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Legislative Council

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Panel on Security
and
Panel on Health Services

Minutes of joint meeting
held on Friday, 18 July 2003 at 10:45 am
in the Chamber of the Legislative Council Building

Members present :

Panel on Security

Hon LAU Kong-wah, JP (Chairman)
Hon James TO Kun-sun (Deputy Chairman)
Hon Albert HO Chun-yan
Hon Margaret NG
Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP
Hon CHEUNG Man-kwong
Hon Ambrose LAU Hon-chuen, GBS, JP
Hon IP Kwok-him, JP
Hon Audrey EU Yuet-mee, SC, JP

Panel on Health Services

Dr Hon LO Wing-lok, JP (Chairman)
♦ Hon Michael MAK Kwok-fung (Deputy Chairman)
Hon CHAN Kwok-keung, JP
Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP
Dr Hon YEUNG Sum
Hon Andrew CHENG Kar-foo
Hon LI Fung-ying, JP

Member attending : Hon Emily LAU Wai-hing, JP

Members absent	:	Panel on Security Dr Hon LUI Ming-wah, JP Hon Andrew WONG Wang-fat, JP Hon WONG Yung-kan Hon Howard YOUNG, SBS, JP Panel on Health Services Hon Cyd HO Sau-lan Hon CHAN Yuen-han, JP Dr Hon LAW Chi-kwong, JP Dr Hon TANG Siu-tong, JP

\# Also a member of Panel on Health Services
♦ Also a member of Panel on Security

Public Officers attending	:	Mrs Jennie CHOK Deputy Secretary for Security Miss Ida LEE Assistant Secretary for Security Mr Thomas YIU Deputy Secretary for Health, Welfare and Food (Health) Mr PANG Sung-yuen Commissioner of Correctional Services Mr WONG Man-chiu Superintendent (Nursing and Health Services) Correctional Services Department Mr LEUNG Kam-shing Superintendent (Siu Lam Psychiatric Centre) Correctional Services Department Dr LAM Ping-yan Deputy Director of Health Dr Mandy HO Principal Medical and Health Officer Department of Health

By invitation	:	Prof Karen S L LAM Chair Professor in Medicine and Chief of Endocrinology The University of Hong Kong
		Prof Kenneth K C LEE Professor and Head Division of Pharmacy Practice The Chinese University of Hong Kong
		Dr Bernard M Y CHEUNG Associate Professor in Clinical Pharmacology The University of Hong Kong
		Dr MONG Hoi-keung Consultant Forensic Pathologist Forensic Pathology Service Department of Health
Clerk in attendance	:	Mrs Sharon TONG Chief Assistant Secretary (2) 1
Staff in attendance	:	Mr LEE Yu-sung Senior Assistant Legal Adviser 1
		Miss Lolita SHEK Senior Assistant Secretary (2) 7

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I. Election of Chairman

Mr LAU Kong-wah was elected Chairman of the joint meeting.

II. Follow-up on issues relating to the death of an inmate in Siu Lam Psychiatric Centre in November 2001 - Way forward

(LC Paper Nos. CB(2)2833/02-03(01), LS80/02-03, CB(2)1323/02-03(01), CB(2)947/02-03(01) and (02))

2. At the invitation of the Chairman, Deputy Secretary for Security (DS for S) briefed Members on the background and the latest development of the case involving the death of an inmate, Mr CHEUNG Chi-kin (the deceased), in Siu Lam Psychiatric Centre (SLPC) on 19 November 2001. She said that at the joint meeting of the Panel on Security and Panel on Health Services on 5 March 2003, the Superintendent of SLPC, Correctional Services Department (S(SLPC)/CSD) put forward a hypothesis which might explain the high chlorpromazine level found in the blood of the deceased. The Administration had then invited three independent medical experts to look into the hypothesis that the deceased,

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being a chronic diabetic patient, might have suffered from uncontrolled diabetes which could lead to cellular breakdown of adipose tissue (lipolysis) and the release of a large amount of chlorpromazine originally stored there. The experts had also been invited to explain the causes of the three unusual needle marks found on the right shoulder of the deceased during autopsy and to examine the medical issues which might be relevant to the death of the deceased. In addition, the Administration had invited Consultant Forensic Pathologist in-charge of the Forensic Pathology Service of the Department of Health (CFP(FPS)/DH) to review the original autopsy findings and the original analysis of the body fluid samples of the deceased in the light of the opinions of the medical experts.

