

死因裁判法庭

THE CORONER'S COURT



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死因裁判法庭

死因裁判法庭負責為若干類死亡個案而展開研訊，確定死因及肇事情況。本冊子將扼要敘述死因裁判官在處理有關死亡個案時，所具有的廣泛權責。

死因裁判官的職權範圍

死因裁判官為司法人員，有權：

- 發出埋葬命令
- 發出火葬命令
- 批准免將屍體剖驗
- 發出屍體剖驗命令
- 發出檢掘遺骸命令
- 發出命令將屍體運離香港
- 命令警方調查死亡個案
- 命令進行研訊
- 批准切除及使用死者部份器官
- 簽發死亡事實證明書

哪些死亡個案須向死因裁判官報告？

依照死因裁判官條例，共有20類死亡個案須向死因裁判官報告（見附錄I）。當獲悉死亡事故時，任何有責任呈報死亡個案的人士（見附錄II），均應盡速向死因裁判官報告。

如何處理須呈報的死亡個案？

並非所有須呈報的死亡個案都須要進行研訊，只有某些類別除外。當有死亡個案須向死因裁判官報告，屍體將被送往醫院或公眾殮房，並由病理學家展開以下程序：

- 進行屍體外部檢驗
- 若死因已確定，向死因裁判官提交報告及檢驗結果
- 若死因已確定，可建議免將屍體剖驗，並要求發出埋葬或火葬命令
- 若未能確定死因，則要求發出屍體剖驗命令
- 向死因裁判官簡述各情況，例如臨床病徵背景等

死因裁判官仔細考慮病理學家提出的報告後，按個別情況發出以下其中一項命令：

- 屍體剖驗命令
- 批准免將屍體剖驗的命令
- 埋葬命令
- 火葬命令

倘若死因裁判官不能斷定死因或有其他原因，則會：

- 命令剖驗屍體
- 研究病理學家提交的屍體剖驗報告
- 考慮是否需要進行調查

倘若病理學家建議剖驗屍體，而死者家屬申請豁免，死因裁判官將於內庭會見家屬，以便決定是否發出屍體剖驗命令或批准免將屍體剖驗。

倘若死因裁判官決定調查一宗須呈報的死亡事件，則由警方進行調查，然後向死因裁判官提交死亡調查報告。死因裁判官研究報告後，便決定應否開庭研訊，或徵求專家的意見。

死因裁判官亦可發出手令，授權有關人員進入並搜查任何曾發生死亡事件的處所和地方。

倘若死因裁判官否決開庭研訊，有適當利害關係人士可致函死因裁判官，索取死亡調查報告的副本。

研訊

每當有人在下列情況中喪生，死因裁判官便可會同五人陪審團或在沒有陪審團參與的情況下開庭研訊：

- 突然死亡
- 意外死亡
- 暴力死亡

- 在可疑情況下死亡
- 及屍體如在香港發現或被運入香港

如發生下列情況，必須開庭研訊：

- 有人在官方機構看管下死去，例如在獄中或羈留中心死亡（研訊必須有陪審團參與）
- 順應律政司司長的要求

一般來說，工業意外導致的死亡事件均會開庭研訊。

死因裁判官可進行研訊前檢討，以決定如何能用最佳的方式，公正及迅速地完成研訊。研訊前檢討不會在法庭公開處理；但研訊則須在公開法庭進行，除非死因裁判官另作指示。

死因裁判官會向證人發出傳票，傳召他們出庭作證及呈交文件。有適當利害關係人士可由律師代表出庭。有適當利害關係人士可付費索取醫學或其他技術報告書。

當值律師服務計劃會向在研訊中可能作出可導致自己入罪的証供而有被刑事檢控之虞的証人提供法律代表。

處理複雜的個案時，死因裁判官可要求律政司司長協助處理研訊。

研訊如何展開？

研訊時，死因裁判官及陪審團須確定：

- 死者的身份
- 死者是如何，何時和在何處死亡
- 根據《生死登記條例》須就該宗死亡個案登記的詳情
- 對該宗死亡個案的結論

研訊程序以下列方式進行：

- 死因裁判官展開研訊
- 傳召證人出庭作證，由死因裁判法庭主任或政府律師、陪審團、死者家屬、其他有適當利害關係人士及死因裁判官分別訊問
- 死因裁判官總結該案
- 死因裁判官或陪審團宣讀裁斷（有關裁斷的例子可參考附錄III）

