

**THE LAW REFORM COMMISSION
OF HONG KONG**

**REPORT ON CORONERS
(TOPIC 14)**

We, the following members of the Law Reform Commission of Hong Kong, present our report on Coroners.

The Honourable Michael Thomas CMG QC
(Attorney General)

The Honourable Sir Denys Roberts KBE
(Chief Justice)

Mr J J O'Grady JP
(Law Draftsman)

Mr Robert Allcock

Mr Graham Cheng JP

The Honourable Mr Justice Fuad

The Honourable HU Fa-kuang OBE JP

Dr the Honourable Henrietta Ip OBE JP

Mr Simon S O Ip JP

The Honourable Mr Martin Lee QC JP

Miss Christine Loh

Mr Maximilian Ma Yung-kit MBE

Mr Brian McElney JP

Dr Byron S J Weng

Mr Peter Willoughby JP

THE LAW REFORM COMMISSION OF HONG KONG

REPORT ON CORONERS

CONTENTS

<i>Chapter</i>	<i>Page</i>
Introduction	
Terms of reference	
Appointment of sub-committee	
Method of working	
Acknowledgements	
1. The role of the coroner	
Historical development in England	
Development in Hong Kong	
The importance of the office of coroner	
Our perception of the role of the coroner	
Annual reports by coroners	
2. The duty to report to the coroner	
Present position	
The Police	
Death in official custody	
Members of the public	
Registrars	
The medical profession	
The position in England	
The need for reform	
Deaths which must be reported	
Uncertain cause of death	
Accidents and crimes	
Operations and anaesthetics	
Industrial disease	
Still births	
Maternal deaths	

Septicaemia	
Suicide	
Deaths in official custody	
Deaths in nursing homes	
Deaths in other premises offering care for reward	
Executions and homicides	
Drugs and poisons, ill-treatment, starvation and neglect	
Dead body brought into Hong Kong	
Death of psychiatric patient	
Impact of these proposals	
The persons responsible for reporting	
Doctors	
Government departments	
Members of the public	
Registrar	
Government officials receiving statutory notice of deaths	
Police	
Diagram of duty to report	
Time for reporting	
Sanctions	
The decision to hold an inquest	

3. Investigation into the circumstances of a death

Current procedure	
The need for reform	
The coroner	
The process of investigation	
Death enquiry police constables	
Death certificates	
The post mortem report	
The coroner's officer	
Medical records	
Previous recommendations	
The process of investigation	
The coroner's officer	
Post mortem reports	
Our conclusions	
Death certificates	
Delay and inefficiency	
A new approach to investigations	
Coroner's officers	
Coroner's powers : search and seizure	
Other powers of the coroner	
(a) Post mortems	
(b) General powers of the coroner	

4. The inquest – civil liability

The present position

 The object of an inquest

 The right to question

 The protection of witnesses

Recommendations in England

 The Brodrick Report

 Other commentaries

Our recommendations

 Interested persons

 Questions relating to civil liability

5. The inquest – criminal responsibility

Present position

Need for reform

 Criminal liability : Homicide Cases

 The Brodrick Committee's Proposals : Homicide Cases

 Criminal liability : Non-homicide Cases

Our recommendations

6. The inquest – general matters

Procedure

Recording of evidence

 Present position

 The reason for depositions

 Need for reform

 Our recommendations

The verdict

 Our recommendations

Riders

The Jury

Deaths outside the jurisdiction

Evidence and contempt of court

“Inquest” and “Inquiry”

Witness summonses

Costs

Right of persons to address the court

Immunity of coroners from civil action

7. Review of inquests and the role of the Attorney General

The present law

 The position in England

 Previous recommendations

Our proposals

8. Summary

Summary of defects in present system

Summary of recommendations

 Annual report

 The duty to report to the coroner

 Death certificates

 Investigation into the circumstances of a death

 The inquest – civil liability

 The inquest – criminal responsibility

 The inquest – general matters

 Review of inquests

9. Minority report

Annexures

1. Commentators on the working paper
2. Still-birth statistics
3. Sample statistics on man-hours spent per death report
4. General powers of the coroner under the Magistrates Ordinance
5. Statistics Government laboratory post-mortem reports
6. Inquest statistics
7. Verdicts
8. Diagrammatic outline of the Commission's proposals

Introduction

Terms of Reference

1. On April 9 1984 the Chief Justice and the Attorney General referred to the Law Reform Commission for consideration the following questions:

- (1) Whether any changes are desirable in the existing duty to report a death to a coroner and in current practices of investigation into the circumstances of such a death.
- (2) With a view to enhancing the powers of the coroner whether any changes are desirable in the law and practice relating to the investigatory role of the coroner and the function of the coroner's office relating to a death.
- (3) Whether any changes are desirable in the law and practice relating to the holding of, and procedure at, an inquest, with particular reference to the recording of evidence, the requirement of a coroner's court to name persons to be charged with criminal offences arising from a death and the extent to which interested parties at an inquest should be permitted to pursue questions relating to civil liability.
- (4) Whether any changes are desirable in the power of the Attorney General under the Coroners Ordinance to order the holding or re-opening of an inquest.
- (5) Whether the conduct of an inquest should be subject to judicial review.

Appointment of sub-committee

2. A sub-committee was appointed under the chairmanship of Dr. Henrietta Ip, OBE, JP, a member of the commission, to consider these questions. The other members of the sub-committee were: -

Mr. Robert Allcock	Senior Crown Counsel, Attorney General's Chambers and Member, Law Reform Commission; formerly Head of Department of Law, University of Hong Kong
--------------------	--

Dr. Frederick Ong, OBE	Consultant Forensic Pathologist
Mr. J. R. Johnston, QPM, CPM	Regional Commander, Hong Kong Island Regional Police Headquarters
Mr. John W. Hansen	Assistant Registrar, Supreme Court former Coroner
Miss Peggy Chan Jong-yee	Field Instructor, Social Work Department, University of Hong Kong
Ms. Patricia Tse	Senior Court Reporter, South China Morning Post
Mr. Stuart Cotsen (Secretary)	Assistant Principal Crown Counsel, Attorney General's Chambers

(Mr J. R. Johnston, QPM, CPM succeeded Mr. C.A.J. Sheppard, MBE, CPM who retired from the sub-committee in December 1984).

Method of working

3. The sub-committee met on 38 occasions and consulted various interested individuals and organisations. In October 1985 it published a Working Paper setting out its provisional views and inviting comment. A list of the persons and organisations who were sent a copy of the Working Paper is shown at Annexure 1. Over 150 written responses were received. The sub-committee made a number of revisions to its provisional views as a result of these responses and in October 1986 submitted its report to the Commission. The subject was considered by the Commission at its 48th, 49th, 50th, 51st and 52nd meetings.

Acknowledgements

4. We wish to record our gratitude to all those individuals and organisations who have assisted the sub-committee and the Commission in its deliberations. The Commission is particularly indebted to the members of the sub-committee who gave unstintingly of their time and energy for more than two years. We wish also to express our gratitude to the secretary of the sub-committee, Mr. Stuart Cotsen, upon whom fell the main burden of drafting this report.

Chapter 1

The role of the coroner

1.1 We deal first with the role that the coroner plays in present day Hong Kong. Although a coroner is a judicial officer, he functions in a way which is quite different from other types of judges. Instead of adopting a neutral position whilst an adversarial battle takes place before him, a coroner takes an active role in investigating the matter before him. In this respect, he is closer to the civil law concept of an examining magistrate than to the common law concept of the judge. To understand this phenomenon it is necessary to look briefly at the historical evolution of the coroner.

Historical development in England

1.2 The office of coroner in Hong Kong is based on that which developed in England. As with many English legal institutions, the office of coroner developed over many centuries and saw many changes. The source for the following information is the Report of the Committee on Death Certification and Coroners (1971; Cmnd. 4810), known as the Brodrick Report.

1.3 The office of coroner can be traced back to the 9th Century and is one of the oldest offices known to English law. In medieval times, the judicial system was concerned mainly with raising revenue for the Crown by way of fining individuals and taxing whole towns held responsible for the crimes of their citizens. The coroner's judicial function at this time was almost non-existent. He was concerned primarily with protecting the King's financial interests as keeper of the King's Pleas. It was not until the late 13th Century that an attempt was made to extend the coroner's duties beyond this. For the first time, the holding of inquests into deaths was included. Coroners nevertheless continued to act as judges in criminal cases and often conducted jury trials in ordinary civil pleas.

1.4 Most coroners' inquests were held on homicides, but from the earliest times, a coroner was also expected to make enquiries when death was sudden or unexpected, when a body was found in the open and the cause of death was unknown and when a death occurred in prison. Anyone who found the body of a person whose death was thought to be sudden or unnatural was obliged to raise a "hue and cry" and to notify the coroner. Great importance was attached to the coroner's view of the body and it was the responsibility of the neighbourhood or township in which it was found to see that it was not interfered with before the coroner's arrival. Failure to

summon the coroner or intentional removal or burial of a body could lead to a penalty being imposed on the local community.

1.5 As inquests were always held with juries who were familiar with the area in which the body was found and often with the circumstances surrounding the death, jurors also acted as witnesses at the coroner's proceedings. Jurors usually attended the scene and viewed the body with the coroner to see if there was any evidence of wounding and to decide whether the death had occurred where the body was discovered.

1.6 One of the coroner's duties was to ensure the arrest of anyone indicted at the inquest for committing or of aiding and abetting homicide. It was also the coroner's duty to make a record of his proceedings and of all relevant facts.

1.7 By the end of the 15th Century, the severing of the link between local communities and the central law courts (an important reason for the original creation of the office of coroner) seriously affected the position of the coroner. Other officials emerged who took over most of the functions of coroner relating to financial matters and the raising of revenue. The coroner was eventually left with only one primary function – the holding of inquests into violent death but, with the importance of the coroner so eroded, even this was not carried out efficiently.

1.8 An increase in homicides led Parliament in 1487 to pass an Act providing for the coroner to receive a fee for early inquest held "upon the view of the body slain". In 1751, the fee was increased and the standing of the coroner enhanced. Problems nevertheless arose as to the jurisdiction of coroners.

1.9 In 1836, steps were taken to improve the machinery for recording information concerning deaths. The Births and Deaths Registration Acts required the registration of all deaths in England and Wales and imposed duties in this respect on coroners and other persons connected with the death. Also in 1836, an Act was passed giving the coroner power to order a doctor to attend an inquest and perform an autopsy if the cause of death could not be established. Additional medical witnesses could be called upon if required by the inquest jury. Provision was made for witness expenses to be paid and, later, for all reasonable expenses of inquests to be reimbursed.

1.10 In 1860, the County Coroners Act was passed providing for the payment of a salary to coroners rather than a fee. In the same year, a parliamentary report recommended that the coroner's jurisdiction to hold inquests should include every case of violent or unnatural death, sudden death where the cause was unknown and any death where, though the death was apparently natural, reasonable suspicion of criminality existed. These recommendations were implemented in the Coroners Act 1887. The 1887 Act made it clear that the coroner was no longer concerned with protecting the Crown's financial interests, but that his chief function was to investigate both

the cause of and circumstances surrounding the death for the benefit of the community as a whole. The Act provided: -

“Where a coroner is informed that the dead body of a person is lying within his jurisdiction, and there is reasonable cause to suspect that such person has died either a violent or an unnatural death, or has died in prison, or in such place or under such circumstances as to require an inquest in pursuance of any Act, the coroner, whether the cause of death arose in his jurisdiction or not, shall, as soon as practicable, issue his warrant for summoning not less than twelve nor more than twenty-three good and lawful men to appear before him at a specified time and place, there to inquire as jurors touching the death of such person as aforesaid.”

The Act did not, however, make any provision for the reporting of deaths to the coroner.

1.11 By 1901, coroners were being notified of about 60,000 deaths a year – a figure representing about 10 per cent of all deaths in England and Wales at that time. But in almost a third of these cases, no inquests were held. As the coroner had no authority to order an autopsy unless he also held an inquest, these deaths were registered without further medical investigation. Figures published by the Registrar General in the previous year show that in about 7,500 of the cases in which coroners declined to hold an inquest the deaths were eventually registered as “uncertified”.

1.12 1910 saw the first acknowledgement that a coroner might exercise investigatory functions which stopped short of an inquest. The Select Committee on Coroners recommended that “in every case in which a medical certificate is not given, the death ought to be reported to the coroner. It does not follow that the coroner would hold an inquest but he ought to be informed of every uncertified death for the purpose of making enquiry”. They also recommended that a coroner “should, without holding an inquest, have power to order and pay for a post mortem in cases of sudden death where the cause is unknown and there is no reason to suspect that the death is unnatural or violent”. Soon after coroners were able to notify the General Register Office on special forms of their intention not to hold inquests, there was a consequential increase in the number of deaths reported which were disposed of without an inquest.

1.3 With the increased competence of the police in investigating and prosecuting homicides came a corresponding reduction in the interest of the coroner in such investigations. The Coroners (Amendment) Act 1926 attributed to the coroner greater responsibility for accurate certification of the medical cause of death. Among other things the Act empowered coroners to order an autopsy without having to proceed to an inquest in cases where death was due to natural causes; imposed an obligation on a coroner to adjourn the inquest where someone had been charged with murder, manslaughter or infanticide of the deceased; provided that future coroners

should have medical or legal qualifications with not less than 5 years standing in their profession; enabled a coroner to sit without a jury in cases of suicides and most kinds of non-traffic accidents; and provided the Lord Chancellor with power to make rules governing the procedure in coroners' courts and concerning autopsy examinations.

1.14 In 1935, a Departmental Committee under Lord Wright inquired into the law and practice relating to coroners. The Committee's report indicated a change of emphasis from the 1910 Committee which was mainly concerned with enhancing the inquest as a means of obtaining information about crimes. The Wright Committee was clearly more concerned about the damage caused to persons' reputations as a result of coroner's inquests. The Committee recommended: -

- (1) that the number of coroners should be reduced;
- (2) that only barristers or solicitors should be appointed;
- (3) that the duty of the coroner's jury to determine whether any person was guilty of murder, manslaughter or infanticide, and the duty of the coroner to commit a person thus named for trial, should be abolished;
- (4) that coroners should be required to adjourn their inquest if requested to do so by a chief officer of police on the grounds that he was considering whether to proceed for an indictable offence in respect of the death; and
- (5) that in cases of suicide, the verdict of felo de se should be abolished, press reports should be restricted and no enquiry should be made into the state of mind of the deceased except in order to throw light on the question whether he took his own life.

1.15 No action was taken to implement these recommendations for a long time. Eventually, by the Criminal Law Act 1977, the duty of a coroner's jury to determine whether any person was guilty of murder, manslaughter or infanticide and to commit that person for trial was abolished. The Coroners Act 1980 among other things abolished the requirement for a coroner holding an inquest to view the body and empowered the coroner to order exhumation of bodies, and in 1984 a revised set of Rules came into force.

Development in Hong Kong

1.16 When the English common law was introduced in Hong Kong in 1841, the office of coroner became one of the institutions of Hong Kong's legal system. In 1888, however, legislation was passed to abolish the office. The Coroner's Abolition Ordinance was "an Ordinance to abolish the office of coroner, and to make provision for the performance of the duties thereof by magistrates". Section 4 of that Ordinance read: "The duties hitherto

performed by the coroner shall be performed by magistrates or any one of them as the governor may direct who shall have, in relation to such duties, all the powers and privileges which a coroner had by law at the commencement of this Ordinance.”

1.17 The Coroner’s Abolition Ordinance remained in force until 1950 when the Magistrates (Coroners Powers) Ordinance was passed. From the 1950s until 1967, the Chief Magistrate at Central and South Kowloon Magistracy appointed a particular magistrate to carry out the duties of coroner in addition to his magisterial duties.

1.18 In 1967, the Coroners Ordinance (Cap.14) was enacted which provided for the Governor to appoint a coroner or coroners. As a result, from 1967 to 1971 there were two full-time coroners.

1.19 In 1971, the Coroners Ordinance was amended and section 3(1) provided:

“The Chief Justice may by warrant under his hand appoint a magistrate to be a coroner for the purpose of this Ordinance or any other law”.

From this amendment there evolved that creature – “the newly appointed North Kowloon Magistrate who was a 2-days-a-week coroner”.

1.20 Further changes were, however, recommended in 1980 by a working party set up by the Chief Justice and chaired by Mr. Justice Cons. As a result of these recommendations, the Coroners (Amendment) Ordinance was passed in July 1980. Its effect was to widen the class of persons eligible to become coroners, to recognise the office of coroner as a separate judicial office and to lead to the appointment of the present two full-time coroners.

1.21 The present Coroners Ordinance (Cap. 14) gives a coroner a discretionary power to inquire into the causes of and the circumstances connected with a death in the following circumstances : -

- (a) sudden death
- (b) accidental death
- (c) violent death
- (d) death in suspicious circumstances
- (e) where a dead body is found within Hong Kong
- (f) where a dead body is brought into Hong Kong

In each case, the inquiry may be conducted without a jury or with a jury of 3 persons.

1.22 A coroner is obliged to inquire into the cause of death in the following circumstances: -

- (a) within 24 hours of the execution of a person under a death sentence;
- (b) where a person dies in official custody;
- (c) when required to do so by the Attorney General.

In the case of (a) and (b) above, the inquiry must be held with a jury of 3 persons. In the case of (c), the jury is optional.

1.23 Administratively, the coroner is responsible for issuing orders for post mortem and waiving them, issuing burial or cremation orders, classifying deaths into various categories, controlling exhumations and granting permission for the removal of bodies out of Hong Kong. He should be consulted in cases of organ removal and transplantation if the original death was a coroner's case.

The importance of the office of coroner

1.24 The brief description of the historical development of the office of coroner in England and Hong Kong indicates that the office has had mixed fortunes in both jurisdictions. At times the office declined in importance and, in Hong Kong, it ceased to exist for over 60 years. Given that the role of the coroner is an unusual one within the common law system, it may be asked whether there is a need for this office in present day Hong Kong.

1.25 The Cons Committee considered that the primary functions of a coroner in Hong Kong are twofold. Firstly, he is to investigate the causes of unnatural or suspicious death. This will bring to his notice situations which commonly lead to industrial, domestic or other deaths, and by notification to the relevant authority further fatalities may be prevented. Secondly, by means of an inquest held in open court, he is to bring to the attention of the general public the facts and circumstances surrounding a particular death.

1.26 A coroner is in the unique position of being able to ensure a thorough and independent investigation into many types of death in order both to protect the public and to satisfy public interest.

1.27 Inquests are undoubtedly a useful check against practices which may lead to death but which do not in themselves amount to crime, for example, unsafe systems of work in factories and improper medical treatment.

“The mere possibility of a public enquiry is a strong deterrent to persons who may otherwise be tempted to exercise insufficient care. This aspect assumes greater importance here than it would perhaps in more mature societies where the majority of persons likely to be affected have access to well organised associations who employ full time legal staff ever watchful of their members' interests”. (Cons Report).

1.28 The view has been expressed that it is of extreme importance to establish accurate causes of death for the following reasons: -

- (a) Epidemiological and other medical research and the early recognition of new hazards to life such as toxic chemicals and industrial diseases depend very much on the cause of every death being determined.
- (b) Knowledge of the causes of deaths facilitates the better allocation of resources to combat and prevent diseases and to help the Pharmacy and Poisons Board decide whether to ban the sale of certain dangerous drugs.
- (c) Knowledge of the cause of a death is an essential step in any investigation where any person or organization is under suspicion.

1.29 Many abuses might never come to light if post mortems and subsequent inquests were not carried out, for example the unnecessary prescription of chloramphenicol, the unrestrained use of steroids, drugs and some antibiotics, and the performance of unnecessary or illegal surgical operations.

Our perception of the role of the coroner

1.30 We consider that the primary role of a coroner in Hong Kong is to investigate the causes of and circumstances surrounding sudden, accidental, unexpected or suspicious deaths where the cause of death is uncertain or the circumstances are such that it is in the public interest to conduct such an investigation.

1.31 We consider that the time has come to recognize that a coroner in Hong Kong performs an essential role: protecting the interests and safety of the individual. In many types of death, the public demand for a full, open and independent investigation can be satisfied only by a coroner with adequate manpower and resources at his disposal. This latter aspect will be considered later in this report. We believe that such an enquiry fulfills an important social need and enables interested persons to ascertain the true facts surrounding a death.

1.32 Once a coroner has completed his investigation and an inquest has been held, we can think of no person who is in a better position than he to make recommendations with a view to preventing the occurrence of similar deaths in future. We believe that he should continue to have power to make recommendations to prevent the recurrence of similar fatalities.

1.33 Although we do not believe that a coroner should exercise jurisdiction of a criminal nature more properly left to the criminal courts, there always remains a possibility that detection of a criminal offence might slip

through the police net but be subsequently caught during the course of a coroner's investigation or inquest into a death. With this in mind we consider that one of the objects of the coroner's investigation in future should continue to be to uncover cases of crime which would otherwise go undetected.

1.34 We are also aware and attach much importance to the fact that on occasions a thorough investigation has the effect of clearing innocent persons of unjustified suspicion whether this relates to crime or simply to error of judgement.

1.35 One of the effects of a full and open investigation into a death is the heightening of public awareness that conduct leading to a death will be open to scrutiny. Persons who would otherwise be tempted to exercise insufficient care may be deterred if it is generally known that such reckless conduct is likely to be revealed during the course of an investigation.

1.36 We must stress that in setting out our perception of the role of the coroner we are not suggesting that the present role should be changed: we are merely attempting to define the role as fully as possible to take into account the view expressed in the Cons Report and reflect the fact that the object of investigating a death will vary from case to case depending on the circumstances of the individual death.

1.37 In summary, the primary role of a coroner in Hong Kong is to investigate the causes of and circumstances surrounding any death which: -

- (a) is of uncertain cause;
- (b) is accidental;
- (c) is suspicious; or
- (d) requires investigation in the public interest

with a view to : -

- (a) enabling interested persons to ascertain the true facts surrounding a death;
- (b) making recommendations to prevent similar deaths;
- (c) clearing innocent persons of unjustified suspicion;
- (d) enabling early recognition of new hazards to life;
- (e) drawing official attention to preventable diseases causing death and to the misuse of drugs;
- (f) deterring persons who might otherwise be tempted to exercise insufficient care; and

(g) uncovering cases of crime that would otherwise go undetected.

1.38 **We believe that such a goal can be achieved only by a thorough, timely and independent investigation. We further believe that that goal can best be achieved in Hong Kong by a coroner who is provided with sufficient staff and resources to achieve this task.**

Annual reports by coroners

1.39 In our view, the work of the coroners is of such importance in Hong Kong that there should be regular reports by him of the matters that come to his attention. In this way attention can be drawn, for example, to those areas where unnecessary deaths are occurring, to disturbing patterns which are emerging and to preventive measures that could be taken. **We recommend that coroners should publish an annual report giving a breakdown of the cases reported to them and highlighting significant developments.**

Chapter 2

The duty to report to the coroner

Present position

2.1 Although the coroner is expressly bound to inquire into the causes of and circumstances connected with certain deaths (para. 1.22 above), there are few provisions setting out how the death is to be brought to his notice.

2.2 The circumstances in which a report to the coroner might be expected to be made include certain types of deaths which come to the notice of police, doctors, hospitals, registrars and members of the public, and deaths which occur in official custody.

The Police

2.3 In the majority of cases, the initial report of a death comes from the police whose duty to report deaths not due to natural causes is set out in Police General Orders Chapter 38-08. Surprisingly, there is no provision in the General Orders actually requiring the police to notify the coroner of the death of a person in police custody.

Death in official custody

2.4 Official custody (referred to in paragraph 1.22 above) is defined under section 2 of the Coroners Ordinance and means detention: -

- (a) in the custody of a police officer, or officer of the Correctional Services Department;
- (b) in the custody of an officer of the Independent Commission Against Corruption or other officer having statutory powers of arrest or detention;
- (c) in any reformatory school or remand home under the management, control or administration of the Director of Social Welfare in consequence of any detention or committal order.
- (d) in any place of refuge under section 35(1)(a) of the Protection of Women and Juveniles Ordinance; or

- (e) in a mental hospital under Part IV of the Mental Health Ordinance.

2.5 The Correctional Services Department is responsible for prisons, detention centres, refugee camps, training centres and treatment centres. Rule 104 of the Prison Rules (Cap.234) provides as follows: -

“Upon the death of a prisoner, the superintendent shall give immediate notice thereof to the coroner, the Commissioner of Police and where practical, to the nearest relative of the deceased”.

2.6 There is no legislative provision requiring the Independent Commission Against Corruption to notify the coroner in the event of a death whilst in its custody nor is there any such provision in ICAC Standing Orders. However, one would assume that, in practice, the police would be called and the matter reported to them at the earliest possible opportunity.

2.7 Similarly, the Social Welfare Department is not subject to any requirement to make a report to the coroner in the event of a death in a reformatory school or remand home. The procedure adopted is to report to the police.

Members of the public

2.8 The only statutory duty upon the general public to report a death is to be found in section 14 of the Births and Deaths Registration Ordinance (Cap. 174). This provides that where a person dies in a house, the nearest relatives, or each person present at the death, or every occupier of such house shall report the facts to the registrar within 24 hours. Where the death does not occur in a house, the duty falls on any relative or finder of the body to report to the officer in charge of the nearest police station within 24 hours.