3. The medical experts, Prof Karen LAM, Chair Professor in Medicine and Chief of Endocrinology of The University of Hong Kong, Dr Bernard CHEUNG, Associate Professor in Clinical Pharmacology, The University of Hong Kong, and Prof Kenneth LEE, Professor and Head, Division of Pharmacy Practice, The Chinese University of Hong Kong, each highlighted their opinions which were set out at Annexes A to C respectively to, and summarized in paragraph 4 of, the paper provided by the Administration (LC Paper Nos. CB(2)2833/02-03(01)).

4. The opinions of the experts were summarized as follows -

(a) diabetic ketotic coma was a probable cause of death of the deceased;

(b) markedly increased lipolysis occurring in diabetic ketoacidosis could theoretically lead to the release of chlorpromazine previously cumulated in the fat tissue;

(c) lipolysis and post-mortem redistribution could have markedly increased the level of chlorpromazine in the post-mortem blood of the deceased;

(d) it was highly unlikely and physiologically impossible for the high concentration of chlorpromazine in the post-mortem blood to be caused by external injection; and

(e) the three needle marks on the right shoulder and the associated bruises could be the result of attempted cannulation on the right cephalic vein.

5. CFP(FPS)/DH also briefed Members on his expert opinion which was summarized in paragraph 5 of the paper provided by the Administration. He said that while he accepted the expert opinions, it was not necessary to change the medical causes of death as depicted in the autopsy report.

The needle marks on the shoulder of the deceased

6. Ms Emily LAU pointed out that the causes of the three needle marks on the shoulder of the deceased had been investigated at the death inquest at which the medical officer from Tuen Mun Hospital (TMH) who had been responsible for the resuscitation of the deceased stated that he had only undertaken intravenous injection at the left inner elbow of

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the latter. According to the statements of the ambulancemen responsible for transferring the deceased from SLPC to TMH, no such needle marks had been detected or recorded during the transfer. Ms Emily LAU said that she was therefore dubious about how the needle marks had been inflicted on the deceased.

7. In response, CFP(FPS)/DH informed Members that he had formulated his opinion based on the conditions and shape of the marks shown in the photographs of the deceased at the autopsy. He advised that the needle marks were produced by big-gauge needles and were likely to be the result of failed attempts in inserting an intravenous line for infusion of fluid. The oozing of blood during autopsy was not inconsistent with failed resuscitation at TMH shortly before death. CFP(FPS)/DH explained that since the deceased was a drug addict, the more peripheral veins in his forearm or elbow might have been clogged. As a result, the site of the three needle marks might be used for venous access during resuscitation. He added that according to his experience, it was not uncommon that during resuscitation, besides the medical officer in-charge, other medical and nursing staff might try to rescue the patient and attempt to insert an intravenous line for infusion of fluid into the patient at the same time. He said that the three needle marks might have been so inflicted during resuscitation of the deceased at TMH.

8. Dr Bernard CHEUNG said that he agreed with CFP(FPS)/DH that during resuscitation, several medical and nursing staff might attempt to insert an intravenous line for infusion of fluid into a patient at the same time. He added that unsuccessful attempts of venous access during resuscitation might not be recorded. Dr CHEUNG also explained that the needle marks might not be detected immediately since blood might only ooze and bruises appear a short while after the marks were inflicted.

