Clinical Forensic Medicine: Much Scope for Development in Hong Kong

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Introduction
Clinical Forensic Medicine is that area of medical practice whereby medicine and law overlaps. However, unlike the established area of forensic pathology, doctors practicing clinical forensic medicine spend most of their time dealing with the living patient. Internationally, the organization of clinical forensic medicine can be divided into three distinct regimes. In the United Kingdom and Australasia, clinical forensic medicine is practiced by a group of doctors who are not forensic pathologists. Most of these are general practitioners, although there are now more and more members with other postgraduate qualifications. Most are part-time but in some areas, there are now full-time practitioners. They were once referred to as Police Surgeons but now are also referred to as Forensic medical examiners (FME’s). In Australasia, they too are mostly general practitioners and many are also employed as Government Medical Officers (GMO’s). The second regime is that of Continental Europe, where doctors in Institutes of Legal Medicine assume such a role, they often are also forensic pathologists. In Hong Kong, the official set-up is surprisingly that of Continental Europe and thus akin to Mainland China. This system in Hong Kong has been in place however since the origin of the Forensic Pathology Service. Finally, the third regime is that of the United States, where there is no easily identifiable group of doctors providing Clinical Forensic medical service. The nearest that one can find are the doctors working in Emergency Rooms. Since the late eighties, the role has gradually been taken up by Forensic Nurses.

What Does Clinical Forensic Medicine Involve?
In a sense it can theoretically involve every aspect of clinical medicine. However, it is often taken to include the following: -

a. Custodial medicine, i.e. the care of detained persons
b. Medical examination and assessments of victims and assailants
c. Medical examination and assessments of motorists who may be driving under the influence of alcohol and/or drugs
d. Medical examination and assessments of motorists for a declaration of "fitness to drive"
e. Medical examination and assessments of asylum seekers, torture victims, etc.
f. Workers compensation examination and assessments
g. Medical examination and assessments of mental health for legal and court purposes.

Some of the work is now clearly undertaken by some groups of doctors in Hong Kong. Forensic psychiatry is reasonably well established both in Government and private practice. Dedicated prison medical officers are employed by the Correctional Services Department to work in the prisons around Hong Kong. Victims of rape and serious child abuse are seen by doctors from the forensic pathology service. Increasingly victims of child abuse are seen by dedicated paediatricians interested in the area of child abuse. However, a large proportion of clinical forensic medical work is not been covered by dedicated groups of doctors interested in the area. Much of the work is currently done by doctors at Accident & Emergency Departments. It is unclear to me, how much of such work is handled by doctors in private practice. There are certainly quite a few involved in writing reports particularly for insurance-related claims and counter-claims.

What Training Is Available?
Currently, in Hong Kong there is none. Almost any doctor can do the work. It goes without saying therefore that the quality of the work varies greatly. Theoretically, this situation should not exist as lawyers and the courts should be challenging the qualifications of their medical and other professional witnesses and particularly when they are used as "expert" witnesses.

How can doctors gain recognition of expertise in Clinical Forensic Medicine? Currently, they can train with a recognized expert and then sit for the Diploma in Medical Jurisprudence in Clinical Forensic Medicine exams.
offered by The Worshipful Society of Apothecaries in London. This Diploma is well-recognised in the U.K. and allows doctors to charge a "specialist" rate when providing such work for the Police or for other agencies. Alternatively, there is now a 2-year postgraduate Diploma Course offered by the Victorian Institute of Forensic Medicine and Monash University. In Hong Kong, training is only available for those enrolled with the College of Pathologists and is part of the postgraduate training for forensic pathology.