2.9 Although there is no statutory provision requiring members of the public to report a death to the coroner, a duty exists at common law to report a death to the coroner where a body is found in circumstances which may require an inquest (R. v. Clerk 1702 1 SALK 37). This would include industrial deaths and deaths occurring in suspicious circumstances.

2.10 Provision is made in the Civil Aviation (Births, Deaths, and Missing Persons) Ordinance (Cap. 173) in relation to aircraft registered in Hong Kong, and whether the incident occurs within Hong Kong or not. Records sent to the Director of Civil Aviation are transmitted to the Registrar of Births and Deaths. There is no requirement to report to the coroner.

2.11 Provision is also made in the Merchant Shipping Ordinance (Cap. 281). Section 21 provides for a ship's master to make reports to the Director of Marine. But, unlike the Director of Civil Aviation, the Director of

Marine is not required to transmit such reports to the Registrar of Births and Deaths, nor is he under any duty to report to the coroner.

Registrars

2.12 Section 21 of the Births and Deaths Registration Ordinance (Cap. 174) merely requires a registrar “to institute or cause to be instituted inquiries with a view to ascertaining the true cause of death” where that person has not been attended during his last illness by a doctor. The nature and extent of the inquiry is not specified. A duty to report to the coroner in the event of the death being found to be suspicious is not imposed and few cases, if any, are actually reported to the coroner.

2.13 An office memorandum has been distributed to registrars to the effect that the following cases should be referred to the coroner before effecting death registration: -

- (a) where the deceased was not attended during his last illness by a medical practitioner; or
- (b) where the cause of death on the medical certificate is too vague; or
- (c) where there is reason to believe that the death was unnatural or caused by violence, neglect or abortion or was attended by suspicious circumstances; or
- (d) where the death appears to be the result of industrial disease or poison.

In England, unlike Hong Kong, the registrar’s duty to report a death to the coroner is statutory.

The medical profession

2.14 Section 5 of the Coroners Ordinance provides: -

“Whenever a dead body is brought to a hospital, the medical officer in charge of the hospital or such other Government medical officer or registered medical practitioner as he may depute shall make a preliminary external examination of the body and report in writing to the coroner, who may, if he considers it necessary, order a post-mortem examination”.

Apart from the Prison Rules (para. 2.5 above) this is the only statutory provision requiring a death to be reported to the coroner. Even section 7, which relates to executions and deaths in official custody and requires the coroner to inquire into the death within 24 hours, makes no provision for the

death to be notified to the coroner. Despite the common belief that the death of a patient within 24 hours after an operation or admission to hospital must be reported to the coroner, no such rule in fact exists. The test adopted is whether the cause of death is unknown or suspicious. It has, however, been an informal practice for some time to report such deaths to the coroner.

2.15 In 1960, the Medical and Health Department circulated a memorandum amongst medical superintendents indicating that in certain circumstances deaths are to be reported to the coroner. This remains current. There are no other official guidelines governing members of the medical profession and, as a result, doctors, it has been suggested, may not be sufficiently clear as to whether or not a case should be reported to the coroner.

2.16 Advice given to medical practitioners by the Medical Protection Society states that a death should be reported under the following circumstances: -

- (a) All deaths which are sudden or unexpected and where the doctor cannot certify the real as opposed to the terminal cause of death or where the doctor has not attended in the last illness and within 14 days of death.
- (b) Abortions – other than natural;
- (c) Accidents and injuries of any date if in any way contributing to the cause of death;
- (d) Anaesthetic and operations, i.e. deaths whilst under the influence of anaesthetic, and deaths following operations for injuries, or where the operation, however necessary or skilfully performed, may have precipitated or expedited death;
- (e) Crime or suspected crime;
- (f) Drugs – therapeutic or addiction;
- (g) Ill-treatment – starvation or neglect
- (h) Industrial disease arising out of the deceased's employment, e.g. pneumoconiosis, Weils' disease, all diseases covered by the Health and Safety at Work Act 1974;
- (i) Infant deaths, if in any way obscure;
- (j) Pensioners receiving disability pensions where death may be connected with a pensionable disability;
- (k) Persons in legal custody – in prison, borstal institutions, or detention centres;

- (l) Poisoning from any source;
- (m) Septicaemia, if originating from an injury; and
- (n) Still births, where there may be the possibility of the child having been born alive or where there is suspicion.

The position in England

2.17 In England registrars are governed by the Registration of Births, Deaths and Marriages Regulations 1968. Regulation 51 provides: -

“(1) Where a registrar is informed of the death of any person before the expiration of 12 months from the date of the death, he shall report the death to the coroner on a form provided by the Registrar General if the death is one -

- (a) in respect of which the deceased was not attended during his last illness by a medical practitioner; or*
- (b) in respect of which the registrar has been unable to obtain a duly completed certificate of cause of death; or*
- (c) in respect of which it appears to the registrar, from the particulars contained in such a certificate or otherwise, that the deceased was seen by the certifying medical practitioner neither after death nor within 14 days before death; or*
- (d) the cause of which appears to be unknown; or*
- (e) which the registrar has reason to believe is unnatural or caused by violence or neglect, or by abortion or attended by suspicious circumstances; or*
- (f) which appears to the registrar to have occurred during an operation or before recovery from the effect of an anaesthetic; or*
- (g) which appears to the registrar from the contents of any medical certificate to have been due to industrial disease or industrial poisoning.*

(2) Where the registrar has reason to believe, in respect of any death of which he is informed or in respect of which a certificate of cause of death has been delivered to him, that the circumstances of the death were such that it is the duty of some

person or authority other than himself to report the death to the coroner, he shall satisfy himself that it has been reported.

(3) The registrar shall not register any death which he has himself reported to the coroner, or which to his knowledge it is the duty of any other person or authority to report to the coroner, until he has received a coroner's certificate or a notification that the coroner does not intend to hold an inquest."

2.18 These obligations are supplemented by the Registrar General's current instruction to registrars in England which extends the obligation to report: -

- (a) still births, if the registrar has reason to believe the child was born alive;
- (b) any form of poisoning (in addition to industrial poisoning);
- (c) where the medical certificate gives rise to doubt.

2.19 The Brodrick Report recommended additional statutory duties to report to the coroner deaths of persons who are deprived of their liberty. It recommended that there should be a statutory obligation upon the officer in charge of the police station to report a death to the coroner if a person dies in police custody and that a similar duty should be imposed upon the person in administrative charge of a hospital where the death of a compulsorily detained psychiatric patient occurs.

2.20 The Committee gave consideration to defects in legislation designed to ensure that a body would be disposed of only with the authority of the registrar or coroner and only when the medical cause of death had been firmly established.

2.21 There was no legislation in England requiring the certifying medical practitioner to see the body before issuing a certificate nor was there any provision as to the type or extent of any external examination after death and before signing the certificate. As a result, it was possible for a certificate to be issued in the name of a person still alive and even more possible for signs of injury or poisoning to escape notice. Although there was legislation requiring the certifying doctor to be in attendance during the last illness and within 14 days of the death, the word "attendance" was not defined. The cumulative effect of these omissions was to enable a situation to arise where a living person could be named on a death certificate, a death due to trauma or overdose could escape notice or a real possibility could arise that the diagnosis of the cause of death might be inaccurate.

2.22 The Committee recommended: -

- (a) Only fully registered medical practitioners should be allowed to certify the cause of death of hospital patients.

[The intention was ensure that only the more experienced hospital doctors would be charged with the responsibility of certification of death. Such a procedure might, however, result in delay in issuing the certificate.]

- (b) No doctor should be qualified to sign a certificate unless he had attended the deceased person at least once during the seven days preceding death.

[This would increase the accuracy of diagnosis.]

- (c) The certifying doctor should inspect the body of the deceased person prior to issuing any certificate.

- (d) A certificate as to the fact and cause of death should be issued only if: -

- (i) The doctor was confident on reasonable grounds that he could certify the medical cause of death with accuracy and precision.

- (ii) There were no grounds for supposing that the death was due to or contributed to by any employment followed at any time by the deceased, any drug, medicine or poison, or any violent or unnatural cause.

- (iii) He had no reason to believe that the death occurred during an operation or prior to complete recovery from an anaesthetic or arising out of any incident during an anaesthetic.

- (iv) The causes or circumstances did not make the death one which the law required to be reported to the coroner.

- (v) He knew of no reason why in the public interest any further inquiry should be made into the death.

If he was not satisfied on these five points, the doctor would have to report the death to the coroner as soon as possible. The report would in the first instance be made orally, followed as soon as possible by a written report on a new form of certificate, and would include such matters as:

- (1) the National Health Service number of the deceased;
- (2) any major morbid conditions present which had not caused or contributed to death;

- (3) information about surgical operations performed within three months of death, and information of serious accidents occurring within twelve months of the death.

2.23 These recommendations were not implemented, but we have nevertheless found them useful and relevant to Hong Kong.

The need for reform

2.24 The absence of a duty to report which clearly defines the categories of deaths to be reported and the procedure for doing so can seriously impede a coroner's performance of his duties. This is so for two obvious reasons: -

- (a) A coroner cannot assume jurisdiction over a death of which he has no knowledge and the performance of his duty in relation to such a death is thereby frustrated.
- (b) Time is of the essence in any investigation. This is particularly so in coroner's cases where there is a real danger of interference, deliberate or accidental, with exhibits, records and witnesses. The sooner the investigation begins, the more productive it is likely to be and the earlier it will be completed. The sooner inquiries can be completed, the less will be the inconvenience and distress caused to the relatives of the deceased.

2.25 Confusion exists as to what deaths need to be reported and by whom. This results in cases which should be the subject of investigation by the coroner not being reported to him. The number of deaths not reported will of course never be known. The figures for those actually reported in recent years and the outcome of those cases are at Annexures 6 and 7.

2.26 We believe that doctors are often subjected to pressure from relatives of the deceased not to report a case to the coroner and, as a result, may be tempted to issue death certificates when an inquiry might otherwise be desirable. Coroners are also frequently approached by relatives who are anxious to avoid a post mortem being held. **We suggest that certain categories of death should be listed on the back of the death certificate so as to remind doctors of the need to report such cases to the coroner.** Members of the medical profession who constantly face bereaved relatives are undoubtedly subjected to varying degrees of pressure not to make a report. The cumulative effect of such pressure and the absence of a clear category of reportable deaths is the possibility that a death which should be reported is not reported.

2.27 **It is our view that there is a need for a statutory duty to report certain types of deaths to the coroner.** We turn to consider the

categories of deaths which should be reported and the persons who should be made subject to a duty to report.

Death which must be reported

2.28 We take as our starting point our view of the role of the coroner which we set out in Chapter 1. Given the function we believe the coroner ought to perform, it follows that certain types of deaths ought to be reported to him so that he may carry out his investigation. We wish to emphasize, however, that in the vast majority of the cases which we recommend should be reported, there will be no inquest. In most cases, a short and fairly routine investigation will furnish the coroner with all the facts he needs. We say this at this stage to allay fears that our recommendations, if implemented, would lead to an impossible number of inquests or post mortems.

Uncertain cause of death

2.29 **Where a doctor is not confident that he can certify the direct medical cause of death the case must, we believe, be reported to the coroner.** We had initially considered that doctors should report deaths whenever they could not determine both the antecedent and terminal causes of death with accuracy. However, in the light of the submissions received on this proposal, we have reconsidered the matter. We recognise, in particular, that it is often not possible to determine antecedent causes of death with accuracy and it is not our intention to remove from doctors the element of professional judgment which they must have in the proper exercise of their professional duties. Accordingly we have omitted any reference to accuracy and antecedent causes of death in our proposal.

2.30 We have considered whether there should be a duty to report cases where the deceased has not been attended during his last illness by a medical practitioner. We believe that in such circumstances there exists a sufficient element of uncertainty and risk of error in attempting to certify accurately the cause of death to justify the coroner being informed. **We propose that in future any death where the deceased did not consult the certifying medical practitioner in relation to the illness giving rise to the death, or did not consult him within 14 days prior to the death, should be reported to the coroner.** Although we had originally recommended a period of 7 days we have been persuaded by the majority of respondents who favoured 14 days.

Accidents and crimes

2.31 Since we have emphasized the preventive role of the coroner, **deaths which are known or suspected to be due to accident or crime are obvious cases which must be reported.** An investigation into the causes, for example, of a bus crash could lead to recommendations which would avoid further accidents from similar causes. The coroner may also be able to

draw attention to circumstances surrounding a crime which will enable members of the public to protect themselves in future. We deal later with the question of the respective roles of the coroner and the police in relation to criminal investigations.

Operations and anaesthetics

2.32 We have already drawn attention to the practice of reporting deaths occurring after an operation or after the administering of an anaesthetic (paras. 2.14-2.16). There are good reasons for a coroner's investigation in such cases. If, as we believe is so in the vast majority of cases, the death was unavoidable, the investigation will dispel any suspicion of medical neglect. The investigation may also lead to findings which will result in improvements in surgical procedures and to the prevention of similar deaths in future. We note that the Brodrick Committee recommended that cases such as this should be reported to the coroner. **We concur with their recommendation and propose that, in future, the following deaths should be reported.**

- (a) **deaths where an anaesthetic may have precipitated or directly or indirectly contributed to the death, and deaths which occur during or within 24 hours following anaesthesia;**
- (b) **deaths where an operation may have precipitated or directly or indirectly contributed to the death, and deaths which occur within 7 days following an operation.**

Industrial disease

2.33 In any rapidly developing society, the scourge of industrial disease is ever present. We believe that fatalities from such diseases, many of which are avoidable, should be brought to the attention of the community. It follows that reports of such deaths should be made to the coroner for investigation. We have, however, been faced with difficulties in considering how to formulate such a duty.

2.34 In the United Kingdom, the Health and Safety at Work Act 1974 established two independent bodies, the Health and Safety Commission and the Health and Safety Executive, which are responsible for conditions and safety at work.

2.35 In Hong Kong, there are no such bodies but there is, within the Labour Department, a factory inspectorate with an establishment of some 200 personnel responsible for health and safety in industry. We are satisfied that the fact that they are not independent from Government does not in any way detract from their effectiveness but they have an enormous task and are undoubtedly short-handed. In addition to the factory inspectorate, there

exists an Occupational Health Division within the Labour Department which concerns itself exclusively with diseases at work, attempting to identify and prevent such hazards and to give advice to employers and employees. In relation to construction sites, we note that regulations will soon come into operation requiring construction companies employing more than 200 people to employ a safety officer. Nevertheless, we believe that there must be scope for improvement in the identification and prevention of occupational diseases and industrial accidents.

2.36 The Employees' Compensation Ordinance (Amendment of Second Schedule) Order 1973 sets out a list of occupational diseases in respect of which compensation is payable. We had at first thought that it would be convenient to impose a duty to report deaths arising from any of the diseases in the list. This would have enabled the situation to be independently monitored by the coroner. However, the list, which is clearly designed to assist in matters relating to compensation, is only marginally relevant when considering what diseases should be investigated following a death.

2.37 Thus, having begun with the belief that an exhaustive list of reportable industrial diseases could be compiled, we were very quickly persuaded that, in practice, this would not be possible. Not only is the variety of existing industrial diseases enormous but, from what we are told, it is ever increasing. We were also confronted by the fact that diagnosis of industrial diseases is uncertain and notoriously inaccurate. Other countries have apparently not achieved any real success in this area either.

2.38 We were told that even in the case of pneumoconiosis, a sufferer is very likely to die from some other disease such as bronchopneumonia. In addition, the difficulty of establishing accurate case histories, possibly spanning many years of differing occupations, is considerable. But the more we were told of the difficulties in diagnosing industrial diseases, the more we became convinced that such deaths fall squarely within the ambit of our perception of the duty of the coroner to investigate death with a view to enabling early recognition of new hazards to life and drawing official attention to preventable diseases causing death.

2.39 We have noted the observation in "Coronership" by Thurston:-

"Death due to any industrial disease or poisoning must be referred to the coroner. Pneumoconiosis is an example but Government pamphlets listing the prescribed diseases should be consulted. The association of mesothelioma with exposure to asbestos should be borne in mind."

and the Instructions of the Medical Protection Society in England that a report should be made of: -

“Industrial disease arising out of the deceased’s employment, e.g. pneumoconiosis, Weil’s disease, all diseases covered by the Health and Safety at Work Act 1974”.

2.40 The Labour Department has power to investigate cases of occupational disease, to obtain and analyse samples of any type of suspected matter and, where appropriate, to order the closure of factories and supervision of work. We can think of no good reason why the Labour Department and the coroner cannot complement each other’s work in this field. Certainly, the fact that the Labour Department is carrying out an investigation should not preclude the coroner from conducting his own investigation.

2.41 We accept that it may not be possible to provide an exhaustive list of industrial diseases, and we acknowledge that in any given case, death might result from any number of causes. **Nevertheless we do not see why a duty should not be imposed to report deaths where there exists a reasonable suspicion that the deceased’s death might have been caused by or connected in some way with the conditions under which he worked. We accordingly recommend that such a duty be imposed with the rider that any doctor acting in good faith should have a defence to a charge of failing to report the death where he concludes that the disease from which the deceased suffered did not arise as a result of his occupation.**

Still births

2.42 When a human foetus reaches a certain stage of development but is not born alive, this is classified as a still birth. The relevant stage of development varies from country to country but is in Hong Kong 28 weeks. Even though the cause of still births remains generally unknown, the only investigation which is carried out into the cause of such deaths in Hong Kong is conducted by the attending physician. We understand that consideration is being given to the question of how statistics on peri-natal deaths (i.e. deaths occurring shortly after birth) might be improved and thereby a greater understanding of the subject developed.

2.43 Statistics available from the Medical and Health Department indicate the number of reports of still births made to the authorities (see Annexure 2). In the absence of a requirement to report such cases, it is impossible to assess the total number of still-births. There is a clear public interest in establishing the actual number of still-births each year.

2.44 We have considered the arguments for and against recommending that all still births be reported to the coroner. Arguments that may be raised against such a proposal are: -

- (a) Coroners are concerned with investigating deaths and in the case of a still birth, by definition, no death has occurred;
- (b) In the vast majority of cases, a doctor certifies that there was a still birth and it would be unnecessary and wrong to challenge such a finding;
- (c) If research is needed into such cases, this should be carried out by universities and not by the coroner.

2.45 The arguments in favour of the proposal are: -

- (a) Although there is technically no death occurring in the case of a still birth, a potential life has been extinguished;
- (b) In some cases, for example where a foetus or dead child is found in the street, there may be uncertainty as to whether this was a still birth or not, and the matter should properly be referred to the coroner for investigation;
- (c) Even where the case is clearly a still birth, the causes should be investigated, with a view to preventing similar cases. This in no way calls into question the validity of the doctor's certification;
- (d) Research into the causes of deaths or, by analogy, of still births is a legitimate role of the coroner;
- (e) A report to the coroner would enable an independent decision to be made as to whether a post mortem should be carried out and its results monitored. It would also enable the case history of the mother to be studied and inquiries to be made of any person under whose care the mother was during pregnancy.

2.46 Having considered these arguments we originally felt that there should be a duty to report all still births to the coroner. However most respondents were strongly against such a proposal. They agreed that

- (a) The example we have given in paragraph 2.45(b) above would inevitably be reported to the coroner under our proposed list of reportable deaths without the necessity of making still birth a separate category of reportable death.
- (b) The atmosphere and procedure of a court room are not conducive to the conduct of medical research which should more appropriately be dealt with elsewhere.
- (c) Coroners cases should be restricted to those where there are suspicious circumstances or there is evidence to suggest that the baby was born alive.

2.47 **We have been persuaded by the force of these arguments and consequently recommend that cases of suspected still birth be reported where -**

- (a) **there is uncertainty as to whether the baby was born alive or dead;**
- (b) **there is a suspicion that the foetus irrespective of its stage of development might have been born alive but for the willful act or neglect of any person.**

Maternal deaths

2.48 **Although maternal deaths, i.e. deaths occurring during or within one month of birth or abortion, are rare in Hong Kong and amount to no more than 10 each year, we do feel that a duty should be imposed to report such deaths to the coroner.** We believe that a special interest should be taken in individual cases to ensure that other expectant mothers are not subjected to unnecessary risk.

Septicaemia

2.49 Septicaemia, or blood poisoning, presents special difficulties. At present, if a cause of death is certified as septicaemia, registrars in Hong Kong are reluctant to accept the certificate and tend to refer the case to the coroner. This may be because septicaemia is sometimes associated with crime or neglect and may, for example, be caused by illegal abortion or by injection arising out of a criminal activity. However, septicaemia often occurs where there is natural disease. We believe that there is a need to distinguish the two different situations. Where septicaemia is merely a symptom of another medical disorder and not the primary cause of death, we believe that the doctor certifying the cause of death should not indicate septicaemia, but should state the primary cause. It would, in fact, be helpful if there were a note to this effect on all death certificates. Whether such a case has then to be reported to the coroner would depend on the cause of death specified. **Where the cause of septicaemia is unknown, we believe that there is a sufficient element of suspicion surrounding such cases in Hong Kong to warrant an investigation. We therefore recommend that such cases be reported to the coroner.**

Suicide

2.50 Apart from the obvious distress attaching to such deaths, practical considerations such as insurance and religious implications can have a profound effect upon the lives of the bereaved. **We feel that there should always be a presumption against suicide and that the responsibility for investigating cases of suspected suicide should rest with the coroner.**

We propose that a duty to make a report be imposed in respect of such cases.

Deaths in official custody

2.51 The coroner is under a statutory duty to investigate deaths which take place in official custody. It follows that such deaths ought to be reported to the coroner. At the present time, however, only the Correctional Services Department is under any statutory duty to make a report. **We recommend this duty be extended to cover all bodies in Hong Kong which have the power to deprive people of their liberty. This will include for example the Police, the Independent Commission Against Corruption, Social Welfare Department, Customs and Exercise Department, Urban Services Department, Immigration Department and Marine Department. The duty of such departments to report should extend to any case where a person dies whilst in the care or custody of that department.**

2.52 In addition, given the concern which may arise if a person dies whilst in premises occupied by such a department (e.g. within a police station), even though that person was not actually being detained at the time, **we consider that all deaths which occur in such premises should be reported.** Hospitals would be excluded from this category since deaths within such premises are covered by other proposals.

Deaths in nursing homes

2.53 Mindful of the community's responsibility towards those least able to care for themselves, we have considered whether some duty should be imposed in relation to the elderly in privately run nursing homes. There are at present 8 such homes operating in Hong Kong and 9 in Kowloon, each of which charges between \$2,500 and \$5,000 per month. Some are unregistered and, by virtue of the type of patients they care for, not surprisingly, account for a large proportion of the total number of deaths each year.

2.54 We are conscious of the fact that, in the vast majority of cases, patients are well looked after and receive adequate treatment in these homes. Nevertheless criticism, albeit in many cases unfounded, is frequently directed at the service provided in these establishments and the treatment received by patients. We feel that the coroner should have the opportunity to conduct a full investigation into deaths occurring there if he feels it necessary to do so in any particular case. In that way there would be better awareness of the activities of institutions whose doors are not always open for inspection. **We believe that the most satisfactory way of achieving this goal is to impose a duty on doctors to report such deaths.** However, we exclude from this recommendation deaths which occur in nursing homes and maternity homes registered under the Hospitals, Nursing Homes and

Maternity Homes Registration Ordinance (Cap. 165) because provision is made under the Ordinance enabling the Director of Medical and Health Services to inspect these premises and the records kept there.

2.55 We recommend that a duty to report be imposed in respect of deaths which occur in foster homes supervised by the Social Welfare Department.

Deaths in other premises offering care for reward

2.56 The arguments raised above in relation to nursing homes apply equally to other premises in which the care of persons is undertaken for reward, **and we recommend a duty to report deaths occurring in those premises.** In the case of hospitals, nursing homes and maternity homes registered under the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance, we are satisfied that there are adequate safeguards at present. In other cases, we believe that the coroner could provide a useful role in investigating deaths in such premises. We are aware that the category of premises we refer to is wide and includes child care centres and even hotels but it is again emphasized that in most cases no inquest will need to be held.

Executions and homicides

2.57 There are situations in which the killing of one person by another is not, or may not be, an offence and so would not fall into the category of crime referred to in paragraph 2.31 above. These include -

- (a) execution in accordance with a sentence of death;
- (b) killing in the course of preventing crime or arresting offenders;
- (c) self-defence;
- (d) defence of other persons.

We believe that all homicides should be reported to the coroner regardless of whether a crime has been committed. A coroner's investigation may serve several legitimate purposes. In the case of an execution, it will ensure that the extreme penalty was carried out according to law. In other cases, it will ensure that such killings are properly investigated in the absence of any criminal proceedings. This is often in the public interest. For example, where the police kill someone in the street, whether a suspected criminal or an innocent bystander, the coroner should investigate the circumstances in which the death occurred and, where necessary, should bring them to the attention of the relevant authorities. **We recommended that deaths from executions and homicides be reported.**

Drugs and poisons, ill-treatment, starvation and neglect

2.58 **Deaths due or suspected to be due to drugs or poisons should, we believe, be reported.** An investigation can reveal the circumstances surrounding the administration of the drugs or poison and can help to avoid similar deaths in the future. **Similar arguments apply to deaths due to ill-treatment, starvation or neglect.**

Dead body brought into Hong Kong

2.59 Where a dead body is brought into Hong Kong, the coroner is in the best position to carry out an immediate investigation into the cause of the death. **Such deaths ought therefore to be reported to the coroner.**

Dead of psychiatric patient

2.60 Persons suffering from psychiatric disorders are in a peculiarly vulnerable position. Experience in many countries has shown that they may be neglected or positively harmed, sometimes by those responsible for their care. This being so, **we recommend that the death of any psychiatric patient in a hospital and the death of any person admitted to a psychiatric ward or wing of any hospital should be reported.** This should be so regardless of whether the person was a voluntary or involuntary patient. We have framed our recommendation in a broad way in order that the duty to report should not be evaded by a mere technicality e.g. a patient admitted to a psychiatric ward had not been officially diagnosed as a psychiatric patient.

