\textsuperscript{142} Id. § 130A-394.
\textsuperscript{143} Id. § 152-1.
\textsuperscript{144} Id. § 152-7(1).
\textsuperscript{145} Id.
\textsuperscript{146} See id. § 9-5 (describing the procedures for drawing jury panels).
\textsuperscript{147} Id. § 152-7(2).
\textsuperscript{148} Id.
\textsuperscript{149} Id.
\textsuperscript{150} Id. § 152-7(4).
\textsuperscript{151} Id. § 152-7(8).
\textsuperscript{152} Id.
\textsuperscript{153} Id. § 152-7(9).
\textsuperscript{154} Id. § 152-7(10).
\textsuperscript{155} Id.
\textsuperscript{156} Id.
B. Inquest Practices Outside the Fourth Circuit

I. Missouri

Of the 114 counties in Missouri, 100 have elected coroners who are paid out of the county treasury for medical examinations, autopsies, and inquests.\textsuperscript{157} The fourteen other jurisdictions, mostly large metropolitan areas, have full-time medical examiners.\textsuperscript{158} Missouri statutory provisions describing when a coroner should hold an inquest are essentially the same as South Carolina’s statutory provisions.\textsuperscript{159} However, when a coroner decides to call an inquest, the county prosecutor assists the coroner in preparing the jury charge and in questioning the witnesses present at the inquest.\textsuperscript{160}

Missouri has used coroner’s inquests in situations where self-defense or legal justification for the death is claimed.\textsuperscript{161} Recently, a town of about 38,000 has held coroner’s inquests for a number of such deaths, including when “a reserve police officer responding to a hospital emergency room shot a man who charged him with a knife; when two police officers killed a man in a motel room during a gunfight following a ‘knock and talk’ search of his room; when one bar patron shot another in a gunfight at a tavern; and when nurse’s aides trying to restrain a violent teenage mental patient accidentally suffocated the youngster.”\textsuperscript{162} The results of these coroner’s inquests saved prosecutors from having to facilitate and proceed with traditional jury trials.\textsuperscript{163}

Like South Carolina, Missouri currently has no safeguards or requirements regarding how to select a jury for a coroner’s inquest.\textsuperscript{164} One county traditionally had its coroner personally select the six jurors; however, most counties use electronic means to randomly generate coroner’s inquest jurors from the normal juror pool.\textsuperscript{165} Prior to 2002, jurors selected for a coroner’s inquest in Missouri had to hurry to the location where the deceased lay.\textsuperscript{166} However, the amended Missouri statute mandates that the jurors appear before the coroner at a time and place specified in the warrant.\textsuperscript{167} Further, the amended statute allows coroner’s inquest jurors to view the body “by photographic,
electronic, or other means.” 168  The warrant specifies the location of the inquest, which is left solely at the discretion of the coroner. 169  Most inquests occur in a courtroom with the coroner sitting at the bench, the jurors in the jury box, the prosecutor sitting at the counsel table, witnesses being called to the witness stand, and the public and the media sitting in the appropriate spectator seating in the courtroom. 170

Missouri coroners are required by statute to take down all evidence from each witness in writing. 171  Traditionally, this meant that coroners would hand write the testimony and have witnesses sign the document. 172  Today, it is common practice to have a court reporter transcribe the proceeding, although getting a court reporter to do this task is the responsibility of the coroner. 173

At the inquest, the coroner swears in the jurors and all witnesses who take the stand. 174  The coroner then reads the “charge” to the jury, with these instructions often drafted by the prosecutor. 175  In addition to drafting the instructions, the prosecutor also handles the questioning of each witness. 176  The attorney for the accused may provide the prosecutor with questions to ask, but the prosecutor may utilize or avoid these questions at his choice. 177  The accused has “no inherent right” to cross-examine or present evidence of its own. 178  The accused may have an attorney present, and that attorney may sit by the side of the accused to “aid and counsel him in giving answers to questions propounded to him so as to guard against self-incriminating testimony.” 179