Why should a qualified medical doctor need such training? The answer is fairly simple, because the average doctor in Hong Kong really has no training or experience in these issues. Clinical forensic medicine is almost absent from the medical undergraduate curricula in both our medical schools. Young doctors therefore graduate with almost no knowledge on these areas. The absent of post-graduate training in these areas in any of the Specialist Colleges does little to improve the situation. It is therefore easy to see that, even after attaining a specialist registration, doctors are far from equipped to work in these areas. To illustrate the point, a case of fatal head injury was been heard in Court. A doctor with specialist qualification was asked whether he thought a "depressed skull fracture" was the result of a fall. His answer was a simple yes. This is an inadequate answer and is misleading because a depressed skull fracture occurs only when a "shaped" object depressed the skull, therefore suggesting that the impact must be with a "shaped" object. A fall involves in most instances the skull hitting the ground, which is a large flat surface. Fractures arising from such impacts are generally linear fractures. The answer would have been correct if it was qualified by saying that it could be caused by a fall, if the head had struck a shaped object as a result of the fall. Why does it matter? It matters because the family of the deceased person has a right to know what happened and it also matters because been hit by a shaped object generally is attributable to a third party and the family may be able to at least get some financial compensation for their loss.

Conclusion

Finally, is there really scope for such work? Of course there is, published police figures show that in 2001 alone there are 1007 reported victims of indecent assaults, 1701 victims of wounding and 4771 victims of serious assaults. I have not even explored the figures for victims of domestic violence, workplace accidents, etc. We should look at improving services and insist that those who do such work are properly trained and qualified. Not only will we have a new specialty, we will also have improved the quality of "evidence" given by doctors in the Courts of Law in Hong Kong.
It is a basic ethical principle that every person has a right to self-determination. A person of sufficient maturity and mental capacity can choose the service of a doctor and decide what shall be done with his body. He has the right to refuse medical treatment even if it may entail risk of his death. Consent to examination and treatment by a doctor is therefore important before a doctor undertakes to treat a patient. Absence of consent may lead to civil claims or even criminal proceedings. There are of course exceptions.

**Nature of Consent**
It is determined by the intended examination or treatment. It is something we encounter every day, but complaint is not frequent.

**Implied Consent**
It is the most common form of consent in general or hospital practice. It bases on the conduct of the patient. The mere fact of presenting oneself to the out-patient clinic and going through the steps to be seen by a doctor is indicative of consent to medical examination generally. It may involve inspection, palpation, percussion and auscultation. However, having the courtesy of telling your patient what you will do next is good clinical practice. More complicated procedures such as per rectal and vaginal examinations and blood taking for diagnostic purposes need express permission.

**Express Consent**
Consent is express when the patient explicitly agrees to the proposal of the doctor. It may be oral or written. With minor procedures, oral is good enough. It should be taken in the presence of a third party such as a nurse. Obviously, it is not desirable to be witnessed only by a companion of the patient. Although oral consent is as valid as written consent and there is no requirement in law that consent be reduced to writing, for the purpose of adducing evidence, written consent is to be preferred. It is permanent and easy to prove. That is why for more complicated procedures, written consent should always be sought.

**Written Consent**
It is used in all major diagnostic procedures and surgery. A separate consent should be obtained for each specific procedure, witnessed, signed and dated. If the specified procedure is not done within a reasonable period of time, it is necessary to obtain the consent once again to ensure there is no change of mind.

**Informed Consent**
It is important because many civil actions resulted from the allegation that the patients did not fully understand the procedures when they gave their consent. Basically, consent should be obtained after reasonable explanation of the procedures. All substantial risks must be explained in comprehensible language to ensure the patient understands. Standard of care in giving information is the same as that required in diagnosis and treatment, i.e. to exercise reasonable care and competence subjected to peer review. Generally speaking, the patient is required to know his condition, the nature and purpose of the proposed procedure, any options, possible risks or side effects, their consequences and the possible results to the patient if that procedure is not taken. The doctor is to assess whether the patient is able to comprehend and fully understand the information provided and he can modify his explanation according to the mental capacity of the patient. It is the responsibility of the doctor himself to discuss with the patient and to obtain consent. If he needs to delegate the task to someone else, that person must be suitably trained and qualified.

**Who Can Give Consent?**
An adult person with a sound disposing mind is competent to give consent by himself. As age of majority in Hong Kong is 18 years, a person 18 years of age or over is presumed to be able to give a valid consent for medical treatment. In Hong Kong, there is no statutory provision similar to that in the United Kingdom Family Law Reform Act 1969 which recognises the ability of a person above 16 years to give consent to medical treatment.