9. Ms Emily LAU remarked that since the needle marks had caused suspicion of injection of chlorpromazine into the deceased causing death of the latter, the death inquest should have investigated into the needle marks more thoroughly. She considered that the investigation of the case had not been completed since the explanation for the needle marks suggested by the medical experts had not been considered by the death inquest.

10. Prof Kenneth LEE informed Members that based on the standard principles of pharmacokinetics, he had calculated that to achieve a plasma chlorpromazine concentration of 9.7 μg/ml detected in the post-mortem blood sample of the deceased, more than 270 ampoules of the drug (50 mg each) might need to be administered in a single dose 2 hours before death of the deceased, or more than 300 ampoules 6 hours before death. Prof LEE therefore considered it highly unlikely and physiologically impossible for the high concentration of chlorpromazine in the post-mortem blood to be caused by external injection even though there might be mysterious needle marks on the body of the deceased.

11. Dr LO Wing-lok said that he agreed with CFP(FPS)/DH and Dr Bernard CHEUNG that it might be possible that other medical and nursing staff might attempt to insert an intravenous line for infusion of fluid into the deceased during resuscitation hence inflicting the needle marks. He also noted from paragraph 6 of the Administration's paper that the Police had confirmed that of the 17 hours of continuous, un-tampered videotape of

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activities in the cell leading up to the incident of discovery and rescue and shortly going beyond the incident, about 14 was the time immediately before the incident. The videotape had revealed that no external injection had been administered to the deceased during these 14 hours. Dr LO therefore agreed with Prof Kenneth LEE that calculations should be made to find out the number of ampoules of the drug required to be administered to the deceased 14 hours before his death to cause the plasma chlorpromazine concentration in the post-mortem blood.

12. Mr CHEUNG Man-kwong thanked S(SLPC)/CSD for putting forth his hypothesis which led to the analyses of the medical experts shedding light on the case. He noted from paragraph 7 of the paper provided by the Administration that all three medical experts had accepted that it was theoretically possible that lipolysis had contributed to the high level of chlorpromazine in the blood of the deceased. He pointed out that although their opinion could not be proved by experimental evidence due to the lapse of time, it had opened up a new angle from which the case should be considered, i.e., instead of examining only the situation in the cell in which the deceased stayed before his death in SLPC, the health conditions of the deceased should also be considered.

13. As regards the needle marks on the shoulder of the deceased, Mr CHEUNG Man-kwong noted from paragraph 8 of the Administration's paper that expert advice had ruled out the possibility of external injection causing the high concentration of chlorpromazine in the post-mortem blood. He pointed out that while the ambulancemen stated that they had not detected the marks and the medical officer in TMH declared that he had not undertaken intravenous injection at the shoulder of the deceased, the medical experts suggested that the marks might have been inflicted during resuscitation in TMH when other staff attempted to insert an intravenous line for infusion of fluid into the deceased. Mr CHEUNG therefore considered that the causes of the needle marks had remained to be a mystery.

14. In response to the remarks of Mr CHEUNG Man-kwong about the needle marks, Commissioner of Correctional Services (C of CS) pointed out that the deceased had not worn any tops in the cell of SLPC or in the ambulance during the transfer to TMH. Yet, the needle marks had not been detected at those two stages. C of CS therefore considered it most likely that the marks might have been inflicted after the transfer to TMH.

15. Miss Margaret NG opined that the incident had revealed that knowledge was very crucial to an investigation and the opinions of the medical experts had shed new light on the case. However, she pointed out that although the experts had ruled out the possibility of external injection as the cause of the high concentration of chlorpromazine in the post-mortem blood, and suggested that the three needle marks might be inflicted by attempts to insert an intravenous line for infusion of fluid during resuscitation of the deceased at TMH, their explanation had remained theoretical since it could not be supported by direct or experimental evidence. The death of the deceased would remain a mystery.