When all of the witnesses have been questioned, the jury meets in private and returns a written verdict. 180  If the jury finds the death to be the result of a felony, the coroner must “speedily inform one or more associate circuit judges” of the county. 181  The judge must issue an arrest warrant for the apprehension of the accused, but the coroner has no duty or power to order the suspect to be

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168. Id. (citing Mo. ANN. STAT. § 58.260 (West 2014)).
169. Id. (citing 95 Mo. Op. Att’y Gen. (1957)).
170. Id.
172. See State v. Allen, 234 S.W. 837, 844 (Mo. 1921) (explaining that a witness testifying in front of the coroner would have had the opportunity to be cross-examined and that the testimony be “taken down in writing and subscribed by the witnesses”).
173. State v. Onken, 701 S.W.2d 518, 523 (Mo. Ct. App. 1985) (citing Mo. ANN. STAT. § 58.350 (West 2007)).
175. Id. § 58.310.
177. Swingle, supra note 29, at 84 (citing United States ex rel. Musil v. Pate, 427 F.2d 930, 933 (7th Cir. 1970)).
180. MO. ANN. STAT. § 58.360 (West 2007).
181. Id. § 58.370.
arrested. The coroner’s inquest jury verdict is not subject to judicial review. However, the prosecutor may dismiss the case before ever pressing charges if the prosecutor believes there is insufficient evidence to convict the accused.

2. Nevada

In his 2008 Nevada Law Journal article, Michael J. Gayan highlights the concerns and practical problems of the coroner inquest system in Clark County, Nevada (Las Vegas). Coroners in Nevada are required to investigate any death that they suspect has occurred by unnatural means. The individual county codes provide requirements that coroner’s inquests must follow, and which must be conducted when law enforcement officers kill a person in the line of duty for the purpose of “publicly bring[ing] forth all of the details surrounding the incident causing [the] death.” Upon determining that an inquest is necessary, the coroner must notify the district attorney and the police department, or request assistance in the investigation. The coroner must designate a presiding officer over the inquest, often any attorney admitted to the bar. The coroner, a representative from the district attorney’s office, and the presiding officer meet and decide what evidence and witnesses are required for the inquest. Other interested individuals such as the family of the deceased, the accused’s counsel, and concerned citizens may suggest witnesses or questions to ask at the inquest, but these are merely taken as suggestions for the presiding officer. The presiding officer, not the coroner, must request fifteen potential jurors, and then conduct a voir dire examination to select seven jurors to serve as the coroner’s inquest jury.

It is the presiding officer’s job—not the coroner’s—to ensure that the inquest is an investigation and not an adversarial proceeding. However, the presiding officer, representatives of the district attorney’s office, and the

186. Id. at 716 (citing NEV. REV. STAT. ANN. § 259.050(1) (LexisNexis 2011)).
188. Id. (citing CLARK COUNTY, NEV., CODE § 2.12.80(a) (2007)).
189. Id. (citing CLARK COUNTY, NEV., CODE § 2.12.80(c) (2007)).
190. Id. (citing CLARK COUNTY, NEV., CODE § 2.12.80(e) (2007)).
191. Id. (citing CLARK COUNTY, NEV., CODE § 2.12.80(f) (2007)).
192. Id. at 716–17 (citing CLARK COUNTY, NEV., CODE § 2.12.80(h)–(i)(2) (2007)).
193. Id. at 717 (quoting CLARK COUNTY, NEV., CODE § 2.12.80(i) (2007)).
individual jurors may ask the witnesses questions.\textsuperscript{194} Police officers involved usually voluntarily answer questions from the district attorney’s prosecutor and testify to what brought about the death.\textsuperscript{195} Once all of the witnesses and officers have testified and been questioned, the jury deliberates and determines whether the death was criminal, excusable, or justifiable under the law.\textsuperscript{196} A majority vote of four-to-three, not unanimous as in South Carolina, is required for a verdict.\textsuperscript{197} Almost all coroner’s inquest juries in Clark County deliberate for less than an hour.\textsuperscript{198}