2.61 We have considered whether to include deaths occurring within a “half way house” in our list of reportable deaths. Given that amendments to the Mental Health Ordinance are being considered we feel that a decision on this point should be deferred until any such amendments have been made.

Impact of these proposals

2.62 We are conscious of the fact that our proposed list of reportable deaths is lengthy and that, as a result, an increased burden will be placed upon the coroner’s office. The extent of the increase is unlikely, however, to be as great as might at first glance appear. Most of the types of death on the list are already reported to the coroner as a matter of practice. Those which are not (paras. 2.41, 2.48, 2.52, 2.54, 2.55, 2.56 and 2.60) are unlikely to generate an excessive number of new cases. We are convinced, however, that a coroner should be informed that such deaths have occurred in order that he might decide what, if any, investigation is required. That is the purpose of the list. The nature and extent of any investigation and the question of whether or not an inquest is to be held is a matter for the coroner

to decide but, quite obviously, unless the death is reported to him such matters can never even be considered.

2.63 The expected increase in the number of deaths reported will, we believe, be well within the capacity of the coroners and the investigating teams we propose elsewhere in this report.

2.64 We believe that the coroner would be able to conclude many cases without resort to a post mortem or inquest and at a much earlier time than at present. This speeding up of the investigation would be in the best interests of all, particularly the relatives of the deceased.

The persons responsible for reporting

2.65 We now consider the persons who ought to be under a duty to report the deaths listed above. Our aim is to limit the duty to those who are concerned professionally with deaths and who should therefore have no difficulty in understanding the duty and in performing it as a matter of routine.

Doctors

2.66 Apart from the declaration on the form of death certificate that the certifying doctor “attended” the deceased during his last illness and disclosure therein of whether an anaesthetic was administered before death, a doctor is not required to provide any additional information nor make any report to the coroner as to the death.

2.67 Doctors employed by the Medical and Health Department have received guidance in the form of a memorandum as to the circumstances under which a report should be made to the coroner and police. This memorandum is current and has not been updated since it was issued in 1960. We do not consider that these guidelines are adequate to meet present needs nor do we regard it as satisfactory that there should be no obligation on doctors in general to report certain categories of death.

2.68 At present, a doctor is called in to certify the cause of death in all cases. As a matter of practice, he will report many types of deaths to the coroner (see paras. 2.14 – 2.16 above). In all the reportable cases listed above, the doctor who certifies the death is the obvious person who ought to report the death to the coroner. Such a report will ensure that the coroner can begin his examination at the earliest time after the death, and before relevant evidence disappears. We do not consider that the imposition of a duty to report these deaths will cause any difficulty for doctors and it will, in fact, give them an answer to any relatives who attempt to persuade them not to report a listed death. We have considered whether the duty to report should be imposed upon the Registrar rather than the doctor but are concerned that if this were the case the former might be seen to be exercising some sort of watch dog role over the medical profession. In our view this is

not desirable. Doctors are reporting cases now and should, we believe, continue to do so. **We therefore recommend that a doctor who certifies either the fact of death or the cause of death in respect of any reportable death should be under a statutory duty to report the death to the coroner.**

Government departments

2.69 The present statutory duty placed upon the Correctional Services Department to report a death which occurs within its official custody should, we believe, be extended to all Government departments. **We recommend that Government departments should be under a statutory duty to report any death occurring in “official custody” as explained in paragraph 2.51 above.** In order to ensure that there is no delay in investigating any criminal aspect of the death, **we recommend that these departments (with the exception of the police) should report to the police rather than the coroner.** As recommended in paragraph 2.75, the police would then notify the coroner. **In the case of deaths occurring whilst a person is in police custody or on police premises, the police should notify the coroner directly.**

Members of the public

2.70 We have considered whether any duty should be imposed upon the public in general to make a report to the coroner. The Brodrick Report observes (in para. 2.28) that the obligation to report a death to the registrar which devolves from the nearest relative of the deceased to any person knowing of the death is not widely known. We are inclined to agree that a new duty to report the finding of a dead body to the coroner would not increase the effectiveness of the existing provisions. In reality, the finder of a body is not likely to think of reporting to the coroner. He is more likely to call an ambulance or the police or perhaps summon a doctor. It is therefore sufficient, in our view, if an obligation to report is placed on the police or the doctor certifying the death.

2.71 No problems have been brought to our notice which need to be rectified by the imposition of a special duty. We agree with the view expressed by the Brodrick Committee that:

“Responsible-minded members of the public will act without the spur of the law; the evilly disposed will not, even if the law enjoins., it is sufficient if every member of the public should have the right which he has now to report a death to the coroner where he believes that the investigation of the causes or circumstances of the death might serve the public interest”.

We do not propose any amendment to the law in this respect.

Registrar

2.72 In England registrars are governed by the Registration of Births, Deaths and Marriages Regulations 1968. The relevant Regulation and supplementary instructions are set out in paragraphs 2.17 and 2.18 above.

2.73 Having considered the existing provisions in Hong Kong and England, we have come to the view that deaths are more likely to be reported to the coroner if the registrar is under a statutory duty similar to that in England. **We therefore recommend that where a registrar has reason to believe that a death is a reportable death (as explained above) he should be under a statutory duty to report it to the coroner.** In this way, the registrar will ensure that a report is made in those cases where other persons having a duty to report fail to do so.

Government officials receiving statutory notice of deaths

2.74 Legislation requires information concerning certain types of deaths to be notified to specified government officials. We refer in paragraphs 2.10 and 2.11 above to such requirements in respect of deaths occurring in aircraft or at sea. Such deaths fall within our list of reportable deaths and **we recommend that the relevant government officials be required to notify the coroner of them.** This should not, however, apply to the Registrar of Births and Deaths who will be subject to the general obligation recommended in para. 2.73.

Police

2.75 Many reportable deaths come to the notice of the police in the course of their professional duties and we believe there would be a clear advantage in requiring the police to notify the coroner of them. In this way, there will be greater certainty that a report is made. **We recommend that the police should have the duty to report to the coroner all reportable deaths that come to their notice.**

2.76 In order to ensure that the report is made at the earliest possible moment, **we recommend that the obligation to make the report should be imposed on the police officer who is first at the scene where the body is found.**

Diagram of duty to report

2.77 A diagram illustrating the way in which our proposals would operate is set out at Annexure 8.

Time for reporting

2.78 In order to ensure that the coroner is able to start his investigations at the earliest possible moment, **the report of the death should be made to him as soon as reasonably practicable.** That means, in almost all cases, as soon as the death occurs or the body is discovered.

Sanctions

2.79 We are convinced that the importance of a legal obligation to report a death can be reflected only by legal sanctions being imposed in the event of failure to comply with this obligation. We do not believe that our proposals would be satisfactorily enforceable in the absence of such sanctions. **We therefore recommend that where a person is under a duty to report and he has knowledge of the circumstances which render the death reportable, the failure by that person to make a report of the death as soon as reasonably practicable should be made an offence.**

2.80 Given that in some circumstances more than one person will be under a duty to report a particular death (e.g. a doctor and the registrar), **it should be sufficient to discharge each of these duties, we believe, if any one of these persons makes the report. We also think that it should be a defence to a charge of failing to report a death if the person honestly believes that the duty has been discharged by some other person or body.**

2.81 Fears have been expressed to us that the failure to report a death is not a matter for which criminal sanctions are appropriate. Such a failure may occur through inadvertence particularly where, for example, a doctor is extremely busy caring for other patients. We would point out, however, that there are similar offences to the one we propose e.g. failure to report a birth, and where there are extenuating circumstances we would expect these to be taken into account both when proceedings are contemplated and by the courts in imposing sentence.

The decision to hold an inquest

2.82 The reasoning behind our recommendations contained in this chapter regarding the reporting of certain deaths to the coroner is to ensure that a proper investigation of the surrounding circumstances is made in each case. It is the result of that investigation which will enable the coroner to decide whether or not an inquest should be held. We believe that the coroner should retain a discretion to order an inquest in the case of any reportable death, except executions and deaths in official custody. We have already set out the circumstances under which a coroner is obliged by section 7 of the Coroners Ordinance to hold an inquest. In our view the public interest in deaths occurring in official custody and deaths resulting from lawful execution of a death sentence requires a public inquiry into the circumstances.

We therefore recommend that the provisions requiring the holding of an inquest into such deaths should be retained.

Chapter 3

Investigation into the circumstances of a death

Current procedure

3.1 The first notification to the coroner of a death is made by the submission to him of the following forms by the police or the Government pathologist:

- (a) POL 44 containing a brief outline of the known facts.
- (b) POL 75 Post mortem external examination report and identification.
- (c) COR 6 Burial or cremation order for signature by coroner.
- (d) COR 13 Order for autopsy for signature by coroner.
- (e) COR 21 Order for waiver of autopsy for signature by coroner.
- (f) Application for cremation where applicable.
- (g) Application to Waive Autopsy signed by relative and pathologist.

Upon receipt of these documents they are signed, where appropriate, by the coroner and returned to the mortuary. The following day, a copy of the COR 13 or COR 21 together with a copy of the POL 44 and form MD 44 "return of dead bodies received" is sent by the mortuary back to the coroner.

3.2 In practice, the coroner generally makes an order in accordance with the recommendation of the pathologist and will decide from the initial report whether to request a death report. It is apparently not unusual for three to four days to have elapsed before any formal notification reaches the coroner.

3.3 If a death report is requested, the matter is referred back to the police for investigation and preparation of the report. Some police stations have a Death Enquiry Police Constable (DEPC) who is responsible, under the supervision of a police inspector, for investigation of the death. Many police stations do not have a D.E.P.C. and the necessary inquiries are made personally by the assistant sub-divisional inspector. Upon completion of the investigation, a recommendation as to whether an inquest should be held is made by the divisional superintendent who then endorses the file with his recommendation.

3.4 The report together with any post mortem report, toxicology reports, statements and other relevant material will then be considered by the coroner's officer who considers whether any further inquiries are necessary

before passing the papers to the coroner with his recommendation. The coroner will then decide whether to hold an inquest.

3.5 The coroner's officer is invariably a police officer of inspectorate rank on attachment to the coroner's office whose duties are to assist the coroner generally and undertake responsibility for any additional investigation he may order. From time to time, as a result of public interest in a case or because of its complexity, a Crown Counsel from the Attorney General's Chambers may be appointed to supervise the investigation and act as coroner's officer in the request.

The need for reform

The coroner

3.6 Our perception of the role of the coroner has already been set out in paras. 1.30 – 1.36 above. The task the coroner has to perform is a demanding one and it is essential that people of the right calibre are attracted to the post and are content to remain there. At present, a candidate applying for appointment as coroner is required to be a solicitor or barrister of at least 10 years' standing and at least 35 years of age. There are two full-time coroners with a salary of \$33,000 per month i.e. at a level of DJL1 on the Civil Service scale of salaries.

3.7 In England, some coroners have dual qualifications in law and medicine but persons with such qualifications are few and far between and, in reality, it is unlikely that such persons could be found for appointment to the office in Hong Kong. The Cons Committee which reported in January 1980 noted "the legal qualification is the more important since the sifting and evaluation of evidence is a vital part of a coroner's duty, while for medical matters he has easy recourse to expert advice. As a matter of routine, he receives now the daily assistance of the Institute of Pathology and the Forensic Pathologists of the Medical and Health Department. In a few years' time, he will probably be able to turn as well to the Departments of Pathology of both the Hong Kong and Chinese Universities".

3.8 We will return to the question of the coroner's status and salary later in this chapter after we have considered whether extra responsibility should be given to the coroner.

The process of investigation

3.9 It follows from what we have said concerning the role of the coroner that an immediate investigation of a death is essential if the coroner is to carry out his function effectively. At present, the process from first report to receipt by the coroner of the death report can take anything from two to three months and on occasions even longer. Both the delay and the standard of investigation have been the subject of criticism.

3.10 The first report frequently takes several days to reach the coroner, contains only a scant outline of the death, and is not sufficient for the coroner to determine whether, for example, exhibits should be immediately seized. In one case where death occurred in a hospital as a result of an incorrect blood transfusion, the delay between death and the ordering of an inquest was such that the disposal of various important items such as incorrectly labelled bottles could not be prevented.

3.11 Another defect in the present system is that a coroner has no power to order the seizure of relevant exhibits or documents and is completely reliant on a proper investigation being conducted by the police. Further investigation following submission of the death report is frequently impossible as witnesses disappear, exhibits are disposed of and the scene of the death has so changed that expert opinion is valueless.

3.12 A report prepared by Mr. John Hansen in 1981 when he was a coroner in Hong Kong highlights some of the problems:-

“One could list a litany of poor investigations. However, a few examples should suffice to make my point.....

A recent file was received where a woman fell to her death while fleeing from robbers armed with beef knives. The divisional superintendent advised the coroner that this was clearly a case of accidental death! The file was rapidly referred back with a reference to the law on the subject and a suggestion that Legal Department should be consulted. During the time I have been coroner there have been many cases referred to the coroner as accidental death where there has clearly been a strong suggestion of homicide. Without exception these have resulted in open verdicts. There is a strong possibility that any proper investigation of these deaths by trained personnel with appropriate expert assistance would have led to at least some of these being classified as homicides. It is of course impossible to speculate how many such cases have slipped through over the years but certainly some must have. No doubt, even at the moment, this could easily occur in a situation where a coroner must rely on others to do his investigations for him and where he has no direct control over those investigations. The comments I have just made apply to cases of possible homicide but they equally apply to other coroner’s cases. Cases involving consideration of medical treatment are clearly beyond the investigative powers of a D.E.P.C. and probably a number of inspectorate officers as well. Almost invariably such files take the longest to reach the coroner and almost as invariably they have to be sent back for further investigation and expert comment. The investigation of this class of case is hindered further by the coroner or his investigators not being given the power to immediately seize medical records and extract such

copies as his investigation requires. Already in one major inquiry alterations of medical records has been proved. The opportunity for such a practice exists and it must occur on some occasions.”

Death enquiry police constables

3.13 The D.E.P.C., if there is one, is invariably a junior and inexperienced police officer as is his supervising inspector. Generally, they already have a heavy workload and a death inquiry rarely takes priority. The D.E.P.C. serves only for a period of 6 months as a result of advice from the Independent Commission Against Corruption which considers that the post might be open to abuse if the appointment was to be full-time. There is little doubt that such frequent changes are disruptive to the coroner’s office and seriously hamper efficiency. There is little or no opportunity for the coroner to advise during the course of the investigation and the coroner’s officer, being a police officer close to retirement and with no prospect of promotion, lacks both incentive and enthusiasm.

Death certificates

3.14 As a death certificate cannot be issued until the cause of death is established, even in the simplest case, delay can cause considerable inconvenience and hardship to the family of the deceased. There is, apparently, no power or authority to issue a formal certificate that death has occurred where the cause of death has not yet been established. Such a certificate might go some way to ease the burden on the deceased’s relatives. We note that the Immigration Department has adopted the practice of issuing a document containing particulars of a deceased and which they refer to as “temporary certification of death”. We are unable, however, to find any legislative authority for the issue of such a document.

3.15 We note that the present form 18 (Medical Certificate of the Cause of Death) under the Births and Deaths Registration Ordinance (Cap. 174) enables the doctor to write the words “as I am informed” where he does “not feel justified in taking upon himself the responsibility of certifying the fact of death.”

The post mortem report

3.16 Following the post mortem examination and before the pathologist can complete his report and forward it to the Coroner, samples are initially sent to the Government laboratory for analysis. This is currently standard practice in order to ascertain whether drugs or poisons were involved in a death which occurs suddenly and without history.

3.17 It is here that delays frequently occur. An example brought to our attention showed a delay of some four months in producing the autopsy report due primarily to delay in the Government laboratory. This has been attributed to lack of manpower and facilities and considerable pressure of work.

3.18 Frequently, where a death occurs in hospital, the autopsy is conducted at the same hospital. Rule 4(c) of the Coroners Rules provides that: -

“If the deceased died in a hospital, the coroner should not order a pathologist on the staff of, or associated with, that hospital to make a post-mortem examination if -

- (i) that pathologist does not desire to make the examination; or*
- (ii) the conduct of any member of the hospital staff is likely to be called into question; or*
- (iii) any relative of the deceased asks the coroner that the examination be not made by such a pathologist, unless the obtaining of another pathologist with suitable qualifications and experience would cause the examination to be unduly delayed. “*

3.19 Problems may arise, however, when it is not known at such an early stage that conduct is likely to be called into question and the relatives of the deceased fail to make an early complaint. In theory the ideal solution would be to have all post mortems conducted independently of the hospital in which the deceased died. In practice, however, this might prove to be a formidable if not impossible task.

3.20 Rule 8(2) provides that, unless authorized by the coroner, the person making a post mortem examination shall not supply a copy of his report to any person other than the coroner and the Commissioner of Police. Where a death has occurred in hospital, difficulties have sometimes arisen because of doctors' reluctance and, in some cases, refusal to submit reports to the coroner until they see either the pathologist's report or information as to the cause of death. Coroners feel that the autopsy report is confidential and are sometimes reluctant to disclose it if there is concern that such disclosure might interfere with the investigation. In such circumstances, the coroner is powerless to order the submission of reports and relevant medical records.

3.21 In England, an agreed statement between the Coroners' Society and British Medical Association was published in 1962:

“The Coroners' Society has pointed out that most doctors are satisfied with a statement of the cause of death, as established at autopsy, and it has recommended that this information should be given to doctors over the telephone, or upon receipt of a stamped addressed envelope. However, the Society wishes to extend every help to those doctors who desire to see the

detailed autopsy findings, and it has recommended that where a carbon copy of the pathologist's report is available it should be sent to the notifying doctor, if he requests itIt is important that doctors wishing to avail themselves of this offer should make the necessary request when reporting the case to the coroner.

However, the Coroners' Society is not prepared to recommend that copies of the pathologist's report should be sent automatically to notifying doctors.....the report is a confidential communication from the pathologist to the coroner, and in certain cases its premature release might prejudice legal proceedings or even interfere with criminal investigations."

The coroner's officer

3.22 It has been suggested that the post of coroner's officer should be occupied by a civilian which would remove any temptation for the police to manipulate a coroner's officer who was in their disciplinary power. Some consider that it is inappropriate that the coroner's officer should be seen to be a policeman when death inquiries often specifically inquire into the conduct of other policemen.

3.23 Another criticism made is that the coroner's officer receives no special training before he takes up his appointment despite the fact that many investigations require a degree of expertise in the industrial and medical fields and in cases arising from fires, etc.

3.24 Since the primary function of the coroner is to establish the true cause of a death it is incumbent upon him to ensure that cases of unnatural or suspicious death are properly investigated. An improvement in salary and conditions of employment of coroner's officers may be one way of attracting candidates of sufficiently high calibre to ensure this function is properly carried out.

Medical records

3.25 Doctors have claimed that records of a patient are confidential and that they are not at liberty to disclose them to a coroner or the police for the purpose of an investigation into the death of the patient. In such circumstances, the coroner has no statutory authority to seize or obtain copies of records which might be highly relevant to the death or a decision as to whether to hold an inquest. He can only require their production at the inquest itself.

Previous recommendations

The process of investigation

3.26 In England, the Brodrick Committee considered that in order properly to perform his role, the coroner should have complete discretion as to the form which his enquiries should take after a death has been reported to him. The Committee recommended that the coroner have a statutory power to take possession of a body; to enter and inspect the place or area where the body was found, and any place from which the body was moved, and any place from which there are reasonable grounds to believe that the body was moved before it was found; and to enter and inspect the places or areas in which the deceased person was, or the places in which there is reason to believe the deceased person was, prior to his death. Additionally, the Committee recommended that the coroner should have the right to enter into any place, to inspect and receive information from any records or writings relating to the deceased and to reproduce and obtain copies of them; and to take possession of anything that he has reasonable grounds for believing is material for the purpose of his investigation; and thereafter to restore that thing to the person from whom it was taken, unless he is authorized or required by law to dispose of it in some other way.

3.27 The Hansen Report contains three main recommendations concerning the investigatory role of the coroner as follows: -

- (a) There be created a multi-disciplinary independent coroner's establishment to properly investigate sudden death. This would consist of forensic pathologists, forensic scientists and an investigation team and administrative and statistical staff under the coroner's direction.
- (b) As a matter of priority there be provided an efficient staff of field investigators to be attached to the coroner's office and under the direct control of the coroner.
- (c) The coroner be given specific statutory authority to investigate death within his jurisdiction and he and his staff be given authority to enter premises and seize records where necessary.

The report concludes that a complete re-drafting of the Coroners Ordinance and Rules is required in order to implement the recommendations which, the report suggests, should involve an upgrading of the post of coroner and a consequential increase in salary.

The coroner's officer

3.28 The Coroners' Society in England is of the view that the coroner's officer should be a member of the Police Force. A police officer is trained to exercise a degree of expertise in relation to an investigation which

could not be matched by an untrained civilian. He has, in addition, the resources of the Police Force at his disposal.

3.29 The Brodrick Committee, however, while acknowledging that such a man is trained to exercise initiative and has a close link with the Police Force, considered that there was a change of emphasis in coroner's work from crime to its wider medical and social functions.

3.30 The Hansen Report noted that in a number of cases which attracted considerable public interest, Crown Counsel had been appointed to act as coroner's officer at a very early stage. The Crown Counsel supervised the investigation and held numerous conferences with the coroner. At the subsequent inquests no difficulties were encountered as a result of poor investigation standards. Hansen recommended the permanent attachment of a Crown Counsel from the Attorney General's Chambers to the coroner's office in order properly to advise the police, co-ordinate inquiries and conduct the more complicated inquests attracting particular public interest.

Post mortem reports

3.31 The Brodrick Committee recommended that a coroner should be obliged to supply a copy of the post mortem report to the deceased person's family doctor on request. The supply of copies to other doctors and other persons who may ask for it should continue to be a matter for the coroner's discretion.

Our conclusions

Death certificates

3.32 We referred in paragraph 3.14 to the present position that a death certificate cannot be issued until the cause of death is established, and to the inconvenience and hardship that can result from the delay. We see no reason why a certificate of **the fact of death** should not be issued as soon as a doctor is able to say that death has occurred where the cause of death may take some time to be ascertained. **We therefore recommend that express legislative provision should be made for the issue of a certificate which, although not specifying the cause of death, would provide satisfactory and acceptable evidence of the fact of death. Such a certificate should be signed by any doctor who has viewed the body, even though he may be unable to certify the cause of death, and should be readily available to the next of kin.** We would not expect the certificate to be accepted for all purposes. While it would not be sufficient for the grant of probate, for example, we see that it would have practical advantages in initiating certain procedures such as emigration formalities.

3.33 In paragraph 3.15 we noted that a doctor can at present certify that death has occurred without himself having seen the body. We believe,

however, that a certificate of the fact of death should be issued only where the certifying doctor is himself certain that death has occurred. **We recommend that provision should be made to ensure that the certificate of the fact of death is signed only where the person certifying has personally viewed the body and is satisfied that death has occurred.**

3.34 It follows from our previous recommendation that **a certificate of the cause of death should be signed only where the person certifying the cause of death either has personally viewed the body and satisfied himself that death has occurred or has been presented with a certificate of the fact of death.**

Delay and inefficiency

3.35 The period most crucial to a coroner's investigation is the first few days. This is when evidence is to be collected and a decision made as to the direction in which the investigation is to proceed.

3.36 Under the present system, it is not until the third or fourth day following the death or discovery of the body that the coroner comes into the picture. This not only prevents a coroner from conducting an investigation at the scene but also means that the police have to guess whether or not it is likely that a full death report will be called for and conduct themselves accordingly. If no death report is ultimately called for, many police man-hours are wasted. The statistics which appear in Annexure 3 illustrate the number of man-hours involved per death report between January and June 1984. These figures, which are restricted to Hong Kong Island, do not include time spent on initial inquiries at the scene.

3.37 Lack of communication with the coroner's officer, the police and the pathologist accounts to some extent for delay and poor investigation, and we are satisfied that it is necessary to bring the coroner into the picture at a much earlier stage so that he can take positive action in an investigation.

3.38 At present, between the issue by the Coroner to the police of the instruction to report on the death and the submission of the death report, the coroner and his officers are not involved in the case and play no part in the investigation of the death. A recommendation as to whether to hold an inquest comes from the district police commander and the coroner has no power to call for a police file should he deem it necessary.

3.39 We also believe that the way in which police officers assist in coroners' investigations is not the best that can be devised. Currently in one year as many as 1,000 inspectors conduct death enquiries. There are also frequent changes of death enquiry police constables. The consequence is a lack of continuity and experience at the level where most of the early investigation is carried out.