16. Miss NG remarked that thorough investigation should have been conducted at the very beginning to collect direct evidence to remove all doubts instead of being initiated only after wide public concern had been aroused. She pointed out that if not for the failure

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in the local CCTV monitoring system in SLPC, suspicion on the involvement of staff of SLPC in the death of the deceased would not be aroused. Also, if thorough investigation could be conducted immediately after the incident, direct evidence on the causes of the needle marks could have been collected. Although staff of SLPC had indicated that they had not detected the needle marks before the deceased was transferred to TMH, their statements might not be considered as completely reliable because of their involvement in the case. Miss Margaret NG added that the recent development had revealed that thorough investigation had not been made at the death inquest, which could be attributed to the lack of legal representation of the parties concerned at the inquest. She urged that improvement should be made to prevent occurrence of similar incidents.

17. C of CS clarified that it was the responsibility of the Police to collect evidence. CSD had been summoned to give evidence at a very late stage. However, he said that CSD had conducted investigation into its related working procedures and operation systems so that necessary improvements would be introduced to enhance the custodial and medical service for inmates. C of CS said that Members' concern about the investigation of the case would be conveyed to the Police.

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18. Mr Michael MAK thanked S(SLPC)/CSD for putting forth his hypothesis which led to the recent breakthrough in the case. He hoped that the morale of staff of CSD could be lifted with the new development. However, he shared the concerns of Ms Emily LAU and Miss Margaret NG that thorough investigation had not been conducted at the death inquest so that the causes of the three needle marks on the shoulder of the deceased had remained dubious. Mr MAK asked if the marks were inflicted by injections administered in SLPC before the death of the deceased, whether blood would ooze from the marks during his transfer to TMH hence the ambulancemen would be able to detect them, especially when the deceased was not wearing any tops.

19. CFP(FPS)/DH replied in the affirmative. He added that the statement from the medical officer responsible for resuscitation of the deceased at TMH in the death inquest had implied that he had not seen the three needle marks. Therefore, from a forensic point of view, the three marks might possibly be made after resuscitation of the deceased. Mr Michael MAK said that based on the expert advice and the evidence available, he believed that the needle marks were not inflicted during the deceased's stay in SLPC.

20. Mr Albert HO declared interest that one of the lawyers in the law firm he worked for had been representing the family of the deceased. Regarding the comments of some of the Members on the thoroughness of the investigation at the death inquest, Mr HO said that the Coroner of the death inquest should have examined all the documents relating to the case and might consider that no additional witnesses would be able to provide further evidence on the cause of the needle marks. Mr HO opined that although no one had detected the needle marks, it did not necessarily imply that the marks did not exist. He added that the ambulancemen might have missed the marks since they had been fully occupied in rescuing the deceased in the ambulance.

21. S(SLPC)/CSD responded that ambulancemen would conduct a check on a body received and recorded the results of the examination into a log book. In this case, the

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ambulancemen concerned had declared that he had discovered other needle marks on the body of the deceased but not those at his shoulder. It was therefore unlikely that they would have missed those marks at the shoulder.

22. Mr Albert HO, however, pointed out that according to his experience, the records in the Accident and Emergency (A&E) Department of a hospital would contain every detail of the resuscitation process. He remained of the view that if the ambulancemen would not miss the needle marks, it was even unlikely that the marks would go unnoticed in the A&E Department in TMH.

23. S(SLPC)/CSD explained that according to the practice in the A&E Department, only successful attempts of intravenous injection would be recorded and the medical officer in TMH might have given evidence at the death inquest in accordance with the records of resuscitation. As a result, the officer had not mentioned the needle marks. The Administration then circulated the photographs of the three needle marks to Members for reference at the meeting.

The high concentration of chlorpromazine in the post-mortem blood

24. Referring to paragraph 6 of the Administration's paper, Mr James TO noted that the activities in the cell some hours prior to the death of the deceased had not been videotaped by the CCTV monitoring system. He considered that it was still dubious whether any irregularities had happened in the cell during those hours. In assessing the possibility of external injection causing the death of the deceased, Mr TO sought clarification on the following -

(a) the number of ampoules of the drug required to cause death if it was administered just shortly, say a few minutes, prior to death;

(b) possibility of injection of a certain drug shortly before death to trigger lipolysis hence causing death; and

(c) proofs of the impossibility for the injection of high dose of the drug prior to the death of the deceased to cause the high concentration of chlorpromazine in the post-mortem blood.