Clark County coroner’s inquests were almost certain to return a justified or not guilty verdict.\textsuperscript{199} This trend became a pressing issue after a surge of officer-involved shootings in 2006.\textsuperscript{200} The American Civil Liberties Union (ACLU), National Association for the Advancement of Colored People (NAACP), and many concerned citizens began speaking out about the inquests’ one-sided nature and demanded reform.\textsuperscript{201} The main criticism alleged that the current system allowed Clark County police officers a forum to offer an unchallenged “police version” of the death.\textsuperscript{202}

In September 2006, the Clark County Commission created a panel comprised of the Clark County district attorney’s office, the Clark County police department, the NAACP, and the ACLU to work together to reform and implement recommended changes to the coroner’s inquest process.\textsuperscript{203} Although the Commission created the reform panel, the commissioners retained the final say regarding what changes would be put in place.\textsuperscript{204} The ACLU had three main changes it wanted to see in the system, including to: “(1) replace prosecutors from the Clark County district attorney’s office with lawyers from the Nevada attorney general’s office as the main questioners of police during the hearings; (2) require randomly selected justices of the peace to act as hearing masters instead of lawyers from the community; and (3) allow family members and friends of those shot, or their counsel, to question the LVMPD officers during

\textsuperscript{194} Id. (quoting CLARK COUNTY, NEV., CODE § 2.12.80(j)(2) (2007)).
\textsuperscript{196} Id. (citing CLARK COUNTY, NEV., CODE § 2.12.140 (1979)).
\textsuperscript{197} Id. (citing CLARK COUNTY, NEV., CODE § 2.12.140 (1979)).
\textsuperscript{198} Id.
\textsuperscript{199} See id.
\textsuperscript{200} See id. (providing a summary of the police-involved shootings).
the hearings.”205 The ACLU stated that the third suggestion, to allow family members of the deceased to question officers, was “non-negotiable” and that without it the coroner’s inquest system should be scrapped completely.206 However, the ACLU met great opposition from the Las Vegas Police Protective Association (LVPPA) stating that it could “provide fodder for civil lawsuits.”207 Despite the progress on the first two reform points, the negotiations and the panel’s progress came to an abrupt halt when Clark County published a letter with an inaccurate report of the panel’s progress, causing the ACLU to cease working with the panel on reforming the coroner’s inquest process.208

On November 20, 2007, the Clark County Commission expanded the pool of parties allowed to submit questions to the coroner for the inquest who then gives them to the prosecutor, required a qualified magistrate to act as presiding officer over the coroner’s inquest, and revised several definitions in the coroner’s inquest system.209 The ACLU criticized the changes, characterizing them as “completely meaningless.”210 An attorney who represented the family of an individual killed by the police said “Clark County would be better off getting rid of the inquest system than making the changes it made because the system is expensive and will continue to act as nothing more than a superficial means to clear police officers of wrongdoing.”211 However, the Clark County Commissioner and Sherriff have both expressed satisfaction with the reform, recognizing that neither side would be completely satisfied with the changes.212

Gayan also examines how Seattle, New York, Phoenix, and Los Angeles handle officer-involved shootings.213 In all of these cities, medical examiners immediately turn over the investigation to district attorneys, prosecutors, or special response teams.214

For Clark County, Gayan suggests reforming the coroner’s inquest system in order to create a system similar to the traditional courtroom format where both sides have zealous representation from adversarial parties to ascertain the