**What Constitutes Valid Consent?**
The patient is competent to take the decision, provided with sufficient information and acts voluntarily.

**Consideration under Special Circumstances**

**Consent in Minor**
In general, for children under the age of 18 years,
consent to medical procedures should be from parent or guardian. However, if the doctor honestly believes that the child is able to understand fully the information given by him and the implications of giving consent, the child can give the consent by himself.

In Gillick v West Norfolk and Wisbech AHA (1985), the House of Lords held that a child under 16 years had the legal capacity to consent to medical examination and treatment, including contraceptive treatment, if she had sufficient maturity and intelligence to understand the nature and implications of the proposed treatment. It was held that there was no rule of absolute parental authority over a child until a fixed age. The law recognised parental rights only in so far as they were needed for the child's protection. Parental rights yielded to the right of the child to make his own decisions if of sufficient understanding and intelligence.

The Gillick case has not removed the rights of the parents to consent to a child's medical treatment. Those with parental responsibility can override the wish of a child who is 'Gillick competent' by consenting to treatment which the child refuses.

In cases when the parent refuses to consent to an urgent life-saving procedure for an incompetent child e.g. Jehovah's Witness, the doctor can proceed without the parent's consent so long as he acts in good faith that the procedure is urgently required for the child's welfare and interest to save life or prevent permanent disability.

Consent in Unconscious Patients
Doctors should try to contact the nearest relative for permission if time allows. Doctrine of necessity extends only to measures required immediately to save life and restore consciousness. It does not cover non-urgent treatment though it may be more convenient to be carried out at the same time.

Consent in Patients Suffering from Mental Disorders
Mental Health Ordinance Cap 136 provides answers to certain matters regarding examination and treatment of mental disorders.

As with any mentally competent adult, a mentally incapacitated adult can consent to his own medical treatment if he can understand the nature and effect of such treatment. He will be regarded as competent to take the decision if he has the ability to understand the information given, to retain and believe it, and to use it to reach a reasoned decision.

If he is unable to consent, the doctor can provide urgent medical treatment which is necessary and in his best interests without his consent. A doctor can also provide non-urgent medical treatment which is necessary and in his best interests without his consent after taking all reasonably practicable steps to ascertain that there is no guardian appointed or that the guardian appointed has not been given the power to consent to medical treatment. It is good clinical practice to seek the views of the family. The best interests test is that the treatment will save the life, prevent damage or deterioration, or bring about an improvement to his physical or mental health and well being.

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Consent for Medico-legal Examination
Written and witnessed informed consent must be obtained with the patient's full understanding of the nature and purpose of the examination and samples collected. He should also be reminded that the result of the examination may be used as evidence in court against him.

Medical Examination without Consent
- A prisoner on initial admission to prison
- New immigrant on entry to HK
- To prevent spread of infectious diseases, Cap 141B
- Order by Court
- To search for dangerous drugs in body cavities, e.g. rectum, vagina, ears, Cap 134

Confidentiality
The concept of confidentiality in a proper doctor-patient relationship can be found in the Hippocratic Oath: 'Whatever in connection with my professional practice, or not in connection with it, I see or hear, in the life of man, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.'

It is one of the most fundamental ethical obligations which a doctor owes to his patient. If patients are not sure what they tell a doctor in a consultation will be kept confidential, they may not be willing to disclose sensitive information which is essential in helping diagnosis and management.

In general, all information divulged by a patient to a doctor should be treated confidentially. It should not be
passed to other people except for the health care team involved in the management of the patient. Records should be securely kept. The duty of confidentiality does not stop with the death of the patient.

When it comes to relative, there is no automatic right of relative to be told the medical facts about a patient, except in small children. If it is URTI, probably there is no problem, especially when the relative has to care for the patient. What about pregnancy or STD or any condition which threatens intra-family relationship. There are also difficulties with spouse at risk e.g. AIDS.

Failure to observe the duty of confidentiality is liable to civil action. Abuse is considered to be misconduct in a professional respect. Personal Data (Privacy) Ordinance, Cap 486 may be violated as well.

Professional Confidence May Be Broken:

- **Consent of the Patient**
  It is prudent to document the consent.