3.40 In addition, many investigations are conducted by the police into deaths where crime is not suspected and this, we believe, is a factor which contributes to the delay. Police cannot be expected to attach the same priority and urgency to this type of investigation when investigation of crime is their primary concern.

A new approach to investigations

3.41 Merely to suppress the symptoms of an ailment will rarely provide a cure. We believe that the defects which have manifested themselves in the present system of investigating coroner's cases will not be rectified by limited procedural improvements. We believe that the failure of the existing investigatory process to achieve an adequate standard of efficiency is attributable to a fundamental root cause – the remoteness of the coroner from the investigatory process and the degree of dependence which he has upon others to investigate his cases.

3.42 The investigation of coroner's cases must, by definition, be the responsibility of the coroner. Investigation by judicial inquest is only one part of a much longer process which cannot be artificially divorced from the collection of the evidence preceding it. **We propose, therefore, that a coroner should assume responsibility for the investigation of his cases from the time they are reported to him.** In order to carry out this responsibility **coroners should have under their control a legally qualified chief coroner's officer and teams of investigators.**

3.43 The new coroner's office will have to be properly equipped to deal with its increased responsibilities. **The unit should be provided with access to the services and resources of other Government departments such as Forensic Pathology Service, Government Chemist, Labour Inspectors, etc. (and internal regulations of such departments should reflect the confidentiality attaching to coroner's investigations).** It should also be provided with such clerical and administrative support as may be required for it to discharge its duties satisfactorily.

3.44 We believe that officers under the direct control of the coroner who are properly equipped would quickly develop a high degree of expertise and efficiency. They would soon be able to investigate the more complicated coroner's cases in a fraction of the time spent at present. The advantages to the Police Force of such a system are that more officers would be made available for normal police duties and, as better use would be made of existing manpower, efficiency would increase correspondingly. By virtue of the nature of the work to be undertaken by **the unit** and its orientation towards judicial proceedings, it **should be centrally located and housed in the same premises as the coroner's court and, taking into account current requirements, it should ideally be located in Kowloon.**

3.45 These proposals will place additional responsibilities on the coroner, but we believe this to be essential if he is effectively to control the

investigation which he is required by law to carry out. The coroner already occupies an important position within the judicial system and this position will be enhanced if our recommendations are implemented. **The status and responsibility of the coroner would be at least as great as that of a district judge and we strongly recommend that this fact be reflected in the remuneration paid to the coroner. We recommend also that the posts of interpreters and judicial clerks in the coroner's office be upgraded in the light of their increased responsibilities and the complex nature of their work. In the case of interpreters, the necessity to keep up to date with the technical terms used in inquests is such that the unusually demanding nature of their work should properly be reflected in their salary. In the case of judicial clerks, their responsibilities for ensuring the smooth running of the coroner's office and the compiling of statistics in the light of our recommendations should also, we believe, be reflected in their salary.**

Coroner's officers

3.46 Those ideally suited for appointment as coroner's officers and best able to undertake investigation of this kind would undoubtedly be police officers. **We envisage that police officers of inspectorate rank and below will be recruited into properly structured teams of investigators under the control of a chief coroner's officer. These officers should be charged with the duty of investigating coroner's cases independently, free from outside interference and under the exclusive direction of the coroner.**

3.47 We have been impressed by the results of investigations where a Crown Counsel has acted as coroner's officer. We believe that a lawyer possesses the necessary expertise for assessing the evidential value of information obtained during the course of an investigation and would be best qualified to present the evidence properly and to conduct the inquest. As the coroner is himself a lawyer, a chief coroner's officer so qualified would be best able to work in harmony with the coroner in order that cases are properly prepared for hearing. He would, in addition, be independent from Police which is particularly important where the conduct of police officers is called into question during the course of an investigation into a death. By virtue of a requirement that he be answerable to the coroner alone there would also be sufficient independence from any Government department from which he may come. **We would suggest that a member of the Attorney General's Chambers of Senior Crown Counsel rank be appointed to the post of chief coroner's officer.**

3.48 We envisage that the coroner's officers would work on a roster basis so that during each 24 hour period, a minimum number are on duty to receive reports and attend the scene of any deaths which might occur. We do not imagine that any difficulty would arise in devising a system whereby the duty coroner's officer is notified of the finding of a body or report of a death by the police and is able to proceed immediately to the scene.

3.49 It is the duty of the police, and only the police, to investigate a death arising from crime. Where a crime is suspected, therefore, the coroner would not proceed with his investigation unless and until the police indicate that crime is no longer suspected. In the vast majority of cases, it becomes very quickly apparent that foul play is not suspected. Such cases would then become coroner's cases and the coroner's officer on the scene would commence initial inquiries.

3.50 We wish to stress the importance of the independence of the coroner as a member of the Judiciary. **In order to reinforce this independence and to avoid any conflict arising in the minds of his investigators, we propose that coroner's officers should be required to take an oath of confidentiality to the coroner.**

3.51 It is necessary now to give some indication of the size of the new coroner's office that we are recommending. Assuming that our recommendations as to the reporting of deaths are also implemented, we estimate that the number of coroners will have to be increased to four. Under these coroners there would be one chief coroner's officer and about 30 police officers. The police officers would work in teams of three, comprising an inspector and two junior police officers. In arriving at these numbers we have taken into account the fact that very many of the deaths reported are simple, straightforward cases where the investigation may involve nothing more than a perusal of medical records and a conversation with the next of kin.

Coroner's powers: search and seizure

3.52 In order that investigations should be effective, we propose that the coroner be provided with certain specific powers. Many of the powers which he already has as set out in the existing Coroners Ordinance and Rules are inadequate and in many cases irrelevant. Later in this chapter we examine the specific powers under the Ordinance and make recommendations for repeal or amendment in relation to each.

3.53 When considering whether coroners need additional powers we have reminded ourselves that legal powers should not lightly be conferred. A power conferred upon one person necessarily imposes a potential liability upon others. We have, however, taken into account the context and purpose of the coroner's investigation and, in particular, the following considerations-

- (a) a person has died in circumstances that require investigation;
- (b) the investigation is designed to establish, quickly and thoroughly, the true cause of the death;
- (c) in order to achieve this objective, a coroner must be able to obtain reliable evidence as soon as possible;

- (d) the coroner is an independent judicial officer;
- (e) he is seeking to protect -
 - (i) the interests of a person (the deceased) who is no longer in a position to protect himself; and
 - (ii) the public interest, which demands that avoidable deaths do not occur;
- (f) he has no ulterior motive for pursuing his investigation;
- (g) any delay or interference with the coroner's investigation is a denial of justice.

3.54 At this stage we wish to emphasize the absence of any power to enter premises for the purpose of an investigation into a death and of any power to seize exhibits and to collect evidence. The absence of such powers effectively prevents a coroner from immediately seizing important evidence at, for example, a construction site, as well as obtaining maintenance records of machinery, lifts and other equipment before they can be tampered with or lost. In one case arising out of a bus accident the bus company refused outright to supply the maintenance records of the vehicle concerned.

3.55 In the following paragraphs we draw attention to problems coroners have encountered in relation to the medical profession. It is perhaps inevitable that doctors feature prominently in any discussion of coroners' investigations, since most deaths occur in hospitals. The fact that many examples brought to our notice involve doctors merely reflects this fact and does not suggest that doctors are to be singled out for criticism.

3.56 In some cases the coroner may need to see the medical records of the deceased person. We noted in paragraph 3.25 above that some doctors claim that records of a patient are confidential and may not be disclosed to the police or to the coroner. As a matter of law, no privilege prevents information obtained by a doctor from his patient from being disclosed in legal proceedings. According to "Cross on Evidence" (6th ed. at p.405), judicial authority is uniformly against the existence of any such privilege. The question whether there ought to be a privilege has been considered by two law reform bodies in England. In 1967, the Law Reform Committee considered the matter in relation to civil proceedings (16th Report; Cmnd 3472) and advised against any change in the law. The Committee was of the view (at para. 50) that "there may be [situations] in which justice cannot be done without a doctor disclosing information which he has obtained in the course of the doctor-patient relationship". In 1972 the Criminal Law Revision Committee came to a similar conclusion in regard to criminal proceedings (11th Report; Cmnd 4991). We agree with these views and would add that, in any event, if a privilege were recognized it would be in order to protect the patient, not the doctor. Where the patient has died we

believe the interests of the deceased and the community can best be served by allowing the deceased's medical records to be examined by the coroner.

3.57 We are concerned to learn from the coroner that in recent years, where delay has arisen in coroner's investigations, the main cause has been the fact that medical reports have not been provided for the purpose of the investigation. Furthermore, we have been informed that on many occasions there has been outright refusal to supply records and reports to the coroner in the absence of a court order. In some cases a decision to hold an inquest has been made purely for the purpose of obtaining the missing evidence. We have been told of cases where not only have hospitals refused to supply medical records but records have been lost and even altered. In other cases privilege has been wrongly claimed to support the refusal to supply medical records. Reports have sometimes been delayed for many months in order to obtain advice from the medical defence organizations.

3.58 Although a coroner already has power to order production of patients' records, at present he has no statutory authority to obtain them until an inquest is opened. This may be many months after the death has occurred and prevents a coroner from considering the records for the purpose of deciding whether an inquest is, in fact, necessary. In many cases had a coroner had access to the records at an early stage an inquest could have been avoided. We are aware that doctors sometimes fear that suspicion is being cast upon them when a coroner calls for their records but we must say again that in the overwhelming majority of cases where doctors are criticised by the relatives of a deceased the doctor is cleared of all suspicion as a result of the ensuing coroner's investigation.

3.59 From the information supplied to us by the coroner, we are satisfied that substantial delay in investigation has very often been caused by the failure to provide the material required to enable him to carry out his function. We recommend below (para. 3.85) that a coroner should be empowered to order production of evidence at any stage of his investigation and not merely at the inquest. This power will no doubt be useful but will not be as effective as a power of search and seizure. We are conscious, however, that there may be objections to coroners' being given powers of search and seizure. The following arguments may be raised against such powers being conferred -

- (a) they would be an unacceptable extension of executive power;
- (b) they would be exercisable in cases where even the police have no such powers;
- (c) they could lead to medical records being taken away;
- (d) they could be abused; the immunity proposed in para. 6.46 might facilitate such abuse;
- (e) they are unnecessary given -

- (i) a power to order production of evidence;
- (ii) proper co-operation with the police;
- (iii) proper direction of doctors in Government hospitals.

3.60 The answers to these arguments are as follows -

- (a) the coroner is not a member of the executive but is an independent judicial officer: the powers could, in fact, be used **against** the executive, as where the coroner is investigating a death that occurred whilst a person was in police custody;
- (b) the comparison with the police is misguided since the police investigate crime and the coroner investigates deaths where a crime is not suspected; the circumstances in which the powers of the coroner are exercised are therefore bound to differ from those in which the powers of the police are exercised;
- (c) the minimum of disruption to the medical profession would occur if medical records were merely photocopied;
- (d) the fact that a power may be abused is not an argument for not conferring the power; in this case the powers would be exercisable by a small team of trained officers who are working directly under a judicial officer and who have no real motive to abuse their powers; the immunity proposed at para. 6.46 would be enjoyed only where the coroner acted within his jurisdiction, without malice, and with reasonable and probable cause;
- (e)
 - (i) an order to produce evidence would not prevent evidence disappearing or being tampered with;
 - (ii) if the police obtain relevant evidence they may not be entitled to pass it to the coroner;
 - (iii) it is doubtful whether directions given to doctors in Government hospitals would have the desired effect; moreover the problems are not limited to Government hospitals nor, indeed, to the medical profession.

3.61 Having given careful consideration to this matter, **our conclusion is that the coroner should be empowered to obtain relevant information, including photocopies of medical records. To this end he should be given a statutory power of search and seizure to enable him to look for and take away evidence (i.e. machinery and maintenance records) and, in the case of medical records, to obtain temporary possession of them for photocopying purposes.** A minority of the

Commission did not agree with this recommendation. Their minority report is to be found at Chapter 9.

3.62 We believe that such powers should be provided for any one or more of the following purposes: -

- (a) to search the place where the body was found at the time of the finding;
- (b) to search that place at some later stage;
- (c) to search some other place where evidence relevant to the death exists.

3.63 The sub-committee considered whether coroner's officers should be required to obtain a warrant from the coroner before seizing exhibits or photocopying records at the scene of a death. It was satisfied, however, that in many cases an investigation would be prejudiced as a result of the delay which this would cause. Important pieces of equipment, machinery parts or maintenance records could be essential to the investigation and might require immediate seizure. The sub-committee recommended that coroner's officers be given a general power to conduct a search in, and seize evidence from, the premises where a body is lying. In the case of medical records they should be given power to obtain possession of them for photocopying purposes.

3.64 We carefully considered the sub-committee's recommendation. We see the requirement to obtain a warrant in these circumstances as a necessary safeguard against misuse of these powers by a coroner's officer. Before issuing the warrant the coroner will have to be satisfied that the premises to be searched are likely to contain evidence relevant to the death. We do not think that obtaining a warrant from the coroner would need to cause more than a few minutes delay in the operation of searching for and seizing the relevant evidence. Nor do we think that such a small delay justifies dispensing with the requirement. **We therefore recommend that, while the coroner as a judicial officer should himself have a general power to search and seize, his officers should have the power only when specifically authorised by the coroner.** The coroner would thus himself be responsible for deciding whether in each case it was appropriate for the power to be exercised.

3.65 The sub-committee recommended that, **if these powers were to be exercised after removal of the body or in different premises, then coroner's officers should be required to obtain a warrant signed by the coroner. We agree with, and adopt, that recommendation for the same reasons that we gave for our previous recommendation.**

3.66 We considered whether the warrant should be sought from a magistrate rather than the coroner. Having no interest in the investigation, a magistrate might be seen to be deciding the merits of the application with

greater impartiality. We do not think however that that point carries much weight. The coroner is a judicial officer and as such is required, and can be expected, to exercise his judgment with the same degree of objectivity and fairness as he applies to his many other judicial functions as coroner. We believe it is widely understood that magistrates concern themselves only with criminal matters. A warrant issued by a magistrate is likely to be associated in the public's perception with a criminal investigation. In our view, the giving of an impression that a coroner's investigation was concerned with questions of criminality would be wholly undesirable. We have already stressed that in a death investigation time is of the essence. A delay of even a few hours may prejudice the investigation. In practice the coroner will always be more readily accessible to coroner's officers than would be a magistrate, especially outside court hours.

3.67 We note that powers of search and seizure can be authorised by police officers of superintendent rank and above for raids on gambling and vice establishments under the Gambling Ordinance and the Crimes Ordinance. We note further that a commission of inquiry appointed under the Commissions of Inquiry Ordinance (Cap. 86) is empowered to issue warrants for searching premises and seizing there anything of evidential value in the inquiry.

3.68 We considered whether the powers of search and seizure we have proposed would be necessary if it were made an offence to interfere with anything that might be required as evidence by the coroner. We believe that such an offence would be ineffective. It would be difficult to prove, for example, that incomplete records had been completed after the death had occurred or that a vital piece of equipment had been deliberately "lost". Furthermore the purpose of granting the power to search and seize is to enable the coroner to obtain the evidence at the earliest possible moment. The existence of this offence on its own could not achieve that purpose.

3.69 In the event of coroner's officers being prevented from performing their duties, they should be able to call for assistance from the police who would have a power of arrest. Section 23 of Summary Offences Ordinance (Cap. 228) provides: -

"Any person who resists or obstructs a public officer or other person lawfully engaged, authorized or employed in the performance of any public duty or any person lawfully assisting such public officer or person therein shall be liable to a fine of \$1,000 and to imprisonment for 6 months."

For the sake of clarity, **we recommend that a similar provision should be included in a new Coroners Ordinance creating an offence of obstructing a coroner or his officer in the execution of his duties.**

Other powers of the coroner

3.70 Section 15 of the Coroners Ordinance provides that a coroner has the same powers in all respects as a magistrate has under Part II of the Magistrates Ordinance. The vast majority of these are wholly inappropriate to the function of the coroner and are clearly designed for criminal prosecutions rather than a coroner's inquest. **We recommend that section 15 be repealed and that those powers set out in Part II of the Magistrates Ordinance that need to be exercised by a coroner be incorporated into an amended Coroners Ordinance.** Annexure 4 sets out our recommendations in this respect. We now turn to those provisions of the Coroners Ordinance and Rules which we consider require amendment or repeal.

(a) Post mortems

3.71 So far as post mortems are concerned, the relevant provisions are contained in sections 4 and 5 of the Coroners Ordinance, rules 4 and 5 of the Coroners Rules and the Places for Post Mortem Examination Order.

3.72 We consider, on the whole, that these provisions which enable the Governor to set apart suitable places for the conduct of post mortem examinations and which deal with certain procedural matters are satisfactory. Despite the recommendations of the Brodrick Committee (para. 3.31 above), we are not, however, satisfied that a post mortem report prepared for the benefit of the coroner and pursuant to his direction should, as a matter of course, be sent either to the deceased's family doctor or to the Commissioner of Police. We envisage that any interested persons who are anxious to obtain a copy of the report will be able to make appropriate application to the coroner under a proposed new pre-inquest procedure with which we shall deal in the next chapter. **We propose that the relevant part of section 5 which provides for the sending of a copy of the report to the Commissioner of Police should be repealed.**

3.73 We are satisfied that the prohibition against a post mortem being conducted by a pathologist on the staff of the hospital where the deceased died in the circumstances set out in rule 4(c) should remain.

3.74 We have noted the provision of rule 4(c)(iii) that any relative of the deceased may object to a post mortem being conducted by the hospital in which the deceased died, and feel that relatives should be made more clearly aware that they have this right. Generally speaking, the working of coroner's courts and the procedure following a death are, so far as the average member of the public is concerned, shrouded in mystery. We are concerned that the public should be made fully aware of the normal procedure following a death, the role of the coroner and the reason why deaths have to be reported to him as well as the rights which they are entitled to exercise. For this reason, **we recommend that a booklet should be prepared on the subject to be made readily available to the public and, in particular, to persons directly affected by a death.**

3.75 We are satisfied with the provisions of rule 5 but have been somewhat troubled at learning that the deceased's regular medical practitioner is not always informed of the date, hour and place at which the post mortem will be conducted. We believe that it is important that he should be so informed and hope that in future these provisions will be complied with.

3.76 We have already intimated our view that not all deaths are necessarily of concern to the Commissioner of Police and **we therefore recommend that rule 8 should be amended to delete the word "and Commissioner of Police"**.

3.77 We are satisfied that there should be a restriction in rule 9 upon the places in which post mortem examinations may take place and it follows that we are, therefore, satisfied with the provisions of the Places for Post Mortem Examination Order.

3.78 There has in recent years been a considerable drop in the rate of clinical post mortems from an average of around 23% of all bodies received at the Queen Mary Hospital Mortuary before 1981 to about 14% in 1983 and 1984. In terms of the actual number of autopsies, this represents a drop from around 700 per year to 400 per year. There has, however, been a rise in the number of coroner's cases during the same period, the post mortems in these cases being performed by the already over-stretched Government Pathology Institute. According to statistics available, more than two thirds of these are classified eventually as death by natural causes.

3.79 The University of Hong Kong has suggested the following examples of the types of coroners' cases where the post mortems could usefully be conducted by them: -

- (1) Patients with no known relatives to sign the consent form. The University suggest that the head of the institution to which the patient had been admitted, e.g. the medical superintendent of a hospital, could be authorized to sign the consent.
- (2) Patients admitted from old people's homes, especially if they fall under (1) as well. If there is no suspicion of "foul play", the University's autopsy records should be fully acceptable if the coroner wishes to be informed of the cause of death.
- (3) Still-births. The University has been performing post mortems on all still-births from Tsan Yuk Hospital and can see no reason why these should now be transferred to the coroner's team. Again, their findings could be made known to the coroner if so requested.
- (4) Patients admitted by ambulance as "police cases" after seeking the assistance of the emergency services, some of whom may die within 24 hours of admission. In many instances, there is a

suspected “natural cause” of death. Where there is no suspicion of “foul play”, it would seem unnecessary to classify these as “coroner’s cases”. Many of these patients will have suffered cerebral haemorrhage, myocardial infarcts, ruptured aneurysms, or advanced pulmonary disease.

- (5) Patients who have died from certain occupational diseases like silicosis or asbestosis (not industrial accidents) where all that is required is a confirmation that the patient succumbed to that disease.

3.80 **We believe that the existing pressure on forensic pathologists can be alleviated by the conducting of post mortems at the University of Hong Kong and the Chinese University.** We note that the former already plays a role, in appropriate cases, as independent consultant where a death occurs in a Government hospital and a coroner feels that independent advice should be sought. This has the added advantage of providing training for postgraduate junior pathologists who at present have limited opportunity to gain such experience.

3.81 We are extremely grateful to the Government Laboratory for the very useful information provided in their submission to us. We note that a laboratory report for coroner’s cases takes from 4 to 6 weeks but that the turn-around time can be very much longer and can range from 15 to 153 days in normal cases (Annexure 5). We understand that since these figures were obtained some improvement has been achieved. With a view to further reducing delay in making post mortem results available to the coroner, however, **we recommend that a review should be conducted of the staffing, equipment, practice and procedure adopted in the Government Laboratory to ascertain what further improvements could be effected.**

3.82 As to the ordering of a post mortem, we understand that as a matter of practice a post mortem will always be ordered if relatives are suspicious about the circumstances of the death and it is recommended by the pathologist. The procedure in the case of a normal non-suspicious death is that where a doctor is unable for any reason to sign the death certificate the coroner is notified and the deceased is examined by a pathologist. Where the pathologist is satisfied that the death was due to natural causes and the clinical examination bears out the history in the medical records he recommends to the coroner that a post mortem be waived. If the next of kin also wishes to apply for waiver of the post mortem he signs a form to this effect. This document together with the police report, medical records and pathologist’s recommendation are forwarded to the coroner who decides on the basis of the information available whether or not a post mortem should be held. We are told that a post mortem is always ordered where there is no next of kin or the next of kin declines to apply for waiver. **We recommend the retention of the present practice that a post mortem is not waived unless the pathologist agrees to the waiver and no objection to the waiver is received from the relatives of the deceased.**

(b) *General powers of the coroner*

3.83 Section 15 of the Coroners Ordinance provides that a Coroner shall have, in relation to the inquiries provided for in sections 6, 7 and 8, the same powers in all respects as a Magistrate has in Part II of the Magistrates Ordinance. We have already indicated that we regard this provision as highly unsatisfactory and, for the most part, of no practical use. We have listed in Annexure 4 the many provisions which we consider irrelevant and which we recommend should be repealed. Some require particular comment.

3.84 Section 11 of the Magistrates Ordinance which deals with the place and manner of a hearing is, we feel, adequately dealt with by rule 10 of the Coroners Rules and serves no useful purpose.

3.85 The provision as to witnesses as set out in section 21 of the Magistrates Ordinance should again be more properly included in a new revised Coroners Ordinance. Power to order production of documents and other things likely to be material evidence as set out in section 22 of the Magistrates Ordinance should similarly be included in a new revised Coroners Ordinance and can be consolidated with the power of a coroner to seize documents and exhibits. **We recommend that the power to order production should be varied so as to enable the coroner to obtain the document or other thing likely to be material evidence at any stage of his investigation and not merely at the inquest as at present.** The provisions in section 30 and section 32 (suitably adapted) relating to proof by declaration of service of process and of handwriting and to non-avoidance of summons or warrant in the event of the death of a magistrate should similarly be included in a new Coroners Ordinance.

Chapter 4

The inquest – civil liability

The present position

The object of an inquest

4.1 In Hong Kong, as in England, the purpose of a coroner's inquest is limited. Firstly, rule 30 of the Coroners Rules prevents a verdict being framed in such a way as to appear to determine any question of civil liability. Secondly, the rule precludes an inquest from expressing any opinion on matters other than those referred to in rule 23, save that recommendation may be made to prevent similar fatalities. Rule 23 provides as follows -

“The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters -

- (a) the identity of the deceased;*
- (b) how when and where the deceased came by his death;*
- (c) the persons, if any, to be charged with murder, manslaughter, infanticide or causing death by reckless driving, or of being accessories before the fact should the jury find that the deceased came by his death by murder, manslaughter, infanticide or reckless driving;*
- (d) the particulars for the time being required by the Births and Deaths Registration Ordinance to be registered concerning the death.”*

4.2 Rules 12(1) of the Coroners Rules enables any person who, in the opinion of the coroner, is a properly interested person to question witnesses at an inquiry either in person or by counsel or solicitor. The coroner must disallow any question which in his opinion is not relevant or is otherwise not a proper question (Rule 12(3)). A person appointed by a trade union to which the deceased belonged is specifically made an “interested person” if the death may have been caused by an injury received in the course of employment or by industrial disease (Rule 12(4)).

4.3 Prior to the Criminal Law Act 1977, the purpose of the inquest in England was set out in rule 26 of the Coroners Rules 1953 in similar terms to our rule 23. In a similar way to rule 30 of the Hong Kong Rules, rule 33 of the English Rules provided that “No verdict shall be framed in such a way as to appear to determine any question of civil liability”. The Brodrick Report suggests that these two provisions make it clear that it is no part of a

coroner's function to be concerned with any matters of civil or criminal liability – with an exception for homicide cases as set out in rule 23(c) above.