根據法例，死因裁判官或陪審團擬定裁斷時，不得作出任何有關民事法律責任問題的決定。所有賠償及民事法律責任的申索，應向處理民事訴訟的法庭提出，並在該庭聆訊。

為防止類似死亡事故再發生，有關改善建議將被記載於裁斷書內。以工業意外為例，裁判官將提醒主事者採取適當行動，填補工作流程的漏洞，或改進操作方法，避免再發生如研訊證供中提及的致命意外。

研訊中如涉及謀殺、誤殺、殺嬰或危險駕駛引致他人死亡等刑事罪行，死因裁判官須將研訊押後，並將此事轉介律政司司長處理。在刑事訴訟程序終結前，有關死因的研訊不能重新展開。

可否要求死因裁判官進行研訊？

有適當利害關係人士或律政司司長可向高等法院原訟法庭申請展開死因研訊。倘若研訊已完結，亦可要求就同一個案重新研訊。曾擔任首次研訊的陪審團，亦須再度出任重開研訊的陪審員。

死亡事實證明書

死因裁判官可簽發死亡事實證明書，作為死亡事實的臨時證明文件。死亡事實證明書可用於以下情況：如要把屍體運往另一國家安葬，特別是該國要求提交官方文件，證明死者並非死於傳染性疾病。

服務承諾

死因裁判法庭會

- 簽發埋葬命令
 - 簽發火葬命令
 - 簽發檢掘遺骸命令
 - 命令將屍體移離香港
 - 批准免將屍體剖驗
 - 簽發屍體剖驗命令
- 接獲病理學家提交的申請書後盡快進行
- 簽發死亡事實證明書
- 接獲驗屍報告後10日內進行
- 排期研訊
- 死因裁判官決定進行研訊之日起42日內

如何聯絡死因裁判法庭？

地址：香港西灣河太安街29號東區法院大樓十樓

電話：2886 6871

傳真：2568 1735

辦公時間

法庭登記處及會計部

星期一至星期五 上午九時至下午一時

下午二時至下午五時

星期六 上午九時至中午十二時

(星期日及公眾假日休息)

附錄I

20類須予報告的死亡個案

- 死亡原因不明
- 在突然 / 沒有得到診治的情況下死亡，死前被診斷為末期病患者除外
- 意外或受傷所導致的死亡
- 罪行所導致的死亡
- 施用麻醉藥導致死亡，或在接受全身麻醉的情況下死亡，或於施用麻醉後24小時內死亡
- 手術所導致的死亡或在手術後48小時內死亡
- 職業疾病導致的死亡，與現時或以往的職業有直接或間接關連的死亡
- 胎兒死亡
- 產婦死亡
- 敗血症導致死亡，而所涉的敗血症主因不明
- 自殺身亡
- 受官方看管期間內死亡
- 具法定逮捕或羈留權的公職人員在執行職務時導致的死亡
- 在政府部門的處所內死亡，而該部門的公職人員具有法定的逮捕或羈留權
- 法例所規定的某類精神病人在醫院內或在精神病院內死亡
- 在私人護理中心內發生的死亡
- 殺人罪行所導致的死亡
- 施用藥物或毒藥導致死亡
- 受虐待、飢餓、疏忽導致死亡
- 在香港境外發生、而屍體被運回香港境內的死亡