- **Statutory Duties**
  e.g. notification of infectious diseases, birth and deaths. The information is divulged to the proper authority only.

- **Order of a Court**
  Doctor has to comply. He may ask the judge for direction. He may also suggest giving the answer in writing.

- **Interest of Community**
  e.g. bus driver with frequent attacks of epileptic fits. The doctor should persuade the patient to disclose the information, or refer the patient to an appropriate consultant so as to add more weight to his opinion. If persuasion fails, the doctor should inform the patient that he will disclose the information to the appropriate authority. No subsequent legal action under such circumstances is likely to succeed.

In general, the police have no more right than any other person in getting confidential information from doctors. When a doctor believes that his patient has involved in a serious crime, should he divulge the information to the police? He has to rely on his judgement and advice from senior colleagues, department and protection society. If the crime was very serious and if prevention or detection would be made much more difficult without that information, the doctor has more justification to divulge the information to the police. It is deemed to be justifiable when failure to disclose would expose the patient or someone else to a risk of death or serious harm. The test is whether the public good in disclosure of information exceeds his ethical duty of secrecy.

**Confidentiality and Young Children**
If a young person, who in the doctor’s opinion was of sufficient maturity to appreciate all the circumstances, desired the doctor not to disclose his information to his parents, his wish must be respected. Though the Gillick case concerned contraception, the principle of confidentiality applies to all medical activity. Every effort must be made by the doctor to obtain consent to voluntary disclosure to his parents to maintain a harmonious family relationship.

**Contractual Duties to Third Party**
A person may present himself to a doctor for medical examination in connection with insurance, employment, etc. Consent to divulge information to the appropriate body has to be sought. Information disclosed should be limited to what is relevant to the purpose of the examination.

**Personal Data (Privacy) Ordinance Cap 486**
Doctors have to be familiar with this ordinance which protects the privacy of individuals in relation to personal data. Section 59 on Health and Section 62 relating to Statistics and research are relevant. They must comply with the data protection principles in Schedule 1:

- Principle 1 – purpose and manner of collection of personal data
- Principle 2 – accuracy and duration of retention of personal data
- Principle 3 – use of personal data
- Principle 4 – security of personal data
- Principle 5 – information to be generally available
- Principle 6 – access to personal data

**Medical Negligence**
Some people use the term loosely to mean bad clinical practice. It is in fact a sub-section of the law of tort. In the present context, legal action for negligence is the patient’s claim for compensation for losses caused by the doctor. It is the most common legal claims for compensation brought against doctors.

The legal requirements for the finding of negligence are:

- **Duty of care**
- **Breach of the duty**
- **The breach caused the patient’s injury or losses**
- **The injury or losses being reasonably foreseeable**
**Duty of Care**

If a doctor holds himself out as having special skill and knowledge and a patient consults him, a duty of care is established. Agreement to pay is irrelevant. The law does not impose an onus on a doctor to treat a stranger. A doctor is not negligent if he offers no help in an emergency situation in the street, although it is unethical to do so. But if he treats a stranger, a duty exists. There is no need for a bilateral agreement to establish a duty of care. Essential thing is the action to treat. The patient may be unconscious and unaware of the doctor's presence.

**Breach of Duty**

The doctor's duty is to exercise reasonable care. What is reasonable must be determined by taking into account all the circumstances. To establish negligence, a patient has to show that the doctor has not fulfilled his duty as a doctor to treat him. Bolam test – a doctor has not breached his duty if there is a responsible body of medical opinion which would have acted in the same way in the same situation. According to Bolam test, the standard of care is judged by comparing those skilled in the particular specialty, i.e. a family physician to be judged against what is reasonable to be expected of a family physician. He is logically not as good as a specialist surgeon in surgical conditions, but he is expected to refer the case to the specialist when indicated. Health professionals would be judged according to the post they hold. There is no excuse for inexperience. It is therefore essential to consult the more experienced senior staff and refer the cases to the appropriate expert when necessary. An error of clinical judgment may or may not be negligent. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and skill that the doctor held himself out as having, and acting with ordinary care, then it is negligent. If, it is an error that a man acting with ordinary care might have made, then it is not. It appears from recent case laws that the courts would be most unwilling to challenge opinions given by medical experts unless they are clearly unreasonable and do not stand up to analysis. Decision is open to the court.