4.4 In Hong Kong the channels through which individual grievances relating to a death can be aired are arguably more limited than, for example, in the United Kingdom where representative organisations are more readily available to render assistance to those whom they represent. Here, the coroner's court is in the unique position of being able to provide a controlled forum for members of the public to air their personal grievances in respect of a person's death.

4.5 In one case, the death of a young man who was attending an outdoor adventure school was made the subject of a coroner's inquest. A post mortem examination showed the death to be from natural causes, but an inquest was held because public concern was aroused by published criticism made by the deceased's father of the school's vigorous schedule of activities.

4.6 In another case, the wrong blood was given to a patient in hospital. This was quickly found to be the cause of death. During a lengthy inquest, it became apparent that the fault lay not with the doctors or nurses, upon whom unfounded suspicion had originally fallen, but with the laboratory who had confused requests for blood for two different patients admitted at the same time. As a result of the jury's recommendations, the labelling system at the laboratory was improved to prevent a similar error.

4.7 In police "open fire" cases, the coroner's court is the only tribunal available to conduct what the public accept as an independent inquiry into the conduct of the police. A former coroner has said that, in his experience, the vast majority of such shootings are shown by an inquest to have been justified. Without an inquest the public would wrongly suspect improper police conduct. In a volatile community like Hong Kong, an in-depth inquiry into deaths such as these, where there is an opportunity for interested persons to question witnesses, satisfies an important social need.

The right to question

4.8 Any person who is properly interested in the inquest may question witnesses. The term "interested person" is not defined and is a matter within the discretion of the coroner. In England, however, this right is conferred on a number of persons specifically listed in rule 20(2) of the 1984 Rules as follows -

- (a) a parent, child, spouse and any person representing the deceased;
- (b) any beneficiary under a policy of insurance on the life of the deceased;
- (c) the insurer who has issued such a policy of insurance;

- (d) any person whose act or omission or that of his agent or servant may, in the opinion of the coroner, have caused or contributed to the death of the deceased;
- (e) any person appointed by any trade union to which the deceased at the time of his death belonged, if the death of the deceased may have been caused by an injury received in the course of his employment or by an industrial deceased;
- (f) an inspector appointed by, or a representative of, an enforcing authority, or any person appointed by a Government department to attend the inquest;
- (g) the Chief Officer of Police;
- (h) any other person who, in the opinion of the coroner, is a properly interested person.

4.9 If a solicitor or counsel is instructed by interested persons this is generally paid for privately, as an inquest is not considered to be "legal proceedings" for the purpose of the Legal Aid Ordinance.

4.10 The Brodrick Committee considered that there were certain cases in which it was highly desirable that interested persons at an inquest should be legally represented but in which, because of financial circumstances, such representation was not possible. The Committee recommended that legal aid should be extended to cover inquests in the coroner's courts. In Hong Kong, however, legal aid may be granted where there is a civil claim arising from the death and the Legal Aid Department considers that representation at the inquest amounts to inquiries in furtherance of the claim.

The protection of witnesses

4.11 Although there are obvious advantages in allowing witnesses to be questioned at an inquest, there is a need to protect witnesses from being unfairly prejudiced. The proceedings at an inquest are very different from those in other courts. Witnesses facing the inquisitorial procedure of the coroner's court are not afforded the normal protection of witnesses elsewhere (see para. 5.14). It must be remembered that it is no part of a coroner's function to determine questions of civil liability.

4.12 The Brodrick Committee noted that, in England, the majority of inquests were simple and straight-forward but that occasionally contentious and controversial issues arise which sometimes resulted in criticism being directed at the proceedings in the coroner's court. This might occur where a person's conduct was impugned without his having received any prior notice and without his having been afforded adequate opportunity to prepare or put

forward an explanation. It may also happen that evidence which might have put an entirely different construction on that person's conduct was rejected or, for some reason, not admitted in its entirety.

4.13 In Hong Kong, as in England, the only information which a coroner provides to a witness is the date, time and place of the inquest and the name of the deceased person. In England, notification to witnesses is provided for under the Coroners Rules 1953, but in Hong Kong, there is no such provision in the Rules. The power to subpoena a witness is derived from Part II of the Magistrates Ordinance.

4.14 Similarly in Hong Kong, rule 15 provides that a person whose conduct is likely to be called into question, if not summoned to give evidence at the inquiry, should be given reasonable notice of the date, hour and place at which the inquiry will be held. Surprisingly, however, there are no provisions as to the notification of "interested persons". As a result, such persons may be unaware of the date of the inquest and the fact that they are entitled to be legally represented at the inquiry.

4.15 Those who feel that a coroner's inquest should not touch upon evidence relating to a future civil action argue that at such an inquiry, although no criminal element may be involved, a person's reputation is nevertheless called into question. As the rules of evidence applicable in civil and criminal proceedings do not apply to an inquest, the inquest may range over matters the relevance of which might otherwise be in doubt. Moreover, there is no provision requiring adjournment of an inquest which has already begun if the conduct of a person is called into question during that inquest. Although one would expect a coroner to adjourn the inquiry in order that the person concerned might be notified, under the present law he is not obliged to do so. Nor is there any provision to ensure that a person in such a position is given fair notice of the nature of the allegations to be made against him. Those in the medical profession are, by virtue of their work, most often exposed to considerable prejudice as a result of the absence of any protection.

Recommendations in England

The Brodrick report

4.16 Because an inquest should be directed to establishing the cause of death rather than identification of personal responsibility, the Brodrick Committee considered that it was essential that inquests should be divested of features which allowed the examination of issues of individual responsibility more properly left to other civil or criminal courts.

4.17 The Brodrick Committee was not satisfied that the spirit of the rules was always strictly followed. Witnesses who gave evidence before the committee admitted that inquests were sometimes used as "dummy runs" for subsequent civil proceedings. The Committee saw merit in this from the point of view of the relatives in that, in some cases, it was only as a result of

evidence given at the inquest that a civil claim could be established. It therefore did not recommend that this practice should cease but it stressed that questions from interested persons at inquests should be confined to the elucidation of facts relevant to the issues to be determined by the coroner, irrespective of whether or not they affect matters of civil liability.

Other commentaries

4.18 The 1936 Wright Report (Cmnd 5070) recommended that the role of coroners in England should be limited to investigations of circumstances surrounding a death and that questions of civil and criminal liability should not be considered. It further recommended that riders of censure or exoneration should not be expressed and details of a suicide inquest should not be published. Many of these proposals have now become established practice in England.

4.19 On the subject of wide ranging inquisitions, Denning L. J. in *Roe v. Ministry of Health* (1954) 2 QB 66 said this -

“Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way. Something goes wrong and shows up a weakness and then is put right

But we should be doing a dis-service to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.”

Our recommendations

Interested persons

4.20 Rule 12(1) of the Coroners Rules provides that “.....any person who, in the opinion of the coroner, is a properly interested person shall be entitled to examine any witness at an inquiry either in person or by counsel or solicitor.” Apart from rule 12(4) which, in certain circumstances, makes a person appointed by a trade union to which the deceased belonged an interested person for the purposes of rule 12(1), there is no other definition of the term “interested person”. We consider that this is unsatisfactory and that it is desirable that those affected by an inquest should as far as possible be clear as to exactly where they stand in relation to the proceedings.

4.21 We recommended that the following (adapted from Rule 20(2) of the Coroner Rules 1984 in England) should be expressly made interested persons with a right to be represented at the hearing: -

- (a) A parent, child, spouse or any personal representative of the deceased;
- (b) Any person whose act or omission or that of his agent or servant may, in the opinion of the coroner, have caused or contributed to, the death of the deceased;
- (c) Any person appointed by any trade union to which the deceased at the time of his death belonged, if the death of the deceased may have been caused by an injury received in the course of his employment or by an industrial disease;
- (d) Any duly authorised representative of any Government department or enforcing authority concerned with the death;
- (e) Any other person who, in the opinion of the coroner, should be declared an interested person by reason of any particular interest in the circumstances surrounding the death.

Questions relating to civil liability

4.22 We have attempted, in our deliberations, to balance the interests of the community as a whole against those of individuals whose conduct in relation to a death is exposed to the closest scrutiny at an inquest. We find it impossible, however, to divorce the coroner's function of establishing how a death occurred and how to prevent similar deaths in future from the examination of the conduct of those directly connected with the death.

4.23 One member of the Bar in a submission to us made reference to a case in which a coroner allowed "microscopic scrutiny" of medical treatment administered by various doctors on the basis that this was relevant to a finding of lack of care. He considered that such a finding is

"inappropriate to a situation where the issue is, for example, whether a doctor failed to administer highly sophisticated treatment timeously or properly, or not. It is difficult to avoid the conclusion that the coroner allowed the 'lack of care' verdict as a vehicle for exploring the negligence issue, although there was no question of manslaughter, and the verdict could not appear to determine any question of civil liability."

4.24 We deal, elsewhere in this report, with verdicts of lack of care and recommend that, in appropriate cases, a coroner should be entitled to

reach such a finding. We believe that there is a very narrow line between questions which are designed to elicit information directly relevant to the inquest and those which are arguably more concerned with a future civil action. Invariably the two overlap, but we are satisfied that, as a matter of practice, coroners do not allow fishing expeditions for the purposes only of laying the foundation for subsequent civil claims and that to take the discretion out of the hands of the coroners might seriously jeopardize the effectiveness of an inquest.

4.25 The present practice, we believe, stems from rule 30 which provides that no verdict shall be framed in such a way as to determine any question of civil liability; rule 23, which sets out the only matters to be ascertained at the inquest and which makes no mention of civil liability; and rule 12(3) which provides that a coroner should disallow any question which in his opinion is not relevant or is otherwise not a proper question.

4.26 In our view these provisions, taken as a whole, are designed to prevent questions being asked which are not relevant to an inquest and which are designed to pave the way for a subsequent civil claim for negligence. Nevertheless, for the avoidance of doubt **we believe that it is desirable for legislation to provide specifically that questions which, in the opinion of the coroner relate to civil liability alone and which are not otherwise relevant should not be allowed. We recommend that such provision be made.**

4.27 Concern has been expressed that people can easily be taken by surprise when allegations against them are suddenly made in court without any prior warning. **We share this concern and recommend that a notice should be served before the inquest on any person whose conduct might be called into question. Where, however, the coroner is unable to effect service of the notice because the person concerned cannot be found, the coroner should not be prevented from proceeding with the inquest if he thinks fit.** Rule 15 of the Coroners Rules provides "Any person whose conduct is likely in the opinion of the coroner to be called into question at an inquiry shall, if not summoned to give evidence at the inquiry, be given reasonable notice of the date, hour and place at which the inquiry will be held". We do not consider that this provision is adequate to deal with the problem. **We recommend that Rule 15 should be refined by including a provision along the following lines: -**

"Any person or body corporate or Government department whose conduct is likely in the opinion of the coroner to be called into question at an inquiry shall be advised of that fact and be given reasonable notice of the date, hour and place at which the inquiry will be held.

and that express provision should be made requiring notification of an inquest to the next of kin and interested persons.

4.28 **We further recommend that a pre-inquest procedure should be introduced to enable the coroner and “interested persons” of whom he is aware to consider the shape of a forthcoming inquest.** This would provide an opportunity to identify the relevant issues, enable a person whose conduct is likely to be called into question to be informed of the criticism likely to be levelled against him and enable directions to be given upon matters such as the serving of notices on interested persons and disclosure of documents, etc. **Parties should be required to give notice to the coroner at that time of any person against whom they intend making allegations of misconduct and of the nature of such allegations.** A failure to do so which necessitated an adjournment of the inquest would render that party liable to pay the costs of the adjournment referred to in paragraph 6.43. A summary of the evidence according to the statements of witnesses prepared by the coroners’ officer might also be given to “interested persons”.

4.29 **All “interested persons” should receive a notice setting out the date, hour and place of the inquest and listing the various categories of “interested persons” with an indication as to the category into which that person falls. Anyone likely to be criticised at the inquest should be advised at the same time that it is open to them to seek legal advice and be represented at the forthcoming inquest.**

4.30 The 3rd edition (1985) of Thurston on Coronership makes reference to a similar type of procedure in England which, however, must be conducted in public and before the press. **Our proposals differ in that we believe that the pre-inquest review should not be held in public.** We consider that as a procedural step directly affecting interested persons, it should properly be conducted in chambers, thus avoiding unnecessary prejudice which might be caused to persons whose conduct is expected to be criticized in the ensuing inquest but against whom, for any number of reasons, such criticism is not eventually made.

4.31 **Where a person becomes an “interested person” only after the commencement of the inquest or where an interested person’s whereabouts become known only after the inquest has begun, the coroner should have a discretion to adjourn the hearing for notice to be given to him.** Where an interested person does not, however, receive such a notice we do not believe that he should have any automatic right of appeal other than on the grounds that the verdict is wrong and should be quashed, as proposed in Chapter 7 of this report.

4.32 We believe that a combination of such a notice and a pre-inquest procedure along the lines we have suggested above would afford persons whose conduct is likely to be brought into question maximum protection without confining issues which, of necessity, have to be examined at the inquest.

Chapter 5

The inquest – criminal responsibility

Present position

5.1 Rule 23(c) of the Coroners Rules provides that one of the matters which the inquest shall be directed to ascertain is the person, if any, to be charged with murder, manslaughter, infanticide or causing death by reckless driving.

5.2 Section 16(1) of the Coroners Ordinance provides: -

“A coroner may, at the conclusion of an inquiry, issue his warrant in the prescribed form for the apprehension and committal to prison of any person to be brought before a magistrate to be prosecuted according to law and he may bind over any witness who shall have been examined at the inquiry in a recognizance with or without surety to appear and give evidence on such prosecution:

provided that no person who has been charged on indictment may be charged with any offence of which he could have been convicted on the indictment.”

Need for reform

5.3 These powers survive from the days when substantial responsibility rested with the coroner in relation to the criminal aspects of a death. Unlike at present, the investigation of crime was limited and unsophisticated and there was no procedure for committal for trial by an examining magistrate.

5.4 The inquisitorial nature of a coroner’s inquest and the absence of strict rules of evidence places a witness who may be a potential defendant in a position of considerable disadvantage. At an inquest, as distinct from committal proceedings before a magistrate, there is no restriction on press reporting, no specific charges against any one and no person has the right to address the coroner or the jury on the facts (rule 28 of the Coroners Rules).

5.5 The position in Hong Kong, outlined above, contrasts with that in England. Implementing the recommendations of the Brodrick Committee, section 56(1) of the Criminal Law Act 1977 now provides:

“At a coroner’s inquest touching the death of a person who came by his death by murder, manslaughter, or infanticide, the purposes of the proceedings should not include the finding of any person guilty of the murder, manslaughter or infanticide; and accordingly, a coroner’s inquisition shall in no case charge any person with any of those offences.”

5.6 In considering this particular aspect of a coroner’s jurisdiction, it is interesting to note that in Hong Kong there were no cases in which a warrant under section 16 of the Coroners Ordinance was issued in 1982 or 1983. In 1981, two warrants were issued. One was withdrawn following a re-opening of the inquest and in the other case, the Crown did not ultimately proceed on the charge in respect of which the warrant was issued (see Annexures 6 and 7). There was a case in 1984 where a jury returned a verdict of manslaughter against a doctor. The inquest was re-opened following intervention by the Attorney General and a verdict of accidental death was substituted after additional evidence was heard.

5.7 The Hansen Report suggests that a conflict exists between section 16(1) of the Coroners Ordinance and rules 23(c) and 24(1). Section 16(1) provides -

“A coroner may, at the conclusion of an inquiry, issue his warrant in the prescribed form for the apprehension and committal to prison of any person to be brought before a magistrate to be prosecuted according to law”

In contrast, rule 23 provides -

“The proceedings and evidence at an inquiry shall be directed solely to ascertaining (c) the person, if any, to be charged with murder, manslaughter, infanticide or causing death by reckless driving, or of being accessories before the fact should the jury find that the deceased came by his death by murder, manslaughter, infanticide or reckless driving.”

and rule 24(1) provides -

“Neither the coroner nor the jury shall express any opinion on any matters other than those referred to in rule 23.”

It would seem, therefore, that under section 16(1), a coroner may have unrestricted power to issue a warrant in respect of any criminal offence and indeed there have been a number of cases where persons have been brought before magistrates for a variety of offences not covered by rule 23(c), and in conflict with rule 23. This requires urgent clarification.

5.8 The whole question of the coroner’s criminal jurisdiction was considered by the Brodrick Committee and, in the following paragraphs, we shall examine this aspect of the Committee’s report.

Criminal liability: homicide cases

5.9 The Brodrick Report suggests that a verdict pursuant to rule 26(c) of the U.K. Coroners Rules 1953 (charging a person with homicide) has the same effect as the preferment of an indictment and the person named must be committed for trial in respect of the offence charged. In Hong Kong, however, section 16(1) of the Coroners Ordinance states that the person must be “brought before a magistrate to be prosecuted according to law”. Committal proceedings before a magistrate or the preferment of a voluntary bill in the High Court is therefore necessary before actual trial.

5.10 Such verdicts are, in practice, rare. In a murder case in England, the coroner simply opens the inquest, takes evidence of identification, medical evidence of the cause of death and other particulars required for registration purposes and the adjourns the proceedings until the result of proceedings in the criminal courts is known. In practice, the inquest is never resumed but the coroner sends to the registrar a certificate in which he records the findings of the criminal court.

5.11 In Hong Kong, the coroner will not hold an inquest where a homicide charge has been preferred but simply informs the registrar of the cause of death. If no arrest has been made, it is a matter for his discretion whether an inquest should be held.

5.12 The Brodrick Committee pointed out that these few “homicide” inquests can cause great difficulties where, for example, evidence given on oath by a witness at the inquest puts a new complexion on the case or where the coroner or his jury differs from the police and Director of Public Prosecutions as to whether there is sufficient evidence to charge a suspect. In these circumstances, a person may be committed to a prison to be brought before a magistrate for an offence in respect of which it has already decided not to prosecute.

5.13 The duty of a coroner’s court to name persons to be charged with homicide offences is left over from the days when substantial responsibility rested with the coroner in relation to the criminal aspects of a death. At that time criminal investigations as we know them today were never undertaken and there was no procedure for committal for trial by an examining magistrate. The Brodrick Committee argued that the duty was “archaic and unnecessary”. Indeed as far back as 1936, the Departmental Committee on Coroners in England recommended that this duty should be abolished. This recommendation was almost unanimously supported by the witnesses who appeared before the Brodrick Committee.

5.14 The Brodrick Committee concluded as follows: -

“The strongest argument in favour of the abolition of both these duties is that they are incompatible with present day concepts of justice, which are firmly founded in an accusatorial system incorporating proper protection for suspected persons. The

inquisitorial nature of a coroner's proceedings places a suspected person in a position of considerable disadvantage. He may be compelled to give evidence in public in a court whose rules offer him protection much inferior to that which he could expect to find in a magistrate's court and which, unlike a magistrate's court, may go so far as to name him as guilty of the most serious crime of all. Moreover, the person whose reputation may suffer or whose liberty may be removed by these proceedings may be someone who, before the inquest begins, has no real awareness of the extent to which he was likely to fall under suspicion.

On those few occasions when a coroner finds himself obliged to hold a full inquest on a death from homicide, his proceedings may bear a much closer resemblance to a criminal trial than do committal proceedings before magistrates. The fact that this is so arises directly from the shape of the two sets of proceedings. At committal proceedings in the magistrate's court, a suspected person is faced with a definite charge; he need make no statement and will not normally do so; no judgment is passed on the value of the evidence in his favour and the committal proceedings can only be reported at the request of the defence. At an inquest, on the other hand, there is no restriction on press reporting, there is no specific charge against anyone and no one has the right to address the coroner or the jury on the facts. The rules of evidence applicable in civil or criminal proceedings cannot apply to inquests and since there is no specific charge, the inquiry may range over matters which would be of no relevance to such a charge, if it were made, but which may be prejudicial to a person accused in subsequent criminal proceedings. It is true that a witness may refuse to answer questions on the ground that the answer may incriminate him, but this may sometimes appear to a coroner's jury to be an admission of guilt. Nor is it only a witness under suspicion who is placed in an awkward situation. In order to help his jury determine whether or not they should find any person to be guilty of homicide, the coroner may have to examine closely a witness against whom suspicion has been levelled in order to clarify his statement. Yet, through all this, he must try to preserve the appearance of impartiality.

In face of these clear disadvantages attaching to the jury's duty to name an individual and the coroner's duty to commit a named person for trial, we believe that only the strongest argument on grounds of usefulness should suffice to justify the retention of these features of a coroner's inquest. We have not found any such justification." (Brodrick Report, paras. 16.13 to 16.15).

The Brodrick Committee's proposals: homicide cases

5.15 The Committee concluded that the best way of balancing the interests of the individual who is liable to suspicion against the need to protect the public interest would be to provide the coroner with a discretion to terminate the inquest and refer his papers to the Director of Public Prosecutions at whatever stage he considers appropriate. He would then certify the medical cause of death and conclude his investigation by forwarding his certificate to the registrar with an endorsement that the death had been referred to the D.P.P.

5.16 The Committee conceded that no hard and fast rule could be laid down as to exactly when the inquest should be concluded and the papers sent to the D.P.P. as the coroner would wish to hear sufficient evidence to justify taking such a step. As a general rule, however, this should be done when the coroner realizes, as a result of evidence adduced during the inquest, that there is a real likelihood that if the proceedings continue they will lead, directly or by inference, to a suggestion of guilt against a particular person. This decision would be announced, in neutral terms, in open court. The effect of this procedure would be to remove the coroner's function of assessing the extent of criminal liability which, in the opinion of the Committee, belongs to the prosecuting authorities and the criminal courts.

5.17 The procedure would not be appropriate, however, where a suspected murderer is dead and there is therefore no likelihood of a criminal prosecution. In these circumstances, the inquest should consist of the taking of medical evidence of the cause of death and such other evidence as is necessary to show that the deceased died as a result of homicide. A statement in standard form should be given by a police representative to the effect that their inquiries are complete and no prosecution is to be instituted as a result of the death. The coroner, the Committee recommended, should avoid making any statement directly implying that the dead person, believed to be the murderer, was in fact responsible for the death as the argument against naming a living person applies equally to a person who is dead.

5.18 The situation where the suspected murderer is not necessarily dead but where there is insufficient evidence to prefer charges against anyone is much more difficult. Here, the Committee considered that the coroner's problem will be to avoid asking, or allowing others to ask, questions which bear on the responsibility of any individual for the death. This is not part of his function. In such a case the Committee recommended that he should conclude the inquest as soon as evidence is taken which may indicate that a particular person is responsible for the death. Under the present system, he has no choice but to continue to the bitter end when the jury will name an individual to be charged with the offence.

5.19 A third situation which may arise is where the possibility of homicide emerges only after the inquest has been opened. In this case, if there is no evidence to suggest who the murderer is, the coroner may pursue his inquiries of the circumstances leading up to the death without the danger

of suggesting an individual's guilt. If, however, the identity is known or suspected, the inquiry may not be able to be conducted properly without revealing the identity of the suspect. The prejudice which would result is the basis of the Committee's recommendation to abolish the power of committal.

5.20 The report sets out a fictitious example to illustrate the position: -

"An elderly woman is found burnt to death beside her fireplace, and at the material time there is only one other person in the house with her. Preliminary inquiries suggest that she fell into the fire when alone in the room, but during the inquest evidence emerges which shows that the lady may not have fallen accidentally but may well have been pushed and that, if she was pushed, the only person who could have done it must have been the other person in the house. If, in such a case, the coroner were to hear the evidence in full and then announce a finding (as he is entirely free to do at present) that the deceased was deliberately pushed into the fire, that would be tantamount to a statement of the guilt of the other person in the house, even though the coroner were to be precluded from actually naming that person or committing him for trial. In terms of prejudice to the individual at risk, such a conclusion would be scarcely less damaging than a finding of guilt and a committal. Under the new proposal, a coroner would no longer be required to pursue his inquiries to the point at which an individual is manifestly at risk. In the hypothetical example we have quoted, we believe that the coroner should conclude his inquest and refer the case to the Director of Public Prosecutions as soon as he hears the new evidence that the woman may not have fallen accidentally."

5.21 In circumstances where, having received the papers from the coroner, the D.P.P. decides that there is to be no prosecution, the Committee recommended that he should notify the coroner accordingly and the coroner should publish a statement in non-committal and standard terms to the effect that the D.P.P. is satisfied that upon the evidence presently available there is no case for any criminal proceedings. The Committee was primarily concerned that, in such circumstances, suspicion which may have fallen on an individual as a result of referring the paper to the D.P.P. should be dispelled. To this end, it recommended that it should not be open to the coroner to make more elaborate public statements about the D.P.P.'s decision and stressed that, when the coroner reported the decision that there was to be no prosecution, it would not imply either that an offence had actually been committed nor that suspicion had fallen upon any particular individual.

Criminal liability: non-homicide cases

5.22 The Brodrick Committee recommended that if, during the course of an inquest, evidence is adduced for the first time which suggests that an offence which has a bearing on the cause of death may have been committed,

the coroner should make a report to a responsible public authority and announce in neutral terms that he is doing so. He should not, however, concern himself with an alleged offence which has nothing to do with the circumstances in which the death occurred.

5.23 In relation to road accident cases the Committee felt that, if the coroner decides to hold an inquest in a case which has not been the subject of criminal proceedings, he should have available to him the same power as in homicide cases to refer the papers to the D.P.P.