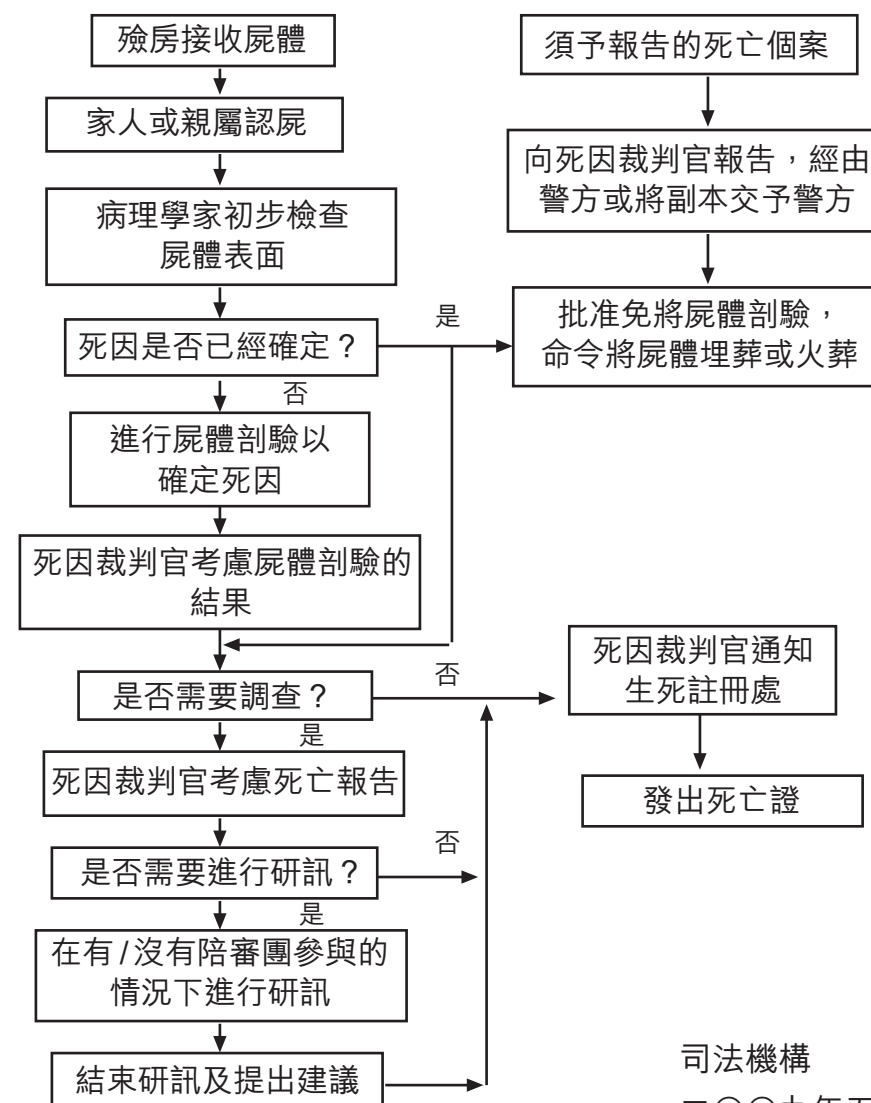
有責任呈報死亡個案的人士

須就死亡個案呈報的人士	向下述人士呈報
若醫生要為死者切除部份器官，須獲死因裁判官同意	死因裁判官
在警方看管期間或在警方範圍內發生的死亡事件	死因裁判官
接獲法定通知書，須予報告任何死亡事件的部門主管	死因裁判官
警務人員	死因裁判官
生死登記官	死因裁判官
任何執行官方看管職責的人士 (警方除外)	經由警方向死因裁判官報告
政府的建築物範圍內負責人士	經由警方向死因裁判官報告
醫院或其他護理設施主管人員	死因裁判官，副本交予警方

死因裁判官或陪審團可作出的裁斷例子

裁斷	例子
死於自然	疾病，例如癌症或心臟病發作
工業 / 職業疾病	因工染病，例如：石棉沉着病
倚賴藥物 / 非倚賴性地濫用藥物	過量使用麻醉藥或其他藥物
出生時欠缺照顧	嬰兒在出生時未獲足夠照顧而死亡
自殺	自我終結生命
企圖墮胎 / 自我引發的人工流產(墮胎)	因墮胎或企圖墮胎而導致死亡
意外	因意料之外或不幸的事件而導致死亡，例如：交通意外或工作時失足
死於不幸	合法的行為導致意料之外的死亡
自我疏忽	因厭食症而死
合法殺人(自衛殺人)	因警方使用槍械自衛或防止某人受傷害而導致死亡
非法殺人	謀殺或誤殺
胎兒死亡	胎兒於出生前死亡
死因不明	證據不足，除「死因不明」外無法作出任何其他裁斷

工作流程表



THE CORONER'S COURT

The task of the Coroner's Court is to inquire into the causes and circumstances of certain deaths. As this booklet outlines, the Coroner has extensive powers related to the conduct of affairs relating to such deaths.

What are the Coroner's powers?