25. DS for S clarified that the local CCTV system in SLPC had maintained about 17 hours of continuous, un-tampered videotape of activities in the cell prior to the death of the deceased and shortly going beyond the incident. Out of these 17 hours, 14 was the time immediately before the incident of discovery and rescue and 3 was the time immediately afterwards.

26. Prof Kenneth LEE advised that statistics referred to in paragraph 24(a) and (b) above were not available on hand. However, based on the calculations that more than 200 ampoules of the drug were required to cause the level of chlorpromazine in the post-morem blood if they were administered 2 hours prior to death, he estimated that more than 50 ampoules would be required if the drug was administered half an hour prior to death. Prof

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LEE commented that external injection, both intravenous and intramuscular, of such a high dose of the drug was highly unlikely and physiologically impossible. He explained that to administer the estimated dose, 50 ampoules of the drug had to be opened. Moreover, it would be physiologically impossible to administer the dose by intramuscular injection since the space between cells was so small that injection of only a few ampoules would be allowed at a time.

27. Dr Bernard CHEUNG added that intravenous injection would need to be administered by a person with medical knowledge so as to locate the vein. He also advised that if external injection of the drug was administered to the deceased, the level of chlorpromazine concentration in blood would drop drastically after death. Therefore, in order to achieve the level of chlorpromazine recorded in the post-mortem blood, an extremely high dose of the drug would be required to be administered prior to death of the deceased.

28. C of CS informed Members that according to the inventory record of the drug in SLPC on 19 November 2001, i.e., the day of the incident, there were altogether 86 ampoules of the drug in SLPC including 75 ampoules kept in the pharmacy, 3 in the wards of the deceased and 8 in other wards, of SLPC. According to the records on 17 July 2003, there were altogether 169 ampoules of the drug in SLPC, of which 158 were kept in the pharmacy, and 11 in the wards. C of CS stressed that that was the usual level of stock of the drug kept in SLPC. He added that these inventory records, which were inspected by the Chief Dispensers of the Pharmaceutical Service of DH on a regular basis, indicated that the level of stock of the drug available in SLPC was significantly below the number of ampoules required to achieve the level of chlorpromazine in the post-mortem blood according to the calculation of Prof Kenneth LEE. In response to a question from the Chairman, S(SLPC) confirmed that no administration of the drug had been recorded on the day of the incident.

29. Mr James TO, however, considered the inventory records of the drug as irrelevant since the drug could be obtained from outside SLPC. He then sought further advice from Prof Kenneth LEE whether calculations could be made on the dose of the drug required to cause the death of the deceased shortly prior to death, taking into account the process of lipolysis before death and the post-mortem redistribution from various organs and tissues, which might lead to further increase in the blood level of chlorpromazine.

30. Prof Kenneth LEE explained that there were limitations in the application of the pharmacokinetic models. He said that calculations could only be made on the assumption that the subject was still alive and his body functioned normally. The models did not apply to cases when body metabolic activities stopped after death. Prof LEE added that in the present case, calculations were made on the assumption that the plasma chlorpromazine concentration of 9.7 μg/ml detected in the post-mortem blood sample of the deceased was the level of concentration at the time of death.

31. Mr Michael MAK remarked that since the evidence available indicated that the needle marks had not been inflicted before or during resuscitation at TMH, it might be possible that the drug was administered after the deceased had been certified dead and

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before autopsy. If such being the case, he asked whether the drug could be detected around the needle marks at autopsy.