5.24 Where a prosecution is instituted the coroner, having already opened the inquest, is obliged to adjourn it for at least 14 days if requested by the police and, in practice, will not resume the inquest. Instead he sends his certificate to the registrar notifying him of the medical cause of death, the other registrable particulars which he is bound to supply and the result of the criminal proceedings.

Our recommendations

5.25 The principal justification for the existence of rule 23(c) (set out in paragraph 5.1 above) is that it catches those cases which might slip through the police investigation net. As against this is the very real unfairness to a person who is not protected by the normal rules of evidence and procedures and perhaps, most fundamentally, the fact that a person who may be named as criminally responsible for a death may not, for any number of reasons, be brought to trial and thus afforded the opportunity of clearing his name.

5.26 The fact that, over the last few years, the coroner's power to issue a warrant under section 16 of the Coroners Ordinance following a homicide verdict has only sparingly been used indicates its lack of relevance to law enforcement in the 1980s. In the context of our proposals for a new and improved investigatory process for coroner's cases, we do not believe that there remains any justification for the continued existence of such an antiquated and outmoded procedure which so wholly deprives a potential defendant of his fundamental rights. **We recommend that, in future, no person should be charged in a coroner's court with any homicide offence nor should a coroner issue a warrant for committal to prison of any person.**

5.27 Having said this, we do feel that provision has to be made for situations which might arise where it appears from evidence given at an inquest that there may be an element of criminal liability arising from the death. In order to cater for this situation, **we recommend that the coroner be given specific power to refer a case at any stage to the Attorney General for decision as to the question of criminal proceedings.**

5.28 No difficulty arises where this occurs during the investigation stage prior to inquest because the file can be forwarded immediately to the Attorney General for a decision on the matter.

5.29 As to the referral of papers during the course of the inquest, we do not believe that it is possible to spell out precisely when this should happen. This is something which must be left to the discretion of the coroner with the reservation that it **should be done at the earliest possible stage**. In order to minimise any possible prejudice to persons who might be the subject of subsequent prosecution, we feel that a simple statement by the coroner that he proposes to adjourn the inquest and forward paper to the Attorney General would suffice, without the need for any further elaboration.

5.30 **If the Attorney General decides that criminal charges will be preferred the coroner should adjourn the inquest in accordance with the practice presently adopted.** Upon conclusion of the prosecution the coroner could then resume the inquest. This would enable a formal finding to be recorded. In certain circumstances, moreover, we envisage that a coroner may wish to hold a full inquest notwithstanding the fact that criminal charges had been preferred. By way of example, a death might occur as a result of a fire deliberately started by a person who is subsequently charged with murder and arson. It may be, in such a case, that escape from the premises was impeded by the obstruction of stairways or locked doors which, in the public interest, should be investigated by inquest. A coroner should not be prevented from holding an inquest in such cases merely because criminal charges have flowed from the death.

5.31 Despite the provisions of the rule 14(1) of the Coroners Rules that “no witness in an inquiry shall be obliged to answer any question if to do so would tend to incriminate him”, we believe that, in practice, it is not always possible to anticipate the answer which the witness might give nor all the implications of questions which may be put to him. This is particularly so in the case of a witness who continues his evidence after a decision is made that there is insufficient evidence to launch a prosecution against him.

5.32 Regardless of whether the Attorney General decides to prefer charges, we believe that the person in respect of whom the papers were referred should not be required to expose himself to unlimited further questioning. If the person is recalled to give evidence it would, in our view, be quite wrong for him to be asked to give answers which might incriminate him. **We therefore recommend that legislative provision be made preventing further questioning of such a witness on any aspect of his evidence which led to a criminal prosecution being contemplated and reference of the papers to the Attorney General.** Subject to this such a witness should be compellable to continue his evidence.

5.33 In order to minimise the risk of a person absconding during such an adjournment, **we recommend that a coroner be given express power to order a person to surrender his travel documents pending the Attorney**

General's decision and to direct a restriction on press reporting pending that decision.

5.34 This referral procedure is designed to replace section 16 of the Coroners Ordinance and **we propose that the duty to refer be made obligatory in cases of suspected murder, manslaughter, infanticide and death by dangerous or reckless driving. In other cases where a suspected criminal offence comes to light during an inquest the coroner should be able to refer the matter to the Attorney General as and when he thinks fit.**

Chapter 6

The inquest – general matters

Procedure

6.1 Proceedings at an inquest are governed largely by the Coroners Rules. Rule 23 provides that the proceedings and evidence at an inquiry shall be directed solely to ascertaining the following matters: -

- (a) the identity of the deceased;
- (b) how, when and where the deceased came by his death;
- (c) the person, if any, to be charged with murder, manslaughter, infanticide or causing death by reckless driving;
- (d) the particulars required by the Births and Deaths Registration Ordinance to be reported concerning the death.

6.2 Rule 13 of the Coroners Rules provides that, subject to the coroner's discretion, a witness shall be examined first by the coroner or his officer and, if the witness is represented at the inquiry, lastly by his representative.

6.3 The coroner has power under Rule 14(1) to adjourn an inquest either to a fixed date or a date to be fixed subsequently and may, if he considers it necessary, use the same jury when the inquiry is subsequently held and resumed.

6.4 Where a person is charged with murder, manslaughter, infanticide or causing death by reckless driving, section 14(2) of the Coroners Ordinance provides that the inquiry shall be adjourned.

6.5 The normal order of witnesses called at an inquest can be illustrated by reference to a road traffic fatality: -

“The first witness identifies the deceased person and gives registrable particulars. Following identification, the plans and photographs should be produced so that they are available for reference throughout the hearing. This may be done by a police officer; if he is to give other evidence his examination may continue or, at his stage, he may be asked to stand down and be recalled later. He may also produce material exhibits.

The next witnesses should be independent members of the public who have been present at the incident. These may

follow a time sequence or be grouped according to their situation as pedestrians, occupants of another car or passengers in a public service vehicle. The passengers in a car whose driver may bear some responsibility are called next, but the driver should be the last witness.

Police witnesses give details of the scene of the occurrence together with the state of the light and weather, marks on the road and verbal statements made by involved persons at the time. There are usually several police officers and their statements should be studied in advance to avoid repetition and keeping them away from their normal duties. It may not be necessary, for example, to call an officer whose only part has been to accompany in an ambulance a deceased person.

Experts in vehicle examination may next be called but if the report is negative, the coroner may decide to accept the documents.

The medical witnesses may be heard at any time during the inquest although the logical chronological order is after the incident when the deceased person has been taken to hospital: if the deceased was dead on arrival only the pathologist need be called. A blood alcohol test should be performed if the person has lived for up to 12 hours after receiving his injuries. If this test has been done in a laboratory other than that of the pathologist, he may read and interpret the report.

If the deceased person has survived in hospital for an appreciable time, a hospital doctor should give evidence but it is unnecessary to call a number of doctors who may have participated in his care. If incorrect treatment is alleged, the doctor or other person concerned should attend the inquest.

The driver of a car involved in an accident should give evidence last.

The person who last saw the deceased alive and the person who found the body are important witnesses though not particularly in road traffic cases. Among other things, they assist in determining the condition of the deceased when last seen and the time of death." (Thurston on Coronership," page 111)

Recording of evidence

Present position

6.6 Under rule 27 of the Coroners Rules, the coroner is required to take notes of the evidence or depositions at every inquiry except in the case of murder, manslaughter, infanticide or death by reckless driving when he must take depositions. The effect of this Rule is considered later in this chapter.

6.7 A deposition is a written statement of the evidence given on oath by a witness. Although depositions are normally signed by the witness, there is no requirement in law for this to be done. A coroner cannot attempt to shorten the procedure of taking a deposition by reading over a previous statement to a witness and asking him to sign it. Statements made prior to an inquest should be used solely as the basis of questioning.

The reason for depositions

6.8 If a case is likely to result in criminal charges it is necessary to have an accurate record of exactly what a witness said under oath at the preceding inquest. Formal depositions may subsequently be used for a number of purposes. These include deciding whether there is sufficient evidence to prefer a criminal charge; if a charge is brought which is to be preferred on indictment in the High Court, the depositions can be used at the committal proceedings in place of calling the witness; and for the purpose of examination in chief and cross-examination at the court of trial if there is a criminal prosecution. The deposition may also provide sufficient evidence of what was said to support a charge of perjury if the witness has lied on oath and may, in some circumstances, actually be admissible in evidence in civil and criminal proceedings.

6.9 Currently a coroner has power under section 16(1) of the Coroners Ordinance to commit a person to prison and to be brought before a magistrate to be “prosecuted according to law”. This power is directly relevant to the taking of depositions in that any criminal charge preferred will be based on such depositions. Section 16(2) provides that the person committed must be provided with a copy of those depositions.

Need for reform

6.10 The time taken by the coroner during an inquest in recording notes and depositions in longhand is considerable. At the conclusion of the witness’s evidence, the deposition is read over to him and more time is spent in correcting what has already been recorded. All this inevitably lengthens the proceedings and has been the subject of much criticism. It has been calculated that simply to read back the deposition to the witness adds fully a third to the time a witness spends giving evidence.

6.11 David Steel, QC, wrote to the Attorney General following the “Sunshine Island” inquest which lasted some 8 weeks. He considered that the length of the inquest was due, to some extent, to the fact that a full

manuscript note of the proceedings had to be kept by the coroner and that the depositions had to be read back to the witnesses.

6.12 The somewhat confused right of a witness to alter his deposition when it is read back to him has also been criticised. Different courts take different views as to the extent of this right. Some consider it is limited only to correcting inaccurate recording, others extend it to a right to correct all or any of the evidence given. “Jervis on Coroners” (9th edition) at page 168 refers to the case of *R. v. Divine Exp. Walton* [1930] 2 K.B. 29 and says “...it is desirable that the deposition of a witness be read over to him in open court as soon as he has given his evidence so that he or any person interested in the case can check **any inaccuracy or slip of the pen.....**”[emphasis added].

6.13 No such right is given to a witness in a criminal trial. His evidence is recorded contemporaneously by a stenographer and a transcript subsequently prepared if called for. There are no known cases in Hong Kong where a witness has, at a later appeal, successfully claimed that a transcript did not accurately record what was said at the trial. It has, however, been known for the accuracy of a magistrate’s notes, taken in longhand, to be called into question. The Brodrick Committee recommended that a full transcript of evidence be taken at every inquest.

Our recommendations

6.14 The necessity to take depositions is justified only as long as a coroner has power to prefer criminal charges. In the absence of such a power, the usefulness of depositions is limited and the need to take depositions open to question. We are satisfied that the length of an inquest can be considerably shortened if a coroner is not required to take depositions. In the light of our proposal to abolish the duty to charge persons with homicide offences, **we recommend that the duty to take depositions should also be abolished and that rule 27 should be amended accordingly.**

6.15 We have recommended in Chapter 5 that provision should be made for referral of evidence to the Attorney General for consideration of the question of criminal proceedings. If this recommendation is implemented, we believe that a full transcript should be available for this purpose. We do not however, consider that it is reasonable to expect a coroner to record everything which is said in longhand. This is especially so in the case of a long inquest and **we consequently propose that, in future, stenographers should be provided for this purpose as they are for proceedings conducted in the High Court.**

6.16 We have considered whether provision might be made for the reading out of a witness’s statement made prior to the inquest where the evidence is not contentious, but we are concerned that unrepresented persons would be confused by such a procedure. This is particularly so in the case of highly technical evidence such as post mortem reports and other medical evidence where an unrepresented interested person would invariably

need to have an explanation of the terms and procedures. There is, of course, the added difficulty of translation of such statements which are generally written in English. We consider that the additional work involved in the translation process would impose an unacceptable burden upon interpreters. **We do, however, recommend that where a coroner is satisfied that all interested persons are legally represented, the coroner should have a discretion to allow any statement to be read by consent.**

The verdict

6.17 In England, a form of “Inquisition” (the official written record of an inquest) is set out in the Third Schedule to the Coroners Rules 1953. The form provides for the findings of the court under five headings: -

- (1) The name of the deceased (if known).
- (2) The injury of disease causing death.
- (3) The time, place and circumstances at or in which the injury was sustained.
- (4) The conclusion of the jury/coroner as to the death.
- (5) Particulars for the time being required by the Registration Acts to be registered concerning the death.

6.18 In Hong Kong, there is no form of “Inquisition” but the Coroners (Forms) Rules provide for the following certificate to be signed by the coroner following “an inquiry”:-

“I hereby certify that on theday of19....., I held, under the provisions of the Coroners Ordinance, an inquiry as to the cause of a death in.....and that the following particulars were then disclosed -

1. *Name of deceased.*
2. *Residence and occupation.*
3. *Where found, and when, and in what circumstances.*
4. *Date of death.*
5. *Cause of death.*
6. *The names of the persons last seen in the company of the deceased.*
7. *Any suspicious circumstances which point to any person or persons as having caused the death.”*

6.19 Section 13(1) of the Coroners Ordinance provides: -

“At the conclusion of an inquiry, the coroner shall record in writing his finding or the finding of the jury and in a case where there is a jury each member thereof shall sign the finding.”

6.20 There is no mention of “verdict” either in the Coroners Ordinance or in the Coroners Rules save for the prohibition in rule 30 against

a “verdict” being framed so as to appear to determine any question of civil liability. It seems, however, that for many years coroner’s courts in Hong Kong have been following the English practice of delivering a verdict without having any express authority to do so. This is clearly undesirable. If the concept of a verdict is to be retained, we believe that proper provision should be made for it by way of legislation.

6.21 In England, a list of verdicts is suggested by the Coroners Rules. At the end of schedule 4 of the Coroners Rules 1984, Form 22 is the form of inquisition. Under the subtitle “Notes” there are suggested forms of conclusion to the verdict. They are:

- (a) Natural causes;
- (b) Industrial disease;
- (c) Dependence on drugs/non-dependent abuse of drugs;
- (d) Wants of attention at birth;

and in those cases, but in no other, it is suggested the following words may, where appropriate, be added: “and the cause of death was aggravated by lack of care/self neglect”;

- (e) killed himself (while the balance of his mind was disturbed);
- (f) as a result of attempted/self-induced abortion;
- (g) accident/misadventure;
- (h) execution of sentence of death;
- (i) killed lawfully;
- (j) open verdict;
- (k) killed unlawfully;
- (l) stillbirth;

6.22 The necessity of pronouncing such verdicts is a direct result of the coroner’s existing duty to decide whether a person is to stand trial for a homicide offence. The Brodrick Committee argued that abolition of the coroner’s criminal jurisdiction in relation to the power to commit renders the pronouncement of a verdict of no practical value. Indeed such verdicts would be inconsistent with the coroner’s future function which the Committee saw as seeking out and recording as many of the facts concerning the death as the public interest requires, but without deducing from the facts any determination of blame. The facts uncovered in an inquiry will speak for themselves and be available for all to see without the necessity of a coroner actually sitting in judgment.

6.23 The Brodrick Committee considered it was essential that a change should be effected in what the public expects of an inquest, away from the attribution of blame and towards a merely fact-finding inquiry. It recommended the abolition of the “verdict” in its popular sense by abolishing the form of inquisition and with it the requirement to reach a formal “conclusion as to the death”. It recommended that the term “verdict” should be replaced by “findings”.

Our recommendations

6.24 In the light of our proposal to abolish the coroner's duty to charge persons with homicide offences and the removal of the coroner's power to issue warrants under section 16, we have considered whether there is any necessity for a coroner's court to retain the concept of a verdict. The term, after all, is normally only used in criminal courts and has clear connotations of a criminal nature. We believe, however, that a coroner would be unable to perform his duties satisfactorily if, at the conclusion of an inquest, he could not state in a way easily understandable to the public his final conclusion as to the death. We believe that the absence of a clear finding and classification of the death would impede the effectiveness of a coroner's proceedings.

6.25 **We recommend, therefore, that coroners should continue to deliver what has become known as a verdict at the conclusion of an inquest but that, in order to get away from the criminal connotation associated with the term "verdict", the term should be replaced by "findings".**

6.26 In our Working Paper we proposed that a standardized list of findings should be prescribed. This, we thought, would help to ensure consistency in practice and would enable the coroner to place a definitive list of possibilities to the jury. Some commentators objected to this approach as placing an unnecessary restriction on the coroner and the jury. After further consideration we agree with these objections. There is also a risk that something might be omitted from the list by oversight. **We have therefore decided to recommend the approach adopted in England of having a suggested list of findings.** This has the merit of guiding the coroner's court without running the risk of being too limited. In drawing up our suggested list of findings we have omitted any that imputes, or even suggests, civil or criminal liability. We have emphasised earlier in this report that it is no part of the coroner's function to make such findings. Absent from the list, therefore, are findings such as "murder" and "manslaughter".

6.27 One finding that caused us some difficulty was the finding of "lack of care". Even if no person is named in such a finding, the circumstances surrounding the death will often make it inevitable that blame is attached to a particular person or institution. In our Working Paper, we recommended that this finding should not be permissible. Some commentators objected to this as being unduly restrictive. Moreover, there is authority in England for the proposition that such a verdict of lack of care might, in some circumstances, be returned (see *Watkins L.J.R. v. Surrey Coroner ex parte Campbell* (1982) 2 W.L.R. 626 at 638; and *R v. H. M. Coroner for East London, ex parte Rubenstein*, *The Times*, February 19, 1982). We remain of the view that a finding of "lack of care" should be used with caution. One way to encourage such caution is to adopt the English approach of using the finding in conjunction with others on the list, in order to indicate that lack of care was an aggravating cause of the death. **We**

therefore recommend that the words “and the cause of death was aggravated by lack of care” may be added to any of the suggested causes of death.

6.28 The standardized list of findings we recommend is as follows: -

- (a) Suicide
- (b) Accidental death
- (c) Misadventure
- (d) Natural causes
- (e) Execution of sentence of death
- (f) Justifiable homicide
- (g) Homicide
- (h) Industrial disease
- (i) Still birth
- and
- (j) Where the Coroner is unable to reach a conclusive finding, that finding be left “open”.

We have considered whether deaths caused by drugs and deaths which occur following an abortion should be included within our suggested list of findings. We are satisfied, however, that any such deaths will inevitably fall into one or other of the existing categories – suicide, accidental death or homicide. In the light of our recommendation in paragraph 2.47 above, we have included still births in the recommended list of findings. We consider that such cases do not conveniently fall into any other category and, by reason of their nature, justify a separate classification.

6.29 We have considered whether there is any necessity to retain a finding of “misadventure”. The 2nd edition of “Thurston on Coronership” makes reference to verdicts of accidental death and death by misadventure as follows:

“Coroners have often debated the difference between accident and misadventure. It has been suggested that an accident is the result of an unexpected factor intruding into a regularly performed procedure whereas misadventure is a fault in the procedure itself. A finding of accidental death in medical mishaps may appear to impute blame, particularly in surgical cases. When an adverse drug reaction causes death, ‘accident’ might imply that the wrong drug or dose was given. Misadventure suggests that the drug was given intentionally or the operation was properly performed but that misfortune supervened.

The Oxford Dictionary makes no distinction between the two. As both deaths from accident and misadventure are entered in the same column of the annual return to the Home Office, there is no point in labouring a semantic problem. The term may be regarded as interchangeable.”

The 3rd edition of the work states, however, that -

“It is submitted that a verdict of accident is the appropriate verdict to return when the death is caused by an occurrence which could not have been foreseen, whereas misadventure should be reserved for those circumstances when the death occurred as the result of a lawful or unlawful intentional human act unforeseeably leading to death.”

Having considered these references, we remain unconvinced that there is a definable difference between the terms “accident” and “misadventure”. Given that both findings are commonly used in Hong Kong and some commentators objected to the deletion of one or other of them, we have decided to include both in our list of suggested findings.

Riders

6.30 We believe that an important part of a coroner’s function is to make recommendations with a view to preventing unnecessary deaths occurring in future. A power to make such recommendations exists at present by virtue of rule 24 of the Coroners Rules. We have noted that in England, the power of a jury to make riders has been abolished by the Coroners (Amendment) Rules 1980. We believe that in Hong Kong it would be quite wrong to prevent a coroner’s court from making recommendations designed to prevent unnecessary deaths from occurring in future. **The power to make recommendations is sufficiently important, in our view, to justify moving the provision from the Rules to the Ordinance itself, and we so recommend.** A conflict in terminology between rule 24 and rule 31 (the former referring to “recommendations” and the latter to “riders”) needs to be resolved and, in order to make the expression more understandable to the public, **we propose that in future the term “recommendations” should be used and that Rule 31 should be amended accordingly.**

6.31 We have considered whether a duty should be imposed on persons to comply with a coroner’s recommendation. We feel, however, that making an identified individual responsible for implementing recommendations and imposing liability for failure to do so would present too many difficulties. We believe that the direction in which recommendations should be channelled should continue to be left to the coroner’s discretion. The informal procedure which presently exists of coroners writing to relevant Government departments, private companies, industrial undertakings and others setting out the recommendations appears to be working satisfactorily and, in the absence of any complaints, we see no reason to recommend any change in this respect. Government departments and others who fail to comply with a Coroners recommendation expose themselves to the very real risk of severe public criticism as a result. We believe that this serves as an adequate deterrent to those who might choose not to act upon such a recommendation.

The jury

6.32 We believe that juries can fulfil a valuable role at an inquest and that coroners should continue to have a discretion to sit with a jury where they consider it appropriate. Presently, the only occasions on which a coroner is obliged to sit with a jury are where a sentence of death has been carried out and where a person dies in official custody. We believe that, in the public interest, such deaths should be considered in a special light and the holding of an inquest with the jury should remain mandatory in those cases. We do not think, however, that there is any case for extending the mandatory jury provisions beyond these two situations.

6.33 At present, a coroner's jury consists of only 3 persons and concern has been expressed about problems which can arise where one juror, for any reason, is unable to continue sitting. Unlike a criminal trial, however, most coroner inquests tend to be relatively short, often being concluded within one or two days. For inquests of such a duration the small likelihood of a juror being unable to continue does not in our view justify increasing the number of jurors beyond three. Problems are most likely to arise in long inquests and, in order to avoid difficulties arising during such a hearing, **we recommend that a coroner should be given power to direct that the jury be increased to five in appropriate cases in order that a maximum of two jurors can be discharged should the circumstances warrant it.**

6.34 Finally, **we recommend** that coroner's juries should be brought into line with other juries which are specifically provided for in the Juries Ordinance 1984 and **that any person who has served on any jury should be exempt from further service for a period of two years.**

Deaths outside the jurisdiction

6.35 The Merchant Shipping Ordinance enables all marine courts to inquire into marine casualties involving a British ship along the coasts of Hong Kong and into casualties to ships registered in Hong Kong occurring in any part of the world. Under the Hong Kong Civil Aviation (Investigation of Accidents) Regulations, an inquiry can be held in relation to accidents to civil aircraft over Hong Kong or, in respect of aircraft registered in Hong Kong, in relation to accidents occurring anywhere.

6.36 **We recommend that the coroner should be given express power to hold an inquest where a death occurs in such circumstances.**

6.37 We have also been concerned about cases which might arise where, for any reason, a baby cannot be recovered. In England, section 18 of the Coroners (Amendment) Act 1926 enables the Home Secretary to direct a coroner to hold an inquest in cases where the death has occurred in

England and Wales and the body has been destroyed or is irrecoverable. The section reads as follows: -

“Where a coroner has reason to believe that a death has occurred in or near the area within which he has jurisdiction in such circumstances that an inquest ought to be held, and that owing to the destruction of the body by fire or otherwise or to the fact that the body is lying in a place from which it cannot be recovered, an inquest cannot be held except by virtue of the provisions of this section, he may report the facts to the Secretary of State, and the Secretary of State may, if he considers it desirable so to do, direct an inquest to be held touching the death, and an inquest shall be held accordingly by the coroner making the report or such other coroner as the Secretary of State may direct, and the law relating to coroners and coroners’ inquests shall apply with such modifications as may be necessary in consequence of the inquest being held otherwise than on or after view of a body lying within the coroner’s jurisdiction.”