The Coroner is a judicial officer who has the power to:

- grant burial orders
- grant cremation orders
- grant waivers of autopsy
- grant autopsy orders
- grant exhumation orders
- grant orders to remove dead bodies outside Hong Kong
- order police investigations of death
- order inquests to be held
- approve removal and use of body parts of the dead body
- issue certificates of fact of death

What types of deaths should be reported to the Coroner?

The Coroners Ordinance sets out 20 categories of deaths (see Appendix I) which should be reported to the Coroner. Anyone responsible for reporting deaths to the Coroner (see the list in Appendix II) should do so as soon as they reasonably can after they know of the death.

What happens when a reportable death occurs?

The fact that a death is reportable to the Coroner does not necessarily mean that an inquest has to be held, except for certain categories of death. When a reportable death occurs, the body is sent to either a hospital or a public mortuary, where the pathologist:

- conducts an external examination of the body
- reports the findings of this examination or the cause of death, if ascertained, to Coroner
- recommends waiver of autopsy, and seeks a burial or cremation order if the cause of death can be ascertained
- seeks an autopsy order if the cause of death cannot be ascertained
- submits a brief description of circumstances, for example the clinical background.

The Coroner considers the pathologist's report and, depending on the case, makes one of the following orders:

- autopsy
- waiver of autopsy
- burial order
- cremation order.

If the Coroner is uncertain of the cause of death or for other reasons, he will:

- order an autopsy
- study the autopsy report from the pathologist
- consider whether an investigation is needed.

If the pathologist recommends an autopsy, but the deceased's family applies for a waiver, the Coroner sees the family in chambers, and then decides whether to order an autopsy or a waiver.

If the Coroner decides that a reportable death should be investigated, the police carry out the investigation and submit a death investigation report to the Coroner. The Coroner considers this report and decides whether an inquest should be held, calling on expert advice where he so chooses.

The Coroner can issue a warrant of entry and search in respect of any premises and place where a death has occurred.

If the Coroner decides not to hold an inquest, properly interested persons can write to him to request a copy of the death investigation report.

Inquests

The Coroner may hold an inquest with a jury of five or without a jury when a person dies

- suddenly
- by accident
- by violence
- under suspicious circumstances
- and when the dead body of a person is found in or brought into Hong Kong

An inquest must be held:

- when a death occurs in official custody, for example in a prison or a detention centre (this inquest must be held with a jury)
- upon the request of the Secretary for Justice.

The Coroner will usually hold an inquest where a person dies in an industrial accident.

The Coroner may conduct a pre-inquest review to decide how the inquest may best be carried forward promptly and justly. Pre-inquest reviews do not take place in open court, but inquests are held in open court unless the Coroner directs otherwise.

Summonses will be issued to witnesses to attend the inquest to give evidence and to produce documents. Legal representation for a properly interested person is allowed. Properly interested persons may upon payment of fees obtain copies of medical and other technical reports.

The Duty Lawyer Scheme also provides legal representation to persons who are at risk of criminal prosecution as a result of giving incriminating evidence in the inquest.

In complicated cases, the Coroner may request the Secretary for Justice to assist him to conduct the inquest.

What happens at the inquest?

At the inquest, the Coroner and the jury should ascertain:

- the identity of the deceased
- how, when and where the deceased died
- the particulars required under the Births and Deaths Registration Ordinance to be registered concerning the death
- the conclusion as to the death.

The proceedings of the inquest are as follows:

- the Coroner opens the inquest

- witnesses are called and examined by the Coroner's Officer or Government counsel, the jury, family members of the deceased, other interested persons and the Coroner
- the Coroner sums up the case
- the Coroner or the jury delivers the finding (Typical examples of findings are set out in Appendix III)

By law, the Coroner and jury may not frame a finding in such a way as to determine any question of civil liability. Claims for damages and civil liabilities should be lodged and heard in the civil law courts.

Recommendations may be recorded if they are designed to prevent the recurrence of similar fatalities, for instance in cases of deaths in industrial accidents, to prevent other hazards to life disclosed by evidence at the inquest and to bring deficiencies in a system or method of work to the attention of a person who may have power to take appropriate action.

The Coroner must adjourn an inquest and refer the matter to the Secretary for Justice where it appears that a criminal offence of murder, manslaughter, infanticide or death by dangerous driving may have been committed by any person. An inquest cannot be resumed until the criminal proceedings are finished.