32. CFP(FPS)/DH said that a police officer had escorted the body of the deceased to the mortuary after the latter was certified dead. CFP(FPS)/DH also pointed out that if homicide was the motive, it was most unlikely that the drug would be administered when the deceased was so critical or even certified dead. CFP(FPS)/DH further said that the needle marks were produced by big-gauge needles. If administered by big needles, the drug would diffuse into the blood swiftly and could not be detected around the marks at the time of autopsy.

33. Referring to the expert opinion of Prof Karen LAM which was summarized in paragraph 4 of the Administration's paper, Mr Albert HO noted that the deceased had suffered from symptoms of severe hyperglycaemia during the few days prior to his death which could lead to a fatal outcome if undiagnosed and untreated. Mr HO enquired whether any drug could be administered to the deceased to precipitate the development of such severe metabolic disturbance hence causing his death.

34. Prof Karen LAM replied that it was unlikely that the administration of high dose of chlorpromazine would precipitate the development of diabetic ketoacidosis. Prof LAM explained that under the influence of the drug, the deceased would be sedated and the secretion of stress hormones would be reduced. Under such circumstances, it was unlikely that diabetic ketoacidosis would have been precipitated.

35. In response to Members' concerns about the causes of the high level of chlorpromazine concentration in the post-mortem blood, S(SLPC)/CSD said that the changes in methadone level in ante-mortem and post-mortem blood of the deceased had substantiated the expert opinions that the high chlorpromazine concentration in post-mortem blood was the result of lipolysis and redistribution. He explained that from the expert opinion provided by Prof Kenneth LEE at Annex C to the Administration's paper, the deceased had been given two doses of methadone in Queen Elizabeth Hospital (QEH) two days prior to his death. No further record of methadone administration was reported since then. The calculated concentration of methadone on the day of death was 0.118 μg/ml. However, the toxicological analysis of the deceased's post-mortem blood showed that the methadone level in blood was 0.88 μg/ml. The most reasonable explanation for the elevated post-mortem plasma level of methadone was therefore the process of redistribution of the drug from storage tissue where the concentration was high to areas of lower concentration such as blood after the death of the deceased. Since both chlorpromazine and methadone have similar character, the same process could also account for the high chlorpromazine concentration in post-mortem blood.

36. Dr LO Wing-lok pointed out that there was strong evidence to indicate that the death of the deceased was caused by diabetic ketoacidosis and the adverse effects of chlorpromazine in blood which was released due to lipolysis. He said that the long history of diabetes mellitus of the deceased and his failure to return to QEH for follow-up since two years prior to his death had all supported the opinions of the medical experts on the cause of his death.

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A new death inquest or inquiry

37. Ms Emily LAU noted from paragraph 9 of the Administration's paper that despite expert opinions had supported the hypothesis put forward by S(SLPC)/CSD, the Administration considered that conclusive evidence of the cause of death and the actual occurrence of lipolysis before death was still lacking, and that the Court of First Instance might not be satisfied that it was necessary or desirable that another inquest should be held. In view of this, the Administration had decided not to apply to the Court for another death inquest into the incident pursuant to section 20(1) of the Coroners Ordinance (Cap. 504), or to appoint a body to inquire into the incident pursuant to section 2(1) of the Commissions of Inquiry Ordinance (Cap. 86). Ms LAU, however, was of the view the decision on whether the new evidence discovered had warranted the conduct of a new inquest should be made by legal advisers and the Court. She added that staff of SLPC had been put under great pressure over the incident and might look forward to a new inquiry which might reinstate the integrity of CSD and hence the public's confidence in the Department. She invited the views of S(SLPC)/CSD on the decision of the Administration.

38. S(SLPC)/CSD reiterated that the working procedures and monitoring system in SLPC would not allow inappropriate administration of chlorpromazine to its inmates. He said that the acknowledgement by the public and the parties concerned of this fact would relieve the stress caused by the incident on CSD staff.