208. Id. (citing David Kihara, Inquest Reform Questioned, LAS VEGAS REV. J., Jan. 4, 2007).
209. Id. at 718–19.
210. Id. at 719 (citing Lisa Kim Bach, ACLU Chief Slams Rules, LAS VEGAS REV. J., Nov. 21, 2007, at 1B).
211. Id. (citing Bach, supra note 210, at 1B).
212. Id. (citing Bach, supra note 210, at 1B).
213. Id. (citing Bach, supra note 210, at 1B).
214. Id. at 719–20 (citing Bach, supra note 210, at 1B).
Gayan suggests that having a justice of the peace—an objective figure the public trusts—as the inquest master is the first step to creating that format. Additionally, Gayan argues that it is vital that the Clark County district attorney’s office not participate in the coroner’s inquests, especially not in a prosecutorial role. The nature of the district attorney’s work requires a substantial amount of interaction with the police, the party at the center of the inquest and the party that the inquests’ must determine whether they acted within the confines of the law and their authority. Gayan also mirrors the ACLU’s suggestion in stating that the families of the deceased should be able to question the officers while in the jury’s presence, “to give the proceedings at least an appearance of an adversarial nature and to provide the jury with the necessary information to come to a well-informed verdict.” Some of the dangers in the ACLU’s proposed reform are that, “officers face questions from two parties—prosecutors from the attorney general’s office and attorneys representing the decedent’s family—and must fend for themselves without counsel. Such a system could completely turn the tables from a biased system in the LVMPD’s favor to a system stacked against the LVMPD from the start.” Ultimately, Gayan advocates for a system where the police officers and family of the deceased are allowed representation from the state’s attorney general’s office.

V. HOW SOUTH CAROLINA SHOULD REFORM ITS CORONER’S INQUEST PROCESS

First, there should be some guidelines set regarding when a coroner’s inquest is necessary. By statute, a coroner must summon a jury if he decides the blame for the deceased is attributed to a living person. However, coroner’s inquests are often bypassed in the interest of efficiency for a variety of different reasons such as the fact that no person is present to attach blame to, no witnesses were present, or the killer is present and confesses. In these cases, the investigation is turned over to the prosecution and the coroner’s only responsibility is to perform an autopsy, issue the death certificate, and file his report. Missouri only utilizes coroner’s inquests in situations of self-defense or questions of legal justification in the death, although the statute does not limit

216. Id.
217. Id.
218. Id.
219. Id.
220. Id. at 720–21.
221. Id. at 721.
223. Interview with The Honorable Gary Watts, supra note 49; Interview with Joanna McDuffie, supra note 92.
the situations applicable to a coroner’s inquest. Clark County in Nevada limits coroner’s inquests by only holding coroner’s inquests for those who were killed by on-duty police officers. South Carolina should limit the instances where coroner’s inquests are necessary by statute or through an Attorney General opinion. The Nevada police officer limitation might be too narrow for South Carolina with its “stand your ground” laws. A practice similar to Missouri that would utilize coroner’s inquests for deaths related to self-defense or other questions of legal justification, including officer-involved shootings, would be an effective investigative tool to allow for more accuracy and transparency in the coroner’s inquest process, thus, leading to increased accuracy and transparency in the justice system overall.

Coroner’s inquests often save the prosecution from having to prepare and proceed with trials that are unnecessary or deaths that have a justifiable excuse. Further, the public nature of these inquests is an appropriate forum to view all evidence related to the death, especially with the media attention that officer-involved shootings and stand your ground laws garner. Holding a coroner’s inquest would allow the coroner—an independent party from the police, prosecution, and the accused—to show the public and a jury the evidence surrounding the death, as well as giving the coroner the ability to question witnesses and the accused.

The biggest reform needed in South Carolina’s coroner’s inquest system concerns the jury selection process. Currently, the coroner has complete discretion in selecting the jury for an inquest. The South Carolina General Assembly should enact safeguards to ensure that the coroner does not abuse his authority in selecting the jury for a coroner’s inquest. For example, coroners should have to use the same county juror pool and electronic means of selection used by the clerk of court to compile juries for civil and criminal cases to summon the initial pool of fourteen people for a coroner’s inquest.

The electronic database and service implemented in the traditional jury selection process is the appropriate random selection that should also be used for coroner’s inquests. Additionally, this will ensure that jurors may not be eligible for jury duty for three years after their service. These measures will make sure that the coroner’s jury cannot be repeatedly composed of the coroner’s friends or groups of people with political agendas or strong biases.