**Causation**

The law makes a doctor liable if his negligent act or omission resulted in injury to the patient. The law also requires that doctor's mistake "made a difference". "But for" test is used.

**Losses Being Reasonably Foreseeable**

An injury is deemed to be foreseeable consequence of the negligent act if damage of that general nature can be foreseen.

Bad clinical practice does not mean that patient's claim for negligence will be successful. However careless the doctor, the patient can bring no action for negligence if there is no damage. Doctors should inform patient of mistakes made, but should not admit negligence before seeking advice.

**Duty to Third Parties**

As a result of medical mistake, a patient's relative suffered psychological harm. Does the doctor owe a duty of care to the patient's relative?

It is likely that the doctor owes a duty of care if
- he is close relative
- he was involved in the immediate aftermath
- it constituted a horrifying external event
- the psychological harm is reasonably foreseeable
- he suffered from a well defined form of psychiatric illness rather than just sorrow.

**Medical Advice Affecting Third Party**

e.g. sexual partners of patients affected by contraceptive decisions. It appears that doctors may be liable to third parties whom they would reasonably be expected to know about at the time the advice was given.

**Categories of Medical Negligence**

The list is inexhaustible. It can occur anywhere along the chain of patient care. Some common ones are error in diagnosis or treatment, failure to give proper advice, giving wrong drug or right drug but with wrong dose, failure to x-ray fractures, oversight of foreign bodies, tight plaster casts, transfusion of incompatible blood, and so on.

**Damages**

The amount of compensation does not depend on the degree of negligence but upon the effects of the negligence on the person who has been harmed. A minor fault may lead to a vast compensation if the harm suffered by the patient is substantial. The damages awarded are intended to compensate the patient and to place him as near as possible to the same position as if the negligent act had not happened.

**Vicarious Liability**

Employer may be held responsible for the negligence of any employee in the course of his employment. The employee remains himself liable for his own negligent acts.
**Burden of Proof**
The burden of proof is on the party who brings the action, and the standard of proof is on balance of probabilities. In other words, to bring an action for negligence, the patient (plaintiff) has to satisfy the court that on balance of probability, he had suffered damage as a result of the doctor's (defendant's) negligence.

**Res ipsa loquitur (the Fact Speaks for Itself)**
The burden of proof may sometimes be shifted to the doctor in obviously wrong acts, e.g., amputation of the wrong limb, wrong side, wrong patient, retained instrument in abdomen, etc.

**Novus Actus Interveniens**
It means a new intervening act. The harm suffered by the patient is aggravated or contributed by an unforeseeable and separate event which is not the fault of the doctor or patient.

**Defence**

**Delegation of Duties**
A doctor should not delegate tasks unless he is confident that the one he delegates is adequately trained and competent.

**Contributory Negligence**
Patient's own action aggravated or contributed to the harm, e.g., pulling off dressings leading to infection, defaulted follow-up.

**Minimizing Risk**
- Be familiar with working guidelines and protocols and keep abreast of recent development of knowledge.
- Exercise due care and skill within your competence.
- Be ready to consult others.
- Keep accurate and legible contemporaneous notes.
- Ensure good communication with the patient and the health care team.
- Informed consent is important.
- Duties should only be delegated to competent and reliable staff, with a system of monitoring.
When it is the inevitable fact that in spite of the most dedicated and determined effort of the attending physician to treat his patient, the patient succumbs ultimately to either the disease or injury causing death, the doctor is entrusted with the legal authority to pronounce the fact of the death and follows with this, the proper certification, and if deemed indicated, the reporting of such a death to the appropriate authority. The practising medical practitioner is therefore expected to be conversant with the legal requirement of such procedures so as to better equip himself in discharging his professional duties. Below are references to the relevant practicalities and procedures of the whole process.