39. In response to the concern of Ms Emily LAU about the decision of the Administration, DS for S explained that being a properly interested party over the incident as specified in schedule 2 to the Coroners Ordinance, the Administration might apply for a new inquest. However, the Administration would need to satisfy the Court of First Instance that it was necessary or desirable that another inquest should be held. DS for S added that according to the legal advice obtained, the Administration should not make such application unless it was satisfied that the new evidence collected would result in a different verdict of the Court. In the present case, since the deceased had passed away for nearly two years, the medical experts were not able to confirm the actual cause of death. The medical causes of death as recorded in the autopsy report appeared to remain valid. In addition, it was questionable if the new expert evidence might have made a material difference to the "Open Verdict" recorded at the previous inquest. She said that a new death inquest or inquiry might reopen wounds, and unduly prolong the grief of the deceased's family.

40. DS for S added that the death of the deceased had also been the subject to deliberations in CSD's own Board of Inquiry and the special task group with two independent non-official Justices of the Peace as members to identify inadequacies and improvement measures required. Thorough discussions had been held at the joint meetings of Panel of Security and Panel of Health Services, and further comments by independent medical experts had been obtained. Although worthy of thorough scrutiny, it appeared that little was to be further gained from a new death inquest or inquiry into the incident that might better serve the public interest.

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41. Mr CHEUNG Man-kwong said that he agreed with the Administration that while the expert opinions had shed more light on the death of the deceased and the causes of the needle marks had remained a dubious point worthy of further investigation, a new inquest or inquiry might not be warranted unless there was sufficient strong new evidence to indicate that a different verdict might be resulted, or it was in the public interest to do so. Moreover, a new death inquest or inquiry might also reopen wounds of the deceased's family.

42. In response to a further question from Ms Emily LAU about the views expressed by the family of the deceased on the decision of the Administration, DS for S said that the Administration had provided the family with copies of the opinions of the medical experts. The Administration took it that the family did not prefer a new death inquest since the family's lawyers had indicated in a letter to the Administration their view that there were no new facts or evidence that would persuade the Court to order that a new inquest be held. They had separately written to demand compensation from the Administration. Members agreed that in view of the grounds put forth by the Administration and the preference of the family of the deceased, a new death inquest or inquiry might not be necessary.

Measures to enhance the services of SLPC and other penal institutions

43. Mr CHEUNG Man-kwong noted from the report provided by Prof Karen LAM at Annex A to the Administration's paper that the deceased had suffered from symptoms of severe hyperglycaemia and diabetic ketoacidosis during the few days prior to death. Unfortunately, despite his history of diabetes mellitus, no blood sugar had been measured at SLPC so that diagnosis was completely missed ante-mortem and appropriate and timely treatment had not been provided to him. Mr CHEUNG suggested that CSD should consider conducting blood test on inmates in order to better monitor the health conditions of the latter so as to prevent recurrence of similar incidents.

44. C of CS responded that since the deceased had not reported his condition of diabetes mellitus but only his history of drug addiction was known to staff of SLPC, only urine test for narcotics was conducted. C of CS added that to prevent recurrence of similar incidents, a revised procedure had been adopted since 1 September 2002 under which urine test would be conducted on all inmates upon admission so as to find out the level of sugar and albumin. He further explained that blood test would be conducted only after the consent of the inmates concerned was obtained. However, he assured Members that urine test could also help identify abnormal health conditions of inmates.

45. Sharing the views of Mr CHEUNG Man-kwong, Miss Margaret NG said that CSD had full responsibility for the health and safety of all its inmates. The Department should be more proactive in finding out the medical history and health conditions of the latter upon admission, instead of waiting for the report from the inmates.

46. Expressing similar concerns, Dr LO Wing-lok said that it was not acceptable to him that the consent from the inmates had to be obtained before blood test could be conducted. He pointed out that in case of emergencies and when the inmates concerned had become

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unconscious, blood test should be conducted to facilitate diagnosis of the conditions of the patients even though their consent had not been obtained. Dr LO was of the view that blood test should be conducted on all inmates upon admission given the simplicity of the procedure.