Can anyone ask the Coroner to hold an inquest?

Properly interested persons or the Secretary for Justice can apply to the Court of First Instance of the High Court for an inquest to be held

into a death including, where an inquest has already been held, a new inquest into that death. The jury who served in the first inquest will also serve as the jury for the re-opened inquest.

Certificate of the fact of death

The Coroner may also issue a certificate of the fact of death. This is in effect an interim document certifying the fact of death. The certificate of the fact of death can be used, for example, to assist in the transport of a dead body to another country for burial, in particular where the relevant authorities of that country require official documentation that the deceased did not die from an infectious disease.

Performance Pledge

- The Coroner's Court will
- grant a burial order
 - grant a cremation order
 - grant an exhumation order
 - grant an order to remove dead bodies outside Hong Kong
 - grant a waiver of autopsies
 - grant an autopsy order
- as soon as possible upon the receipt of an application from the pathologist
- issue a certificate of fact of death
- 10 days after receipt of the post-mortem report
- list an inquest
- 42 days from the date of the Coroner's decision to hold an inquest

How to contact the Coroner's Court?

Address: 10th Floor, Eastern Law Courts Building, 29, Tai On Street, Sai Wan Ho, Hong Kong
Telephone: 2886 6871
Facsimile: 2568 1735

Business Hours

Registry and Accounts Office

Monday to Friday 9:00 a.m. to 1:00 p.m.
2:00 p.m. to 5:00 p.m.
Saturday 9:00 a.m. to 12:00 noon
(Closed on Sundays and Public Holidays)

Appendix I

The 20 Categories of Reportable Deaths

- Death the medical cause of which is uncertain
- Sudden / unattended death, except where a person has been diagnosed before death with a terminal illness
- Death caused by an accident or injury
- Death caused by crime
- Death caused by an anaesthetic or under the influence of a general anaesthetic or which occurred within 24 hours of the administering of anaesthetic
- Death caused by a surgical operation or within 48 hours after a surgical operation
- Death caused by an occupational disease or directly / indirectly connected with present or previous occupation
- Still birth
- Maternal death
- Deaths caused by septicaemia with unknown primary cause
- Suicide
- Death in official custody
- Where death occurred during discharge of duty of an officer having statutory powers of arrest or detention
- Death in the premises of a Government department any public officer of which has statutory powers of arrest or detention
- Death of certain mental patients (as defined by law) in a hospital or in a mental hospital
- Death in a private care home
- Death caused by homicide
- Death caused by a drug or poison
- Death caused by ill-treatment, starvation or neglect
- Death which occurred outside Hong Kong where the body of the person is brought into Hong Kong.

Appendix II

Persons Responsible for Reporting Deaths

Person Responsible for Reporting Death	Report made to
Medical practitioners for cases requiring Coroner's consent for organ removal	Coroner
Police for death in police custody or premises	Coroner
Department heads receiving a statutory notice of reportable death	Coroner
Police officers	Coroner
Registrar of Births and Deaths	Coroner
Any person (except police) exercising official custody duty	Coroner via police
Any person in charge of Government department premises	Coroner via police
Administrator of a hospital or other care facilities	Coroner with a copy to Police

Appendix III

Examples of Findings which may be made by the Coroner or the Jury

Finding	Example
Natural causes	An illness such as cancer or a heart attack
Industrial / occupational disease	A disease arising from employment, e.g. asbestosis
Dependence on drugs / non-dependent abuse of drugs	An overdose of narcotic drugs or other medication
Want of attention at birth	Death as a result of insufficient care being given to a child at birth
Suicide	Taking one's own life
Attempted / self-induced abortion	Death resulting from an abortion or an attempt to abort a child
Accident	Death resulting from an unexpected or untoward event, e.g. a traffic accident or a fall at work
Misadventure	Where act that is lawful but that has an unexpected consequence has caused the death
Self-neglect	Death from anorexia nervosa
Lawful killing	Death as a result of police use of firearms to prevent injury to a person or self defence
Unlawful killing	Murder or manslaughter
Stillbirth	The death of a foetus prior to birth
Open verdict	This finding is made if the evidence is not sufficient for any other finding to be made

Appendix IV

Workflow Chart