I. Births & Deaths Registration Ordinance Cap. 174

Whenever the registered medical practitioner has certified the death of his patient, he has a moral obligation to provide the next-of-kin the necessary documentation for registration with the Registrar of Births & Deaths so that proper funeral arrangement could be made to put the deceased to rest. The document is named the Form 18 or more properly as the Medical Certificate of the Cause of Death (死因醫學證明書). This however is often wrongly quoted as the Death Certificate (死亡證). In essence, the doctor is accepted as the most appropriate person to certify the fact of the death and more so, the cause of the death of his patient whom he has examined and treated. The doctor is also respected for his high esteem and his signing the Form 18 alone is therefore accepted as proof of sufficient information to register the death and for funeral arrangement. The practicing doctor is therefore well advised to be careful in the filling in of such important document.

In theory, the Registrar of Births & Deaths will scrutinise the doctor's Form 18 when the next-of-kin registers the death at the Births & Deaths Registry. He is supposedly to vet all the information contained in the Form 18 and if he feels that the death might not have been a natural one, or there are unexplained areas described in the form, the Registrar can report the death to the attention of the Coroner. This is to safeguard that all unnatural deaths and/or suspicious deaths could be properly investigated under legal authority from the Coroner's office.

II. Coroners Ordinance Cap. 504

The present Coroners Ordinance replaced the previous Cap. 14 in 1997 and brought in a number of changes:

1. Certification of the Fact of Death

   The law now actually requires the doctor who issues the Form 18 to personally view the patient to view and therefore to certify the fact of the death. In the hospital setting, it is accepted that the doctor who issues the Form 18 can take in the information of the fact of the death certified by his fellow colleague in the hospital but has to be in writing.

2. Reportable Deaths (Schedule 1)

   The law now defines 20 categories of reportable deaths for which the certifying doctor is disallowed from issuing a Form 18 and for which he is under a legal duty to report such reportable deaths to the Coroner for further action. Any failure on his part in not reporting such a reportable death is a criminal offence and the doctor is at risk of a fine at level 1 and to 14 days imprisonment.

   Here we might as well look carefully at the list of the 20 categories of such reportable deaths:

   #1 is self-explanatory. The doctor who does not know the medical cause of death should be understandably unable to state it in the Form 18.

   #2 requires the doctor to establish a professional consultation with his patient during the latter's last illness within 14 days prior to the death. To avoid ambiguity, it stipulates a minimum interval of 14 days in between the last consultation and the death. An exception is allowed for a diagnosed terminal illness and leaves the onus to the doctor to decide on what constitutes as ‘terminal’.

   #3, 4, 11, 17, 18 & 19 are related to unnatural deaths for which an autopsy is indicated for confirmation of the cause and circumstances of the death.
#5 relates to anaesthetic deaths, either directly as the cause of the death or indirectly died within 24 hours after the administering of a general anaesthetic. This disallows the doctor to issue the Form 18 and provides the authority to the Coroner to investigate.

#6 likewise relates to operation deaths, again either directly as the cause of the death or indirectly died within 48 hours after a major operation. The decision to label an operation as major or otherwise again vests with the doctor as determined in accordance with prevailing medical practice and gives him free hand in so doing dependant on his professional judgement.

#7 refers to occupational diseases as there will likely be issues of compensation forthcoming. Without an investigation including an autopsy, the death should not simply be signed off even though the medical diagnosis is known.

#8 & 9 relate to stillbirths and maternal deaths respectively.

#10 refers to septicaemia and I suspect that it might have been the law drafter's phobia about the sinister nature of the word itself rather than the mechanism in producing septicaemia.

#12, 13 & 14 are deaths under legal custody or related circumstances in which the deceased was deprived of his liberty. A inquest is mandatory and therefore it is only natural that the death should be reported to the Coroner in the first instance.

#15 & 16 are deaths related to deaths in mental institutions and nursing homes for which an investigation is deemed indicated to find out the circumstances of the death.

#20 is technical so as to give authority to the Coroner to investigate into any death where the body is brought into Hong Kong.

Further to the introduction of reportable deaths, the Coroners Ordinance also provides other measures to facilitate the process and some of which affect the medical profession.

3. A doctor having attended to a deceased person prior to his death, either in a clinic or in a hospital, is included into the list of Properly Interested Persons (PIP) and is entitled to certain rights (Schedule 2). He can apply to the Coroner to be present at the autopsy and to receive all documents available to the Coroner. In essence, he can now have access officially to all information related to the death of a patient that he has attended.