6.38 **We recommend that similar provision should be made in Hong Kong to enable an inquest to be held in such circumstances although we feel that the decision as to whether an inquest is to be held in such cases should be left to the discretion of the coroner and should not be the subject of a direction from any other person as in the United Kingdom. We further recommend that the coroner should be given power to make a declaration of death during the course of such proceedings.**

Evidence and contempt of court

6.39 We note that a coroner’s court is not included in the definition of “court” in section 2 of the Evidence Ordinance (Cap. 8). As a result, some of the provisions of the Ordinance that are relevant to the coroner’s court, for example, the admission of Government Chemist’s certificates under section 25 and certificates as to photographic process under section 26, do not apply. **We recommend that necessary amendments should be made to apply such provisions to the coroner’s court.**

6.40 We also note the concern expressed that a coroner presently has no power to commit for a contempt committed in the face of the court. Although it appears from the recent case of *Regina v West Yorkshire Coroner, ex parte Smith* (Times Law Report, 3rd October 1984) that a coroner has such power in the United Kingdom, the position in Hong Kong is far from clear. **We recommend that the coroner should be given express power to deal with contempt committed in the face of the court or arising from matters such as the failure of witnesses to comply with the terms of a summons. He should be given power to impose a fine or imprisonment in such cases.**

“Inquest” and “inquiry”

6.41 In the previous chapter, we set out our recommendations as to the investigatory role of the coroner which begins immediately a death is reported to him. In order that his role in relation to the pre-inquest investigation into a death should not become confused with the subsequent judicial proceedings, **we recommend that in future legislation the word “inquest” should be used at all times to refer to the proceedings in court and that any reference to “inquiry” should be avoided.**

Witness summonses

6.42 Coroners do not at present have power to require the attendance of witnesses in court. We believe that if a proper investigation is to be carried out leading to a full and thorough inquest, **a coroner should have power to summon witnesses to attend the inquest. We recommend that such power be given to coroners. We further recommend that the allowances specified in the Coroners (Witnesses’ Allowances) Rules in 1971 should be increased to a reasonable level and that the coroner should be specifically empowered to use expert witnesses upon payment of a realistic fee.**

Costs

6.43 Although section 69 of the Magistrates Ordinance is not appropriate for a coroner’s court, we consider that some provision should be made in relation to costs. It very often arises that an inquest, perhaps set down for a long hearing, has to be adjourned on the application of an interested party, causing considerable inconvenience and expense to other interested persons. Sometimes these adjournments could have been avoided. **We recommend that the coroner should be given power to award costs against any interested person to any other interested person where avoidable inconvenience or delay is caused.**

Right of persons to address the court

6.44 Rule 28 of the Coroners Rules provides – “No person shall be allowed to address the coroner or the jury as to the facts.” The rule effectively prevents both the coroner’s officer and interested persons from making either an opening or closing address to the court. We have considered the arguments both for and against the retention of such a provision. Those in favour argue that: -

- (a) as inquests are not adversarial proceedings, a factual address to the coroner could serve no useful purpose;
- (b) no person is on trial and no question of civil liability is to be determined so that no one is put in jeopardy;
- (c) in view of the nature of coroners' cases, interested persons who are not represented may tend to become excessively emotive and unable to restrict themselves to a purely factual address.

Those who believe there should be a right of address argue that: -

- (i) Where a person's reputation is being called into question and his character attacked, he should be permitted to draw the attention of the court to anything said in his favour before a finding on the evidence is made;
- (ii) at the very least the coroner's officer should be permitted to open the inquest to the jury so that they may have some understanding as to what the case is about and the issues requiring special attention before the first witness is called. This is particularly so in the case of inquests involving, for example, highly technical medical procedures.

Having considered the arguments on both sides, a majority of the sub-committee believed that the provisions of rule 28 should remain unchanged and that there should be no right of address in coroner's cases.

6.45 We have paid close attention to the arguments considered by the sub-committee. We have been influenced by two additional considerations. Firstly, our recommendation at paragraph 6.28 that the words "and the cause of death was aggravated by lack of care" may be added to any of the suggested causes of death strengthens the argument for allowing an interested person whose conduct has been called into question to address the court. Secondly, an inquest is an open hearing and we feel it is important that it should be seen to be so. We believe that an inquest is more likely to be seen to be an open hearing if all interested parties are given the right of address. We considered whether that right should be limited to those whose conduct had been called into question but concluded that any sense of grievance felt by the relatives of the deceased would be increased if they alone were not allowed to address the court. **In our view all interested parties should have the right of address, and we so recommend.** The address should be confined to the facts and kept strictly within bounds by the coroner himself.

Immunity of coroners from civil action

6.46 At common law it is not entirely clear to what extent a coroner is liable to civil action for acts done by him in the execution or purported

execution of his duty as coroner. A magistrate receives statutory protection under sections 125 to 128 of the Magistrates Ordinance to the extent that he was acting within his jurisdiction and acting without malice and with reasonable and probable cause. **In our view the coroner should enjoy similar limited protection in the exercise of his duties. We recommend that legislative provision should be made accordingly.**

Chapter 7

Review of inquests and the role of the attorney general

The present law

7.1 The Attorney General retains a supervisory function over the work of coroners in four respects: -

- (a) If a coroner considers that an inquiry is not necessary he must, upon the request of the Attorney General, forward to the Attorney General all papers, documents and other evidence relating to the death which he has considered (section 6(5) of the Coroners Ordinance).
- (b) If the Attorney General considers an inquiry should be held, and so informs the coroner, section 8 of the Ordinance requires the coroner to hold an inquiry into the death.
- (c) If, after the conclusion of an inquiry, the Attorney General so requests, the coroner must deliver to him -
 - (i) the depositions taken by him at such inquiry;
 - (ii) any documents which were produced in evidence;
 - (iii) a list signed by the coroner of all exhibits produced in evidence; and
 - (iv) a certificate in the prescribed form duly filled up and signed by him (section 19 of the Coroners Ordinance).
- (d) Notwithstanding that an inquiry has been concluded, the Attorney General may, if it appears to him that further investigation is necessary, require the coroner to re-open such inquiry and make further investigation, and thereupon the coroner must re-open the inquiry and proceed to make further investigation in the same manner as if the proceedings at such inquiry had not been concluded (section 20 of the Coroners Ordinance)

The position in England

7.2 The position in Hong Kong, outlined above, may be contrasted with that in England, where the Attorney General has no power of review. Section 6 of the English Coroners Act 1887 gives power to the High Court, on application by the Attorney General, to order that an inquest be held in specified circumstances. A similar provision exists in section 26 of the New Zealand Coroners Act.

7.3 Section 6(1) of the English Coroners Act 1887 provides: -

“Where Her Majesty’s High Court of Justice, upon application made by or under the authority of the Attorney General [or the Solicitor General – Law Officers Act, 1944, s. 1] is satisfied either -

- (a) that a coroner refuses or neglects to hold an inquest which ought to be held; or*
- (b) where an inquest has been held by a coroner that by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, or otherwise, it is necessary or desirable, in the interests of justice, that another inquest should be held.*

the Court may order an inquest to be held touching the said death, and may, if the Court think it just, order the said coroner to pay such costs of and incidental to the application as to the court may seem just, and where an inquest has been already held may quash the inquisition on that inquest.”

7.4 Under Section 6(2): -

“the Court may order that such inquest shall be held either by the said coroner, or by any other coroner for the county, and the coroner ordered to hold the inquest shall for that purpose have the same powers and jurisdiction as, and be deemed to be, the said coroner”

7.5 Under section 6(4): -

“Any power vested by this section in Her Majesty’s High Court may, subject to any rules of court made in pursuance of the Supreme Court of Judicature Act, 1875, and the Acts amending the same, be exercised by a judge of that Court”.

7.6 Section 19 of the Coroners (Amendment) Act 1926 extended the ground for quashing a coroner’s verdict to discovery of new facts or evidence. The section provides as follows: -

“For the removal of doubt it is hereby declared, without prejudice to the generality of the provisions of section 6 of the Coroners Act 1887, that the powers of the High Court under that section extend to and may be exercised in any case where the Court is satisfied that by reason of the discovery of new facts or evidence it is necessary or desirable in the interests of justice that an inquisition on an inquest previously held concerning a death should be quashed, and that another inquest should be held.”

7.7 *R. v. Divine ex parte Walton* (1930) 2 K. B. 29 states the position in England: -

“The High Court will not attend to mere informalities or minutely criticise the summing up or the nature of evidence or the procedure. But if the inquest is so conducted that there is a real risk that justice has not been done, the Court will not allow the inquisition to stand.”

Previous recommendations

7.8 Various aspects of the review of inquests have been the subject of previous recommendations in England and Hong Kong.

7.9 In England, the Brodrick Committee considered that there was a need for an appellate procedure both against the findings of an inquest and against the coroner’s decision not to hold an inquest. In the case of the latter, a rapid procedure is called for, as time is generally of the essence, and appeal should be to a High Court Judge with power to order an autopsy and to suspend any burial or cremation until the results of the autopsy are known.

7.10 In the case of an appeal against the findings of an inquest, the Brodrick Committee made two recommendations: -

- (a) The right of appeal should be based on any error in any part of the record of the findings in the coroner’s court, including the findings as to the medical and circumstantial causes of death. An appeal based on these grounds would, if successful, result in a fresh inquest being held.
- (b) The right to appeal against the findings of a coroner’s inquest when there is no error on the record would be at the discretion of a High Court judge who would have to designate a judge not lower in status than a circuit judge to hear the appeal. It would then be for the circuit judge to decide whether the re-hearing should be a complete oral re-hearing of the witnesses, or merely a study of the transcript of the evidence at the inquest.

7.11 The Brodrick Committee recommended that in England the Secretary of State should have the power to direct that an inquest be held in the absence of a body and that an application for such an inquest to be held should be capable of being made by the coroner, by the next of kin of the presumed deceased, or by any other interested persons.

7.12 In Hong Kong, the Cons Committee considered whether the power to review the coroner's decision should lie with a court or the Attorney General. The Committee observed that those performing the duties of a coroner resented the Attorney General's power to interfere with the verdict of a jury by requiring a coroner to re-open an inquest under section 20. They considered it a gross violation of judicial independence.

7.13 The Cons Committee considered the merits of replacing sections 8 and 20 of the Coroners Ordinance with a procedure for judicial review in similar terms to section 6 of the English Coroners Act 1887, perhaps with a first application to the coroner himself. The former Attorney General, Mr. John Griffiths, Q.C., however, considered that the time was not ripe for such changes and the Cons Committee, concurring with this view, recommended no change. The Attorney General also questioned the rule that a re-opened inquest at the request of the Attorney General must continue with the same coroner. While appreciating his concern and noting that there may be occasions when the way in which the coroner has conducted the first inquest would make it seem desirable that a further hearing should not proceed before him, the Cons Committee also declined to recommend any change in this respect.

Our proposals

7.14 **We consider that the Attorney General as guardian of the public interest should retain the power conferred by section 8 of the Coroners Ordinance to direct that an inquest be held where he is aware of circumstances which justify it.** This is consistent with his existing jurisdiction to bring any case before any other court for judicial determination. This does not amount to interference in the conduct of an inquest save that the Attorney General can, if he so wishes, be represented in the same way as any other interested person.

7.15 **We do not think, however, that the Attorney General should continue to have the power to require the coroner to re-open an inquest,** particularly in the light of our recommendation in paragraph 7.17 that he should have recourse to the appellate courts. He does not have power to require the re-opening of civil or criminal matters and we are sympathetic to the view that such a power in relation to inquest amounts to an interference in the independence of the judiciary. In removing such a power, however, some procedure has to be devised for the review of coroner's decisions.

7.16 We believe that, in Hong Kong, interested persons should have at their disposal some provision along the lines of the English and New

Zealand provisions. **We consider that the grounds for quashing an inquest should be as provided in English legislation set out in paragraph 7.3 above.** However, we consider that any such appeal procedure should not be subject to the consent of the Attorney General and that the principal ground for such an appeal should be that of public interest. **We further believe that where no inquest has been held, the High Court should be empowered on the application of any interested person, and in the public interest, to order that an inquest be held.**

7.17 It follows that we are satisfied that the Attorney General should have the same right as any one else to apply to have a finding quashed and that the appellate court should have a full discretion to make such direction as it deems appropriate. Any power which presently exists under the common law to apply for a judicial review by way of prerogative order should remain unchanged.

7.18 We have considered whether there should be any provision enabling interested persons to apply in the first instance to the coroner to review his decision. Although we can see advantages to such a procedure in that a coroner would be given the opportunity of reconsidering his decision without the necessity of an application to the High Court, we do feel that in the case of proceedings before a coroner, more than any other, emotions tend to run high and it is unlikely that all interested persons would be satisfied by a coroner's decision. In such circumstances, we would expect large numbers of applications to be made to a coroner to review his decision. **We do not wish to see coroners spending excessive time on frivolous applications and in consequence recommend that such power be vested only in the High Court on the grounds set out above.** In the event of the coroner himself wishing to re-open an inquest, he should be able to make application in the same way as any other interested person as described in paragraph 7.16 above.

7.19 **We recommend that where the High Court orders that a new inquest be held, then subject to any direction by the High Court to the contrary, if the inquest was held with a jury, the same jury should be convened in the new inquest.** Where it directs that the new inquest be held before a different coroner, the new coroner should deal with the inquest *de novo* with all the powers and discretions he has in any other inquest (including a discretion as to whether the new inquest should be held with or without the jury). **The hearing of any such appeal should be conducted in open court in the same way as any other appeal.**

Chapter 8

Summary

“The cutting short of a person’s life before its allotted span is run is one of the greatest violations of human rights. ... Contrary to the belief held by many that the coroner only investigates the cause of death, he has to enquire into all the events and the matters surrounding the deceased which could have led to or brought about a premature decease in order to obtain a true record if subsequent equity is to prevail.”

- Coroner’s Inquests : A Cornerstone of Justice
(The Law Society’s Gazette 9 January 1985)

Summary of defects in present system

8.1 We have attempted, during the course of our deliberations, to isolate specific defects in the present law and procedure governing the work of coroners and to formulate recommendations based on our overall perception of the role of a coroner in Hong Kong.

8.2 At present there is, generally speaking, no legal duty to report any death to the coroner. Although informal practices have developed whereby, for example, doctors and the police report certain types of death to the coroner, there is no guarantee that all deaths of which the coroner should be aware are in fact brought to his attention.

8.3 Even where a death is reported to the coroner, the report is rarely made promptly and the coroner is therefore unable to investigate the case at a time when evidence is most likely to be readily available. Moreover, his powers of investigation are limited. He has no power to collect evidence or conduct even a preliminary investigation at the scene. He cannot seize exhibits, photocopy documents or even insist upon perusing the medical records of the deceased. Indeed, if he were to be given such powers tomorrow, he would not have the manpower at his disposal to be able to exercise them. Such powers as he is given under Part II of the Magistrates Ordinance are almost entirely inappropriate to the nature of his work. As a consequence, the delay in investigating a coroner’s case is inordinate and the standard of investigation generally inadequate.

8.4 No protection is afforded to persons whose conduct is likely to be open to criticism at an inquest. It is presently possible for such persons to attend an inquest without any knowledge of what might be said against them.

They may find, without any warning, that they are balancing precariously between a ruined reputation on the one hand and a homicide charge (which may never eventually be pursued) on the other.

8.5 Wasted hours are spent by a coroner recording depositions in long-hand containing every word said by a witness during the course of his evidence. As criminal charges rarely flow from an inquest, these depositions will, almost certainly, never be used after the proceedings.

8.6 No statutory appeal procedure against a coroner's findings exists although the Attorney General has power under the Coroners Ordinance to order the re-opening of an inquest – an unjustifiable interference, coroners say, with their judicial independence.

8.7 There are numerous other areas in which the current law relating to coroners is defective. The Coroners Ordinance and Coroners Rules contain many provisions which are inconsistent or ambiguous. Moreover, a coroner's court is not included in the definition of a "court" in the Evidence Ordinance.

8.8 Before setting out a summary of our recommendations, we feel compelled to pay tribute to the efforts displayed by our coroners in attempting to discharge their duties efficiently in the face of the profound uncertainty of the law governing their office and the inadequacy of the powers with which they have so far been provided.

Summary of recommendations

Annual report

8.9 Coroners should publish an annual report giving a breakdown of the cases reported to them and highlighting significant developments (para. 1.39).

The duty of report to the coroner

8.10 **A list of reportable deaths** should be prescribed by statute (para. 2.27). They are as follows: -

- (1) Where the doctor cannot certify the direct medical cause of death (para. 2.29).
- (2) Where the doctor has not attended the deceased during his last illness or within 14 days prior to death (para. 2.30)
- (3) Where an accident of any date in any way contributed to the cause of death (para. 2.31).

- (4) Deaths caused by crime or suspected crime (para. 2.31).
- (5) Deaths where an anaesthetic may have precipitated or directly or indirectly contributed to the death and deaths which occur during an anaesthetic or within 24 hours following anaesthesia (para. 2.32).
- (6) Deaths where an operation may have precipitated or directly or indirectly contributed to the death, and deaths which occur within seven days following an operation (para. 2.32).
- (7) Where there is reason to believe that the death is a result of industrial disease or is connected with any occupation or employment undertaken by the deceased (para. 2.41).
- (8) Suspected still births where -
 - (a) there is uncertainty as to whether the baby was born alive or dead; or
 - (b) there is suspicion that a still born foetus might have been born alive but for the willful act or neglect of any person (para. 2.47).
- (9) Maternal deaths, i.e. deaths occurring within one month of child birth or abortion (natural or otherwise) (para. 2.48).
- (10) Deaths from septicaemia arising from unknown cause (para. 2.49).
- (11) Suspected suicide (para. 2.50).
- (12) Deaths of persons in official custody or subject to a care and protection order (para. 2.51).
- (13) Deaths which occur on premises occupied by any Government department which has any statutory power of arrest or detention (para. 2.52).
- (14) Deaths in nursing homes or maternity homes (other than those registered under Cap. 165) and in foster homes (paras. 2.54 and 2.55).
- (15) Deaths in any premises where the care of persons is undertaken for reward (other than those registered under Cap.165) (Para. 2.56).
- (16) Executions (para. 2.57).
- (17) Homicides (para. 2.57).

- (18) Deaths as a result of drugs or poisons (para. 2.58).
- (19) Deaths following ill-treatment, starvation or neglect (para. 2.58).
- (20) Where a dead body is brought into Hong Kong (para. 2.59).
- (21) Deaths in hospital of any psychiatric patient or any patient admitted to a psychiatric ward or wing of any hospital (para. 2.60).

8.11 **A duty to report** any such death which comes to his or their attention should be imposed upon -

- (1) a doctor certifying the death (para. 2.68);
- (2) the Registrar of Births and Deaths (para. 2.73); and
- (3) the police (paras. 2.75 and 2.76).

8.12 A duty should be imposed upon any Government department in whose care or custody the deceased was at the time of his death or which occupied premises in which the death occurred, to report the death to the police. In the event of the deceased being in the care or custody of the police or premises occupied by the police at the time of his death, the police should report to the coroner (para. 2.69).

8.13 A duty should be imposed on any Government department which receives statutory notice of a death, to report the death to the coroner (para. 2.74).

8.14 The report of a death should be made to the coroner as soon as reasonably practicable (para. 2.78).

8.15 Where a person is under a duty to report and he has knowledge of the circumstances which render the death reportable, the failure by that person to make a report of the death as soon as reasonably practicable should be made an offence (para. 2.79).

8.16 A statutory defence should be provided for any person or body that fails to report a death which he is under a duty to report in circumstances where -

- (a) another person has reported that death; or
- (b) he had an honest belief that a report had been made by some other person (para. 2.80); or
- (c) in the case of "industrial death" the doctor certifying the death concludes that the disease from which the deceased suffered at

the time of his death did not arise as a result of his occupation (para. 2.41).

8.17 To avoid any confusion, the form of future death certificates to be used for registration of a death and to be completed by a doctor should contain a check list of all reportable deaths to be considered before certifying the death (para. 2.26).

8.18 There should continue to be a duty on the coroner to hold an inquest in the circumstances set out in paragraph 1.22 and a discretionary power in him to hold an inquest in the circumstances set out in paragraph 1.21 (para. 2.82).

Death certificates

8.19 Express legislative provision should be made for the issue of a certificate which, although not specifying the cause of death, would provide satisfactory and acceptable evidence of the fact of death. Such a certificate should be signed by any doctor who has viewed the body, even though he may be unable to certify the cause of death, and should be readily available to the next of kin.

8.20 Provision should be made to ensure that the certificate of the fact of death is signed only where the person certifying has personally viewed the body and is satisfied that death has occurred (para. 3.33).

8.21 A certificate of the cause of death should be signed only where the person certifying the cause of death either has personally viewed the body and satisfied himself that death has occurred or has been presented with a certificate of the fact of death (para. 3.34).

Investigation into the circumstances of a death

8.22 Responsibility for the conduct of an investigation into a coroner's case should lie exclusively with the coroner (para. 3.42).

8.23 The enhanced status and responsibility of the coroner and his staff should be reflected in their remuneration (para. 3.45).

8.24 The coroner should have under his control a legally qualified chief coroner's officer and teams of investigators (para. 3.42).

8.25 The coroner's office should be expanded to provide an increased number of coroner's officers possessing experience in the conduct of investigations (para. 3.46).

8.26 These officers should be charged with the duty of investigating coroner's cases independently, free from outside interference and under the exclusive direction of the coroner (para. 3.46).

8.27 A chief coroner's officer, who should be of Senior Crown Counsel rank, should be appointed to head the unit (para. 3.47).

8.28 Under the chief coroner's officer, there should be coroner's officers seconded from the Royal Hong Kong Police Force of inspectorate rank and assistant coroner's officers of junior police officer rank (para. 3.46).

8.29 All members of the unit should be required to take an oath of confidentiality so worded as to make it clear that they are responsible, at all times, firstly to the coroner (para. 3.50).

8.30 The unit should be provided with access to the services and resources of other Government departments such as the Forensic Pathology Service, the Government Chemist, Labour Inspectors, etc. (and internal regulations of such departments should reflect the confidentiality attaching to coroner's investigations) (para. 3.43).

8.31 The unit should be provided with such clerical and administrative support as may be required for it to discharge its duties satisfactorily (para. 3.43).

8.32 The unit should be centrally located and housed in the same premises as the coroner's court and, taking into account current requirements, it should ideally be located in Kowloon (para. 3.44).

8.33 The coroner should be given statutory power of search and seizure to enable him to look for and take away evidence (e.g. machinery and maintenance records) and in the case of medical records, to obtain temporary possession of them for photocopying purposes (para. 3.61).

8.34 As a judicial officer the coroner should have a general power to search and seize but his officers should have the power only when specifically authorized by a warrant issued by the coroner (paras. 3.64 and 3.65).

8.35 Provision should be made in a new Coroners Ordinance creating an offence of obstructing a coroner's officer in the execution of his duty (para. 3.69).

8.36 The powers of the coroner presently contained in Part II of the Magistrates Ordinance and the Coroners Rules should be amended as set out in Annexure 4 and paragraphs 3.68 to 3.82 above (para. 3.70).

8.37 More use should be made of the University of Hong Kong and the Chinese University for the conduct of post mortems in cases of hospital deaths, and coroners should be allowed to request these Universities to

perform a post mortem where appropriate and to provide independent advice where necessary (para. 3.80).

8.38 A review should be conducted of the staffing, equipment, practice and procedure in the Government Laboratory (para. 3.81).

8.39 A post mortem should not be waived unless the pathologist agrees and there is no objection to waiver of the post mortem by any relative of the deceased (para. 3.82).

8.40 A booklet explaining procedures following a death should be made available to the public (para. 3.74).

8.41 The power to order the production of a document or other thing likely to be material evidence should be varied to enable the coroner to obtain it at any stage of his investigation and not merely at the inquest as at present (para. 3.85).

The inquest – civil liability

8.42 The term “interested person” in the Coroners Rules should be defined as set out in paragraph 4.21 above.

8.43 Legislative provision should be made preventing questions being asked at an inquest which, in the opinion of the coroner, relate to civil liability alone and which are not otherwise relevant to the matters to be ascertained under rule 23 of the Coroners Rules (para. 4.26).

8.44 Any person whose conduct is likely, in the opinion of the coroner, to be called into question at an inquest should be given notice of this fact (paras. 4.27, 4.29 and 4.31).

8.45 Next of kin and interested persons should be notified of an inquest (paras. 4.27, 4.29 and 4.31).

8.46 A pre-inquest procedure should be introduced to serve the purposes set out in paragraphs 4.28 to 4.30 above.

8.47 At the time of the pre-inquest procedure parties should be required to notify the coroner of any person against whom they intend to make allegations of misconduct and of the nature of such allegations (para. 4.28).

The inquest – criminal responsibility

8.48 The coroner should cease to have the power to charge a person with any homicide offence or to issue a warrant for committal to prison of any person (para. 5.26).

8.49 The coroner should be given the power to refer a case at any stage to the Attorney General for a decision as to whether a prosecution should be brought (paras. 5.27 and 5.34).

8.50 If the Attorney General decides to prefer criminal charges, the coroner should then adjourn the inquest. If the inquest is subsequently resumed, the witness in respect of whom the case was referred to the Attorney General should not be questioned further upon any aspect which led to the papers being so referred (paras. 5.30 and 5.32).

8.51 If the Attorney General decides that no charges are to be preferred and the inquest is resumed, the witness in respect of whom the case was referred to the Attorney General should not be questioned further upon any aspect which led to a criminal prosecution being contemplated against him (para. 5.32).

8.52 The coroner should be given the power to order a person to surrender his travel documents pending the Attorney General's decision and to direct a restriction on press reporting during the same period (para. 5.33).

The inquest – general matters

8.53 The coroner's duty to take depositions should be abolished (para. 6.14).

8.54 Transcripts of the proceedings at an inquest should be made and stenographers should be provided for this purpose (para. 6.15).

8.55 Where a coroner is satisfied that all interested persons are legally represented, the coroner should have a discretion to allow any statement to be read by consent (para. 6.16).

8.56 A coroner's court should no longer return a "verdict" but a "finding" (para. 6.25).

8.57 A suggested list of findings should be laid down in the terms of paragraphs 6.27 and 6.28 above (para. 6.26).

8.58 The recommendations made by the coroner or the coroner's jury should be known as "recommendations" and not "riders", and provision for such recommendations should be made in the Coroners Ordinance rather than in the Rules (para. 6.30).

8.59 A coroner should be given power to increase the number of jurors at an inquest to five in his discretion enabling two to be discharged should the circumstances so justify (para. 6.33).

8.60 Any person who serves on a coroner's jury should be exempt from further jury service for a period of two years (para. 6.34).