After the random panel of fourteen is summoned, the coroner should perform his version of a voir dire process. This would likely be similar to the

225. Swingle, supra note 29, at 81.
226. Gayan, supra note 173, at 716 (citing CLARK COUNTY, NEV., CODE § 2.12.050(1) (2007)).
227. Interview with The Honorable Gary Watts, supra note 49; Interview with Joanna McDuffie, supra note 92.
228. S.C. CODE ANN. § 17-7-90, -100 (2014).
229. Id. § 14-7-140 (1976 & Supp. 2014).
230. Id. § 14-7-850.
judge’s screening and questioning of jurors with the only difference being that the coroner would administer the screening in an attempt to find six truly indifferent jurors. The primary difference between this and the traditional voir dire process in a criminal trial would be that counsel, if any, for the witnesses, accused, or an independent official acting as a prosecutor would not be able to object or strike any jurors. From there, the coroner would then select a jury of six. This would still leave the coroner some discretion in selecting the jury, but also implement some safeguards for the public and the accused from having the coroner choose an agenda-driven jury, time and time again.

To guarantee that coroner’s inquests are an investigative tool and not a judicial proceeding, it is critical that the coroner be a completely independent body throughout the inquest. Currently, if the coroner cannot perform or hold the inquest, the magistrate should fill in. Due to the nature of a magistrate’s working relationship with police officers and solicitors, the chief deputy coroner or deputy coroner should be the appropriate substitute to hold the inquest if the coroner is not available.

The fact that a coroner’s inquest verdict is not binding on the solicitor adds to the transparency and independence of the proceedings. A coroner’s inquest allows the public to view the evidence and listen to witnesses’ accounts of the death. However, if the solicitor disagrees with a verdict from an inquest it is their duty and responsibility to bring or drop charges against those who are or are not criminally culpable in the death. This independence confirms that inquests do not become judicial proceedings, but also ensures that coroner’s inquests do not infringe on a solicitors’ duty to pursue justice via prosecution as they see fit.

Because inquests are merely preliminary investigations and not full trials or judicial proceedings, the accused and witnesses are not constitutionally afforded the right to counsel. This means that public defenders need not be appointed to the accused for inquest purposes. However, if witnesses or the accused choose to procure counsel, South Carolina should stand by the Griffin decision and not allow counsel to be entitled any rights beyond a public citizen. Thus, counsel should be allowed to be present at the inquest, but may not sit next to their client while on the stand or at counsel’s table. Likewise, counsel has no right to participate in the inquest.

VI. CONCLUSION

Ultimately, the coroner files a report on his preliminary investigation of the death, whether or not there was an inquest. Coroner’s inquests are tools from the English law and older times where the justice system was not as complex and

231. Id. § 14-7-1020.
232. Id. § 14-7-1030.
233. Id. § 17-7-20 (2014).
fragmented as it is today.\textsuperscript{236} Further, the fact that the coroner’s inquest jury verdict or the opinion of the coroner himself is not binding on the solicitor tends to shine much doubt on the existence of the system.\textsuperscript{237} Many states have moved away from coroners explicitly by statute and now utilize medical examiners that play little to no part in the investigation.\textsuperscript{238} However, if utilized properly, a coroner’s inquest can be an effective tool to aid the South Carolina criminal justice system. To be effective and within constitutional bounds, coroner’s inquests must be public hearings, operated independently of solicitors and police officers, designed to showcase the facts of the events leading to the death, and initiated in furtherance of procuring the truth. The coroner’s independence from attorneys will help maintain the integrity of these inquests as strictly executive investigations. Otherwise, the inquests would be judicial hearings performed by executive officers, which strip the accused of many of their judicial rights.

\textsuperscript{236} See supra note 10.
\textsuperscript{237} See supra note 85.
\textsuperscript{238} MD. CODE ANN., HEALTH-GEN. § 5-305(a)(2)(i) (LexisNexis 2009); VA. CODE ANN. § 32.1-277 (Supp. 2014); W. VA. CODE ANN. § 61-12-3(a) (LexisNexis 2014).