4. Previously, once a death is reported to the Coroner, there will follow an automatic and immediate investigation by the police and the doctor will unavoidably be asked to give a statement describing what he has done to his patient. Once given, the doctor will be in the dark for an unspecified period of time. There may or may not be an Death Enquiry to follow.

The new reporting mechanism provides flexibility to the Coroner whether to proceed with investigation with or without autopsy even having received a report. This is designed to facilitate and remove the unwarranted worry of doctors in ‘signing’ off an anaesthetic or operation death for fear of the inconvenience that is bound to follow the reporting. The new Coroners Ordinance should be viewed as an aid to the doctor’s work.

5. Also depicted in the previous Coroners Ordinance, if the death is one that attracts public interest, a Death Enquiry requiring the appearance of the doctors having treated the patient is always a must. Many a time, the doctor's evidence is not in dispute and his appearance is merely to verify the originality of his medical report. This causes great inconvenience to the busy practising doctor. The revised Coroners Ordinance now introduces the Pre-inquest Review for undisputed evidence. The setting is in the form of an informal hearing arranged at a convenient time to all parties concerned. Free exchange of views can be shared and explained to all interested parties including the next-of-kin. If all parties are satisfied with the evidence and all doubts are cleared, either due to previous misunderstanding or sheer ignorance of technical matters, a formal Death Inquest can be dispensed with.

To the medical practitioner who might be in a position to certify the death of his patient, the knowledge of death certification and investigation procedures are crucial. All doctors are therefore well advised to be made fully aware of the legal basis of such processes.
Part 1: Reportable Deaths

1. Any death of a person where a registered medical practitioner is unable to accurately state the medical cause of the death in the certificate of the cause of death.

2. Any death of a person (excluding a person who, before his death, was diagnosed as having a terminal illness) where no registered medical practitioner has attended the person during his last illness within 14 days prior to his death.

3. Any death of a person where an accident or injury (sustained at any time) caused the death.

4. Any death of a person where a crime or suspected crime caused the death.

5. Any death of a person where
   (a) an anaesthetic caused the death;
   (b) the person was under the influence of a general anaesthetic at the time of the death;
   (c) the death occurred within 24 hours after the administering of a general anaesthetic.

6. Any death of a person where
   (a) an operation, whether or not lawful, caused the death;
   (b) the death occurred within 48 hours after a major operation (as determined in accordance with prevailing medical practice), whether or not lawful.

7. Any death of a person where
   (a) an occupational disease, within the meaning of section 3 of the Employees' Compensation Ordinance (Cap. 282), or pneumoconiosis, within the meaning of section 2 (1) of a Pneumoconiosis (Compensation) Ordinance (Cap. 360), caused the death;
   (b) having regard to the nature of the last illness of the person, the medical cause of the death and the nature of any known occupation or employment, or previous occupation or employment, of the person, it is reasonable to believe that the death may be connected, either directly or indirectly, within any such occupation or employment.

8. Any still birth where
   (a) there is doubt as to whether the still born foetus was alive or death at the time of birth;
   (b) there is a suspicion that the still birth might not have been a still birth but for the wilful act or neglect of any person.

9. Any death of a woman where the death occurred within 30 days after
   (a) the birth of her child;
   (b) an operation of abortion, whether or not lawful; or
   (c) a miscarriage.

10. Any death of a deceased where
    (a) septicaemia caused the death; and
    (b) the primary cause of the septicaemia is unknown.

11. Any death of a person where there is a suspicion the death was caused by suicide.

12. Any death of a person where the death occurred whilst the person was in official custody.

13. Any death of a person where the death occurred during the course of the discharge of his duty by a person having statutory powers of arrest or detention.

14. Any death of a person where the death occurred in the premises of a department of the Government any public officer of which has statutory powers of arrest or detention.

15. Any death of a person where the person
    (a) is a patient, within the meaning of section 2 of the Mental Health Ordinance (Cap. 136), and the death occurs in a mental hospital within the meaning of that section; or
    (b) is a patient the subject of an order section 31 or 36 of that Ordinance and the death occurs in a hospital other than such a mental hospital.