8.61 A coroner should have jurisdiction over deaths occurring outside Hong Kong and involving ships or aircraft registered in Hong Kong (paras. 6.35 and 6.36).

8.62 Where a body cannot be recovered, the coroner should have jurisdiction in circumstances similar to those set out in section 18 of the Coroners (Amendment) Act 1926 (paras. 6.37 and 6.38).

8.63 Legislative provision should be made extending relevant provisions of the Evidence Ordinance to the coroner's court (para. 6.39).

8.64 A coroner should be given express power to deal with contempts committed in the face of the court (para. 6.40).

8.65 The word "inquest" and not "inquiry" should be used in legislation to refer to the proceedings in a coroner's court (para. 6.41).

8.66 A coroner should have power to summon witnesses (para. 6.42).

8.67 The allowances specified in the Coroners (Witnesses' Allowances) Rules in 1971 should be increased to a reasonable level. Coroners should be specifically empowered to use expert witnesses upon payment of a realistic fee (para. 6.42).

8.68 A coroner should have power to award costs where avoidable inconvenience or delay is caused (para. 6.43).

8.69 All interested parties should have the right to address the court (para. 6.45).

8.70 Coroners should enjoy limited immunity from civil action (para. 6.46).

Review of inquests

8.71 The Attorney General should no longer have power to require a coroner to re-open an inquest but he should retain the power to direct that an inquest be held (paras. 7.14 and 7.15).

8.72 The High Court should be given express power, on the application of any interested person, and in the public interest, to order that an inquest be held or, when an inquest has already been held, to quash the finding of that inquest and make such order as it deems appropriate (para. 7.16).

8.73 Where the High Court orders a new inquest, then, subject to its direction to the contrary, the same jury should be convened (para. 7.19).

8.74 Where the High Court orders that a new inquest be held by a different coroner, the new coroner should be able to exercise all the powers and discretions which he would have in any other inquest (para. 7.19).

8.75 The hearing of such proceedings in the High Court should be conducted in open court in the same way as any other appeal (para. 7.19).

Chapter 9

Minority report

9.1 We disagree with the recommendation to confer a power of search and seizure on the coroner. Paragraph 3.59 of the Report contains the gist of the arguments against conferring the power. We are not persuaded that the power is either necessary or desirable. In 1971, the Brodrick Committee in England made a similar recommendation, but it has not been implemented.

9.2 The Report cites several examples in support of the recommendation (See paragraph 3.54 of the Report). It is said that “the absence of the powers effectively prevents a Coroner from immediately seizing important evidence at, for example, a construction site as well as obtaining maintenance records of machinery, lifts and other equipment before they can be tampered with or lost”. A further example cited in that paragraph involved a bus accident and the refusal of the bus company to supply maintenance records of the vehicle concerned.

9.3 In our opinion, adequate powers already exist to enable other agencies to obtain evidence and other relevant material in the situations described above. Such powers are contained in the Factories and Industrial Undertakings Ordinance (Cap. 59), the Lifts and Excalators (Safety) Ordinance (Cap. 327) and the Public Bus Services Ordinance (Cap. 230). Under section 4 of the first Ordinance, the Commissioner of Labour and his officers have extensive powers to enter, inspect and examine premises where an industrial undertaking is carried on, to require production of documents and to seize anything which may appear to be evidence of any offence against the Ordinance. Further, under section 11B the Commissioner of Labour may conduct an enquiry with all the powers of a magistrate to summon witnesses, call for the production of books and documents and examine witnesses on oath. This procedure has the considerable advantage that the Commissioner does not have to wait for a death to occur before holding an enquiry, as the coroner, by definition, does. The term “Industrial Undertaking” is very broadly defined and includes any factory; mine or quarry; the generation, transformation and transmission of electricity or motive power; a construction site and the transport of passengers or goods. In the example of the bus company, the maintenance records of the vehicle could arguably have been obtained under that Ordinance and in any event could easily and quickly have been obtained under section 18(2) of Cap. 230 by the Commissioner for Transport. That sub-section provides “A grantee (the bus company) shall furnish to the Commissioner, at such times and in such form as he may require, copies of the records kept by the grantee in accordance with subsection (1)”. Section 18(1)(f) requires the grantee to keep proper

records in respect of the maintenance of vehicles and stores. Moreover, section 18(3) empowers the Commissioner to inspect at any reasonable time all records kept by the grantee in connection with its franchise and make copies of them. In these and other situations, the police may also possess powers to search and seize under warrant. Although these powers are not exercisable by the coroner, given proper co-ordination between him and the other agencies, there is no reason why the coroner's investigations cannot benefit from them. It has been argued that those agencies may not be permitted to hand over evidence or other material seized or obtained to the coroner. If this is so, we consider that the appropriate way of remedying this defect is to legislate specifically to allow it to be done rather than to create a new power for the coroner.

9.4 Paragraphs 3.55 to 3.58 focus upon the medical profession. It is said that investigations by the coroner have in some cases been hindered by failure or delay in producing medical records and reports and by the alteration or loss of medical evidence and records. It is therefore suggested that a power to search and seize would overcome these problems. From the information made available to us, we are not convinced that these problems are widespread, and more importantly, we do not believe that the power if granted would necessarily remove them.

9.5 First, we think it is important to distinguish medical records from medical reports. The former are the primary documents on which contemporaneous notes of treatment and events are made whilst the latter are a full description of the doctor's personal involvement in the management of a patient, prepared by him often a considerable period after the relevant event has taken place, by reference to the records. There is no legal obligation of which we are aware on hospitals and doctors to produce medical reports (as opposed to records) nor is there any legal right on the coroner to require them. The position of doctors is no different from that of other individuals. They have a right to refuse to give a statement, whether in the form of a medical report or in some other form. However, in practice, the refusal to supply a medical report when requested by the coroner is rare. With regard to the complaint of delay, the preparation of medical reports is bound to take time especially where several doctors have been involved in the treatment of a patient. The very fact that the coroner requests a report may indicate that the doctor's management of a deceased patient will be subjected to detailed scrutiny and his report will be closely examined. Consequently, the doctor concerned will need and is entitled to a reasonable period of time to obtain legal and medical advice before submitting his report to the coroner. The existence of the power to search and seize will in no way expedite the preparation or submission of medical reports.

9.6 We accept the criticisms made of the present procedural deficiencies regarding the production of medical records. At present, the coroner has no power to order their production until the inquest is held. Unless the doctor voluntarily produces them, these records are usually secured by way of a witness summons addressed to the doctor who is directed to attend court and bring with him the records to produce in court. In

our view, the recommendation contained in paragraph 3.85 of the Report that the coroner should have the power to order production of the medical records immediately when a death is reported to him will overcome the problems of delay in obtaining them. We should at least wait and see how this power operates in practice before giving further consideration to introducing the wider power of search and seizure.

9.7 The information supplied to us concerning the loss or alteration of medical records does not persuade us that the power to search and seize is appropriate or that if the power existed, those records would not have been altered or lost. We did not think it possible to draw any firm inferences from the cases cited to us that the loss or alteration resulted from any deliberate destruction or concealment of evidence or of impropriety on the part of the persons involved.

9.8 The coroner would be in a unique position if he were able to exercise the power of search and seizure as a judicial officer and also enjoy immunity from legal process (See paragraph 6.46 of the Report). It is true that the recommendation conferring immunity on the coroner limits the immunity only where the coroner acted within his jurisdiction without malice and with reasonable and probable cause similar to the protection accorded to magistrates but it must be remembered that magistrates do not carry out investigative functions and are truly independent judicial officers. We believe that there are inadequate safeguards against any abuse or extravagant use of the power. This may result in public confidence in the judicial system being undermined and the high esteem in which the judiciary is held being lowered.

9.9 The Report states that “it is the duty of the police, and only the police, to investigate a death arising from crime” (paragraph 3.49 of the Report). It recognises a change of emphasis of the coroner’s work from crime to its wider medical and social functions. Yet, it recommends that the coroner should possess the power to search and seize for the purposes of investigating deaths not arising from any criminal conduct, a power exceeding even that of the police. The fact, as asserted in paragraph 3.60(a) of the Report, that the power could be used against the executive is of no comfort. In practice, the power would be exercised in the vast majority of cases against members of the public. The comparison we have drawn with the police is said to be misguided (paragraph 3.60(b)). In drawing the comparison, we sought to put the matter in a proper perspective. The Report rightly says that a power conferred upon one person necessarily imposes a potential liability upon others (para 3.53). Before the wide power of the kind proposed is conferred, we believe that we must be completely satisfied, on reliable information and evidence, that the need for it has been shown. From the information available to us, we are not so satisfied. We do not think it right to impose a potential liability on the public when the need for the power is in doubt.

9.10 We conclude this Minority Report by making an observation not strictly connected with the question of search and seizure. In paragraphs 3.25 and 3.56 of the Report reference has been made to the claim of some

doctors that records of a patient are confidential and may not be disclosed to the police or to the coroner. The Report implies that such a claim is groundless in law. We do not think this is so. A doctor owes a patient a duty of confidentiality which arises out of the doctor/patient relationship. The duty requires that a doctor should not without his patient's consent (or if the patient has died, the consent of his personal representative) disclose information to third parties except in certain circumstances. That duty is of paramount importance in doctor/patient relationships and survives the patient. The medical profession and its governing body take a serious view of any unwarranted breach of that duty. In practice, that rule is generally relaxed when the coroner seeks a deceased patient's records and as a result the coroner is usually given the records on request. That does not however mean that a doctor cannot legitimately rely on the duty of confidentiality as a ground for refusing to produce his patient's medical records unless so ordered by the court or consent to such production has been given by the patient's personal representatives. In so far as any claim to confidentiality may in the past have delayed the coroner's investigations, such delay will no longer occur once the coroner possesses the power to order production of the records immediately when a death is reported to him.

9.11 With the exception of the above, we concur with the remainder of the Report.

Commentators on the working paper

1. Organisations invited to comment
(* comments received)

JUSTICE (Hong Kong Branch)

* Hong Kong Bar Association

* Law Society of Hong Kong

Registrar, Supreme Court

Dean of Faculty of Medicine
University of Hong Kong

* Department of Medicine
University of Hong Kong

Department of Community Medicine
University of Hong Kong

* Department of Obstetrics & Gynaecology
University of Hong Kong

* Department of Orthopaedic Surgery
University of Hong Kong

* Department of Paediatrics
University of Hong Kong

* Department of Pathology
University of Hong Kong

* Department of Psychiatry
University of Hong Kong

* Department of Surgery
University of Hong Kong

* Dean of Faculty of Medicine
Chinese University of Hong Kong

Department of Medicine
Chinese University of Hong Kong

* Department of Obstetrics & Gynaecology
Chinese University of Hong Kong

- * Department of Orthopaedic & Traumatic Surgery
Chinese University of Hong Kong

- Department of Paediatrics
Chinese University of Hong Kong

- * Department of Morbid Anatomy
Chinese University of Hong Kong

- Department of Psychiatry
Chinese University of Hong Kong

- Department of Surgery
Chinese University of Hong Kong

- * Department of Community Medicine
Chinese University of Hong Kong

- * The Federation of Medical Societies of Hong Kong

- * The Hong Kong Medical Association

- * The British Medical Association

- American College of Chest Physicians

- Hong Kong Association of Health Service Administrators

- * Hong Kong Dental Association

- Hong Kong Geriatric Society

- The Hong Kong Neurological Society

- * The Hong Kong Neurosurgical Society

- Hong Kong Society of Community Medicine

- * Hong Kong Society of Diagnostic Radiologists

- * Hong Kong Society of Digestive Endoscopy

- Hong Kong Society of Gastroenterology

- Hong Kong Society of Haematology

- Hong Kong Society of Nephrology Ltd

- Hong Kong Society of Plastic & Reconstructive Surgeons

- * Hong Kong Surgical Society
- * The Obstetrical & Gynaecological Society of Hong Kong
The Pharmaceutical Society of Hong Kong
- * The Society of Anaesthetists of Hong Kong
The Society of Physicians of Hong Kong
- * The Western Pacific Orthopaedic Association (Hong Kong Chapter)
Hong Kong Midwives Association
Hong Kong Nurses Association
Hong Kong Society of Critical Care Medicine
- * The Medical Council of Hong Kong
- * The Hong Kong College of General Practitioners
Hong Kong Ophthalmological Society
- * The Government Doctors' Association
Hong Kong Orthopaedic Association
Hong Kong Oto-Rhino-Laryngological Society
Hong Kong Paediatric Society
- * Hong Kong Pathology Society
- * Secretary for Health & Welfare
Secretary for Security
Commissioner of Correctional Services
- * Government Laboratory
- * Director of Immigration
- * Commissioner ICAC
- * Director of Social Welfare
- * Director of Legal Aid

- * Commissioner of Police
- * Director of Medical & Health Services
- * Nursing Director
Medical & Health Department
- * Institute of Pathology
Medical & Health Department
- * The Hong Kong Psychiatric Association

Medical Social Worker Section
Social Welfare Department

Medical Students' Society
University of Hong Kong

Medical Students' Society
Chinese University of Hong Kong

The International College of Surgeons

Alice Ho Miu Ling Nethersole Hospital
- * Baptist Hospital

British Military Hospital Hong Kong

Canossa Hospital

Caritas Medical Centre

Castle Peak Hospital

Duchess of Kent Children's Orthopaedic Hospital, & Convalescent Home

Evangel Hospital

Fanling Hospital

The Grantham Hospital

The Haven of Hope Hospital

Hong Kong Adventist Hospital

Hong Kong Buddhist Hospital

- The Hong Kong Central Hospital
- * The Hong Kong Sanatorium & Hospital
- Kowloon Hospital
- Kwai Chung Hospital
- * Kwong Wah Hospital
- Lai Chi Kok Hospital
- Matilda and War Memorial Hospital
- Nam Long Hospital
- * Our Lady of Maryknoll Hospital
- * Pok Oi Hospital
- Precious Blood Hospital
- Princess Margaret Hospital
- Prince of Wales Hospital
- Queen Elizabeth Hospital
- Queen Mary Hospital
- Ruttonjee Sanatorium
- South Lantau Hospital
- St. John Hospital
- St. Paul's Hospital
- St. Teresa's Hospital
- Tang Shiu Kin Hospital
- Tsan Yuk Hospital
- * Tung Wah Eastern Hospital
- * Tung Wah Hospital
- Tung Wah Sandy Bay Convalescent Hospital

- * United Christian Hospital
- * Yan Chai Hospital
- Prince Philip Dental Hospital
- Arran Street Assessment Clinic
- * Hong Kong Psychiatric Centre
- Li Ka Shing Specialist Clinic
- Lock Tao Maternity Home & Clinic
- Sai Ying Pun Polyclinic
- Siu Lam Hospital for the Mentally Subnormal
- South Kwai Chung Jockey Club Polyclinic
- Yau Ma Tei Psychiatric Centre

2. Individuals who commented

D C Lee	H M Sinclair
Theresa A Howard	Chiu Shin-chak
Chan Kwok-cheung	Dr Langford
Dr Daisy Saw	Louis Lee
Dr Anthony Ng	Portia Sheen
Dr James S P Chiu	Dr Veronica Y C Wai
P J Preston	David Cheng
Chan Chiu-suck	Dr Philip Wen-chee Mao
Kwan Fung	Yip Yu-lap
Dr Chun Ling	Dr Y C Tsao
Dr Leung Nai-kong	Dr Edmund Cheung
David Yip Chi-pang	Wong Wu-shun
Richard Tan	Dr Sung Wing-choon

Dr L C Siu	K C Leung
K H Lee	Dr C S Ng
Dr Tang Chum-yue	Dr Stephen Wing-chiu Leung
Ma Kwok Fai	Willina Lim
Dr Tsui Man-shan	Dr A Van Langenberg
Dr Win Yu	Dr Liang Hung-Kuang
Cheung Ying Man	Sity Tann
Dr Diana Wong	Edmund Chow
Ip Wei Chung	Leung Sau-hung
Tong Moon-tong	Dr Y K Siu
Dr Myint Thein	Ng Wai-cheung
Dr Lai Yiu-ming	Lam Kin-fai
Lay Shing-chuen	Dr Pau Wing-foo
Dr Wong Tu-shin	Leung Cheuk Wai
Chao Pee Soom	Dr S K Yue
Stanley Sun	Dr B D Apthorp
R M Buckley	Ip Lai-sheung
Chan Shun-hung	Dr Theresa Chan Kee-hiang
John Boey	

Annexure 2

Table (1) Number of Still Births by Type of Institution (1983-86)

Year	Government Hospitals *	Subvented Hospitals	Private Hospitals	Government Maternity Homes	Total
1983	191	100	61	9	361
1984	158	81	66	6	311
1985	152	85	58	-	295
1986	152	70	48	2	272

Note:

The totals set out in this table are not always identical with the totals presented in the Annual Report of the Medical and Health Department because this table:

- (a) does not include returns from public mortuaries;
- (b) does not cover the British Military Hospital and private maternity homes.

Table (2) Number of Total Births by Type of Institution (1983-86)

Year	Government Hospitals *	Subvented Hospitals	Private Hospitals	Government Maternity Homes	Total
1983	32 707	23 288	16 330	9 573	81 898
1984	29 995	22 217	15 066	8 771	76 049
1985	30 540	21 976	14 931	7 481	74 928
1986	29 276	19 960	14 835	6 293	70 364

Note: Total Births = Live Births + Still Births
*including Correctional Institutions

Annexure 3

STATISTICS ILLUSTRATING NUMBER
OF MAN HOURS WORKED PER DEATH REPORT BETWEEN
JANUARY AND JUNE, 1984

	No. of Officers	Man-hour worked /day (n)	Total man-hours n x 20 days x 6 mths.	No. of Death	No of Death Report called for	No of Death Inquest
Wch	1 IP 1 Sgt 3 PCs	1.4 2.1 8.4	168 252 1008	111	26	0
HV	1 IP 1 PC	1.4 7.0	168 840	35	11	1
NP	1 IP 1 Sgt 1 PC	3.0 0.5 7.0	360 60 840	74	12	1
SKW	1 IP 1 PC	1.0 7.0	120 840	57	9	0
CB	1 IP 1 PC	2.5 5.0	300 600	37	13	0
CW	1 IP 1 PC	2.5 6.0	300 720	69	20	4
C	1 IP 1 PC	1.4 7.0	168 840	56	14	0
WF	1 IP 1 PC	1.4 7.0	168 840	19	8	2
P	-	-	-	1	1	1
W	1 IP 1 PC	1.4 7.0	168 840	134	26	0
A	1 IP 1 PC	1.4 7.0	168 840	123	30	0
S	-	-	-	5	1	0
T HKI	-	-	-	19	18	1
Total			10608	740	189	10

No. of Death Reports complied by HKI (less P, S & T/HKI) = 169
 No. of Man-hours worked between Jan and June 1984 = 10608
 No. of Man-hours worked per death report = $\frac{10608}{169}$ = 62.77

Points

1. Only Hong Kong Island
2. Hurried figures
3. Initial attendance/enquiries are excluded
4. Based on present reporting system
5. Conclusions are for D. R. (Cor 9), not all deaths
6. May exclude attendance at inquests plus organising such
7. Basic (minimum) requirement for Hong Kong Island:

Inspectorate	-	2
Junior Police Officer	-	10

Present system

- Day 1 Body found (Reported to Police)
 Body to Hospital
 Death certified
 Body to Mortuary
 Witnesses sought
 N O K informed/interviewed
 Pol 44 prepared in Police Station
 Pol 75 prepared in Police Station
- Day 2 Pol 44 + Pol 75 to Mortuary
 N O K to Mortuary (ident)
 Police to Mortuary (ident)
 Pathologist – external examination
 Post mortem conducted
 Pol 44 to Coroner
 Cor 13(s) signed by Coroner
- Day 4 or + Coroner decides on Death Report (Cor 9)
- Day 5 or + Police informed of Coroner's decision
- Day 5 or + Enquiries
- ↓
- Day 28 Report (or interim) to Coroner via Coroner's Officer

GENERAL POWERS OF THE CORONER UNDER
THE MAGISTRATES ORDINANCE

Provisions to be adopted or disappplied

Section 15 of the Coroners Ordinance provides:

“A coroner shall have in relation to the inquiries provided for in the sections 6, 7 and 8 the same powers in all respects as a magistrate has under Part II of the Magistrates Ordinance.”

1. The following sections of the Magistrates Ordinance Cap. 227 have no relevance to the jurisdiction of a coroner and, in so far as they are intended to apply to a Coroner’s Court, should be disappplied: -

8, 8A, 9, 10, 12, 13, 14, 15, 17, 18A, 18B,
18C, 18D, 18E, 19, 19A, 23, 24, 25, 26, 26A 27,
28, 29, 31, 33, 34, 36, 37, 38, 39, 40, 41,
42, 44, 47, 48, 50, 51, 52, 53, 54, 55, 56,
57, 58, 59, 60, 61, 62, 63, 64, 65, 67, 68

2. The following sections of the Magistrates Ordinance Cap. 227, although relevant to the jurisdiction of a coroner, are already provided for in the Coroners Ordinance or Rules. Those provided for in the Rules should be removed therefrom and incorporated in the body of a new amended Coroners Ordinance.

11 Place and manner of hearing
(see Rule 10 Coroners Rules)

16 Rights of parties to conduct case personally or by
counsel
(see Rule 12(1) Coroners Rules)

20 Adjournment of hearing and procedure thereon
(see Section 14 Coroners Ordinance)

3. The following sections of the Magistrates Ordinance Cap. 227 are inappropriate in their present form to a Coroner’s Court and should no longer apply. Each should, however, be suitably adapted for use by a coroner and incorporated in a new Coroners Ordinance: -

21 Provision as to witnesses

22 Power to order production of documents

30 Proof by declaration of service of process and of
handwriting, etc.

32 Non-avoidance of summons or warrant by death of
magistrate

69-71 - Costs (see Report Chapter 6.43)

Annexure 5

Government Laboratory Post Mortem Reports

TURNAROUND TIME 1984

1. Cases given priority

		<u>No. of Cases</u>	<u>No. of Samples</u>	<u>Range of Turnaround Time (days)</u>	<u>Average Turnaround Time per case (days)</u>
(i)	Alcohol	434	871	1-17	6.8
(ii)	Cyanide and/or drugs	6	32	6-29	12.3
(iii)	Carbon Monoxide	60	155	2-53	8
(iv)	Anaesthetics etc	3	12	14-39	24
(v)	Major Crime Involvement	33	162	3-58	21.4
(vi)	Tourists and persons died in custody	10	54	13-55	38.2
(vii)	Special Cases	6	21	1-25	11.3
	Sub-total :	552	1307	1-58	17.4
2.	<u>Normal Cases</u>	480	2324	15-153	47.5
	Total :	1032	3631	-	-

Annexure 6

Inquest Statistics

	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
A. Number of deaths in Hong Kong	24,978	25,460	26,485	25,580	25,325	26,030
B. Number of deaths reported to the Coroner	5,854	5,862	5,999	5,746	5,591	5,777
C. Number of Inquests held and Verdicts recorded	245 (Inquests) 245 (Verdicts)	199 (Inquests) 199 (Verdicts)	188 (Inquests) 189 (Verdicts)	141 (Inquests) 141 (Verdicts)	179 (Inquests) 178** (Verdicts)	224 (Inquests) 224 (Verdicts)
D. Number of Inquests convened with and without a jury	54 (with jury) 191 (without jury)	41 (with jury) 158 (without jury)	50 (with jury) 138 (without jury)	36 (with jury) 105 (without jury)	25 (with jury) 154 (without jury)	54 (with jury) 170 (without jury)
E. Number of cases in which a Warrant under S.16 Cap.14 were issued for what offences, plea and whether a criminal conviction resulted.	2*	-	-	1	-	-

*	<u>Verdict</u>	<u>Plea</u>	<u>Conviction Result</u>	<u>Remarks</u>
(1)	Manslaughter	No	No	This case was re-opened and the Verdict was then Accidental Death. Form 5 Warrant issued previously was subsequently withdrawn.
(2)	Accidental Death, Driver to be charged with Dangerous Driving causing Death.	Nolle prosequi entered but charged with causing bodily harm by willful misconduct and other charges.	Fined \$1,000	

** Excluding one "still birth"

Annexure 7

Verdicts

<u>Type of Verdict</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
Natural Causes	33	32	36	29	17	31
Accidental Death	169	117	124	68	60	65
Death by Misadventure	6	24	6	16	65	96
Suicide	14	12	9	5	7	8
Justifiable Homicide	2	2	4	3	2	2
Manslaughter	2	1	-	2*	1**	-
Murder	-	-	-	3	-	-
Homicide	1	-	1	-	2	4
Lack of Care	-	-	-	2	5	3
Excusable Homicide	2	1	-	-	-	-
Open	<u>16</u>	<u>10</u>	<u>9</u>	<u>13</u>	<u>19</u>	<u>15</u>
Total	<u>245</u>	<u>199</u>	<u>189</u>	<u>141</u>	<u>178</u>	<u>224</u>

* (1) Verdicts of involuntary manslaughter by person or persons unknown within C.M.B. Co. therefore no Form 5 warrant issued.

(2) Form 5 warrant issued but A.G. entered nolle prosequi.

** No Form 5 warrant issued. D.C.P. decided not to proceed with that charge.

The duty to report and subsequent procedures