47. Prof Karen LAM said that she agreed with Miss Margaret NG that to prevent recurrence of similar incidents, CSD should obtain the medical history of its inmates so as to detect any abnormal health conditions. She said that in the absence of any symptoms of abnormal health conditions, urine test might serve the purpose and blood test might not be required. Otherwise, blood test had to be conducted.

48. C of CS assured Members that CSD had the responsibility for its inmates. Superintendent (Nursing and Health Services) of CSD (S(NHS)/CSD) said that medical examinations, including measurement on weight, height, blood pressure, pulse and body temperature, would be conducted on all inmates upon admission, and urine test for narcotics would be conducted on those with a history of drug addiction. He informed Members that to prevent recurrence of similar incidents, with effect from 1 September 2002, a new Health Screen Format had been adopted and detailed medical history had to be obtained from the inmates.

49. As regards the blood test suggested by Members, S(NHS)/CSD explained that since the enactment of the Hong Kong Bill of Rights Ordinance (Cap. 383), blood test could not be made compulsory. He stressed that during emergency and resuscitation, blood test might be conducted without the consent of the patient concerned. However, if the latter was conscious, his consent had to be obtained. He added that an inmate would be required to sign a statement for record if he refused to undergo the blood test. In response to a question from the Chairman, S(NHS)/CSD explained that since the medical history of the deceased was not known, staff of SLPC had not suspected the deceased of suffering from diabetes. As a result, no blood test had been conducted on him.

50. Prof Karen LAM pointed out that since the deceased was a drug addict, his symptoms of severe hyperglycaemia and diabetic ketoacidosis might have been mistaken as withdrawal symptoms. Staff of SLPC might therefore not be alert to his condition of diabetes mellitus.

51. The Chairman requested the Administration to review the medical examination on inmates of penal institutions upon admission in the light of the views of Members so that while complying with the relevant legislation, the Administration could ensure that appropriate medical services would be provided to inmates. The Chairman requested the Administration to revert to the Panels at their next joint meeting in January 2004. C of CS assured Members that CSD would examine the issue jointly with DH so as to provide the best medical care for inmates.

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52. In response to the request from the Chairman, Deputy Director of Health (DD of H) said that while medical officers were posted to CSD from DH, the provision of medical care to inmates in penal institutions was overseen by CSD. He said that he agreed with

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Members that in general, the alertness of medical officers had to be raised so that they would treat the inmates as their patients. He reiterated that blood test might not need to be conducted on all inmates upon admission unless abnormal symptoms were detected. He added that in view of the limitations in the facilities in the penal institutions, DH would remind the medical officers in CSD that they should refer patients to hospitals in case the special treatment and care they required could not be provided with the facilities in the institutions. DD of H assured Members that DH would join hands with CSD in reviewing the guidelines and procedures for medical examination of inmates.

53. Mr Albert HO noted that the deceased had been admitted to QEH for 8 hours before admission to SLPC and that QEH had forwarded his medical records to SLPC. He asked why staff of SLPC had still failed to detect the history of diabetes mellitus from the records. S(SLPC)/CSD clarified that the records received from QEH included only information on the medicine prescribed to the deceased at this last admission as well as the chit of follow-up appointment. There was no mention of the deceased's medical history or his diabetes mellitus.

54. To conclude, the Chairman requested the Administration to review the guidelines and procedures for conducting medical examination on inmates of penal institutions upon admission and revert to the Panel on Security and Panel on Health Services with its recommendations. As agreed at the special meeting of the Panel on Security on 23 January 2003, the Administration would also provide a report on the implementation of the improvement measures recommended by the special Task Group in January 2004. He

Adm requested the Administration to provide the papers for Members' consideration at the next joint meeting of the Panels in January 2004.

III. Any other business

55. There being no other business, the meeting ended at 1:05 pm.

Council Business Division 2
Legislative Council Secretariat
2 October 2003