16. Any death of a person where the death occurred in any premises in which the care if persons is carried on for reward or other financial consideration (other than in any premises which comprise a hospital, nursing home or maternity home registered under the Hospital, Nursing Homes and Maternity Homes Registration Ordinance (Cap. 165).

17. Any death of a person where the death was caused by homicide.

18. Any death of a person where the death was caused by the administering of a drug or poison by any other person.

19. Any death of a person where ill-treatment, starvation or neglect caused the death.

20. Any death of a person which occurred outside Hong Kong where the body of the person is brought into Hong Kong.
### Schedule 1 (Con't)

#### Part 2: Persons under a Duty to Report Reportable Deaths

<table>
<thead>
<tr>
<th>Item</th>
<th>Person required to discharge duty and the particular circumstances, if any, in which duty arises</th>
<th>Person to whom reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Any registered medical practitioner in respect of any reportable death where he-- (a) signs the certificate of the cause of death; (b) if no such certificate is so signed, attended the deceased during his last illness.</td>
<td>Coroner with a copy to the Commissioner of Police at the same time</td>
</tr>
<tr>
<td>2.</td>
<td>The person in charge of a hospital, or another person authorized in writing by the person so in charge, in respect of any reportable death which occurred therein.</td>
<td>Coroner with a copy to the Commissioner of Police at the same time</td>
</tr>
<tr>
<td>3.</td>
<td>Any person (except a police officer) in respect of any reportable death which occurred whilst the deceased was in the official custody of that person.</td>
<td>Coroner via Commissioner of Police.</td>
</tr>
<tr>
<td>4.</td>
<td>Any police officer in respect of any reportable death which occurred whilst the deceased was in the official custody of that police officer.</td>
<td>Coroner.</td>
</tr>
<tr>
<td>5.</td>
<td>Any person for the time being administering or otherwise in charge of premises owned, occupied or in the possession of any department of the Government (other than the police force) in respect of any reportable death which occurred therein.</td>
<td>Coroner via Commissioner of Police.</td>
</tr>
<tr>
<td>6.</td>
<td>Any person for the time being administering or otherwise in charge of premises owned, occupied or in the possession of the police force in respect of any reportable death which occurred therein.</td>
<td>Coroner.</td>
</tr>
<tr>
<td>10.</td>
<td>Any registered medical practitioner in respect of any reportable death where the consent of a coroner is being sought under section 4(4)(a) or (b) of the Medical (Therapy, Education and Research) Ordinance (Cap. 278) in relation to the body of the deceased.</td>
<td>Coroner.</td>
</tr>
</tbody>
</table>

### Schedule 2

#### Properly Interested Persons

1. Any person who is a parent, spouse, sibling or child of the deceased.
2. Any person who is the registered medical practitioner of the deceased.
3. Any person who is a personal representative, within the meaning of section 2 of the Wills Ordinance (Cap. 30) of the deceased.
4. Any person who is a beneficiary under a policy of insurance on the life of the deceased.
5. Any person who is an insurer who has issued a policy of insurance on the life of the deceased.
6. Any person who is appointed by a trade union, within the meaning of section 2 of the Trade Unions Ordinance (Cap. 332), to which the deceased at the time of his death belonged if the death may have been caused by an injury received in the course of his employment or by an occupational disease, within the meaning of section 3 of the Employees’ Compensation Ordinance (Cap. 282), or pneumoconiosis, within the meaning of section 2(1) of the Pneumoconiosis (Compensation) Ordinance (Cap. 360), or any other disease (whether described as an occupational disease or otherwise) which may have been contracted in the course of his employment.
7. Any representative of any department of the Government which is concerned with the death of the deceased and who is authorized by the head of that department to be such representative for the purposes of this Ordinance.
8. Any person whose act or omission or that of his agent, servant or employment may, in the opinion of a coroner, have caused the death deceased.
9. Any other person who, in the opinion of a coroner, should be regarded as a properly interested person by reason of any particular interest in the circumstances surrounding the death of the deceased.