For Information

Legislative Council
Panel on Administration of Justice and Legal Services

Death Investigations and Inquests by the Coroner's Court

Purpose

This paper informs Members of the work of the Coroner's Court regarding death investigations and inquests.

Background

2. A Member of the Panel had raised questions about the difference between the number of death inquests held and the number of further death investigation reports ordered, and the average waiting time for the hearing of death inquests.

Relevant Statutory Provisions

3. Pursuant to section 9(1) of the Coroners Ordinance, Cap. 504 ("the Ordinance"), a Coroner may investigate a reportable death[1]; or any other death of a person which the Coroner considers should be investigated in the public interest. Section 9(2) states that the purpose of an investigation is to investigate the cause of and the circumstances connected with the death of the person.

[1] A reportable death is a death specified in Part 1 of Schedule 1 in the Ordinance.

4. Under section 14(1) of the Ordinance, a Coroner may hold an inquest into the death where a person dies suddenly, by accident or violence, or under suspicious circumstances, or where the dead body of a person is found in or brought into Hong Kong. Section 14(2) further stipulates that a Coroner may hold an inquest under section 14 with or without a jury.

5. If however a person dies whilst in official custody, a Coroner must hold an inquest with jury into the death of that person pursuant to section 15 of the Ordinance.

6. Under section 27 of the Ordinance, the purpose of an inquest is to inquire into the cause of and the circumstances connected with the death, and for this purpose, the proceedings and evidence at the inquest shall be directed to ascertaining the following matters in so far as they may be ascertained, including the identity of the person; how, when and where the person came by his death; and the conclusion of the Coroner/ jury as to the death, etc.

Practice and Operation

7. Every reportable death, supported by relevant reports such as the investigation report by the Police and the post mortem report by the clinical or forensic pathologist, are considered by the Coroner. Having taken into consideration relevant information, including the expert opinions of the pathologists and medical practitioners, medical history of the deceased, the course of events leading to the death and the findings of police investigation, if the Coroner is of the view that there is sufficient information to enable him to exercise his power and perform his duties under section 9 of the Ordinance and that the cause of and the circumstances of the death are clear and that there is no suspicion, the case can be concluded. The Registrar of Births and Deaths would be informed of such decision and could register the death accordingly.

8. If the Coroner considers that further investigation of the death is required, the Court shall order the Police to carry out further investigation and to seek for independent opinion from expert, where appropriate. The length of time required for further investigation and the preparation of independent

expert report depends on which aspect of the case has to be further looked into and the availability of the expert concerned. It is not uncommon to take six months to one year or sometimes even longer to complete, depending on the circumstances of each individual case.

9. When all required information is ready and upon considering all the circumstances of the case, the Coroner shall decide whether to hold an inquest into the death. Other than deaths in official custody in respect of which the law requires that an inquest must be held (paragraph 5 above), whether to hold a death inquest is a decision made by the Coroner on a case by case basis having due regard to all the relevant facts of the death concerned. If an inquest is deemed not necessary, the case would thereby be concluded.

10. Subject to certain circumstances of death where an inquest with jury is mandatory under the law, the Coroner shall also decide whether to hold an inquest with or without a jury.

Workload of the Coroner's Court

11. The numbers of deaths reported to the Coroners, cases requiring further investigations and inquests ordered in the year by the Coroners in the past three years are set out as follows:

Year	**(a) Deaths reported to Coroners**	**(b) Cases requiring further investigations**	**(c) Inquests set down**
2016	10 773	730	83
2017	10 768	1 128	131
2018	10 976	1 083	167

12. For cases where further investigations have been called for, if the Coroner is of the view that the investigation carried out by the Police has come up with sufficient information and that the cause and circumstances of the death are clear with no suspicion, the Coroner will decide not to hold an inquest into the death of the deceased. Most of the cases requiring further investigations would not require an inquest in the end. For the past three years,

the number of cases with inquests ordered had ranged from 11% to 15% of the cases requiring further investigations only.

13. As reflected in the above table, there was an increase in the number of inquests from 2016 to 2018. In recent years, there have in fact been a rise in the number of requests from family members, their legal representatives or interested parties that public inquests be held. Many of those requests involved deaths connected with medical or surgical incidents. Some of the issues involved are much more complicated as compared with past cases, and as a result, a longer period of investigation by the Police would be required and, if the Coroner directs an inquest to be held, more hearing days would also be required[2].

Waiting Time

14. When the Coroner decides to order an inquest into the death upon completion of all further investigations by the Police and consideration of all circumstances of the case, the case will be listed for hearing. The waiting time for cases listed in the Coroner's Court counts from the date when the Coroner orders an inquest to the first day of hearing. The average waiting time for inquests listed before the Coroner's Court in the past three years is as follows:

	Target	**2016**	**2017**	**2018**
Average Waiting Time (Days)	*42*	39	79	65

15. From operational experience, apart from the availability of the court, the waiting time for the hearing of death inquests is contingent upon a range of factors, some of which are outside the control of the Court. For instance, the complexity of a case would dictate the number of witnesses and hearing days required; the availability of witnesses, including expert

[2] The observations on the factors contributing to the rising number of inquests and longer hearing period, etc. can be found in the Coroners' Report 2018, Paragraph 7 on Page 4 (Chinese version) or Paragraph 7 on Page 29 (English version).

witnesses; and the availability of the legal representatives of the parties concerned, would directly affect the timing when an inquest could be listed.

16. As and when necessary, a Deputy Coroner would be appointed to alleviate the workload of the Coroners.

17. The Judiciary will closely monitor the situation and will make every effort to improve the waiting time.

Conclusion

18. Members are invited to note the content of this paper.

Judiciary Administration
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