HCMP 225/2020

[2021] HKCFI 999

IN THE HIGH COURT OF THE

HONG KONG SPECIAL ADMINISTRATIVE REGION

COURT OF FIRST INSTANCE

MISCELLANEOUS PROCEEDINGS NO 225 OF 2020

IN THE MATTER OF LEONITA ARCILLAS QUINTO (DECEASED)

and

IN THE MATTER OF SECTION 20(1)(A) OF THE CORONERS ORDINANCE (CAP 504)

BETWEEN

IMELDA QUINTO ABONG Applicant

and

CORONER Respondent

Before: Hon Mimmie Chan J in Court

Date of Hearing: 8 April 2021

Date of Judgment: 8 April 2021

Date of Reasons for Judgment: 15 April 2021

REASONS FOR JUDGMENT

Background

1. By these proceedings, Madam Imelda Quinto Abong ("**Applicant**") applies to the Court for an order under section 20 of the Coroners Ordinance ("**Ordinance**"), that an inquest be held into the death of her elder sister, Madam Leonita Arcillas Quinto ("**Deceased**"), since the coroner failed to hold such an inquest.

2. The Deceased had entered into an employment contract dated 25 September 2016 ("**Contract**") to work as a domestic helper for Madam Rachel Wong ("**Employer**") in Hong Kong. Her employment was made through the agency of Mr Li Wai Hong (**Mr Li**) and his company, Popular Employment Services ("**Agency**").

3. The Deceased arrived in Hong Kong on about 11 December 2016, and commenced employment with the Employer on about 14 or 15 December 2016, at the residence of the Employer at Mei Foo Sun Chuen in Kowloon ("**Residence**"). Since January 2017, the Deceased had complained repeatedly to Mr Li and the Agency about the conditions of her employment, that she was required to work long hours, was overworked, abused, and underfed. About 3 months after commencement of employment, on 19 March 2017, the Deceased served one month's notice of termination of the Contract. She informed the Applicant in March 2017 that she would be returning to the Philippines.

The death and the subsequent reports

4. In mid-morning of 4 April 2017, at around 11 am, the Deceased was found unconscious in her room. She was taken by ambulance to Princess Margaret Hospital ("**Hospital**") at approximately 12 noon, and was certified dead at 12:27 pm. According to the police report, the Deceased had been found dead upon the arrival of the police at the Residence, at approximately 11:41 am.

5. According to the police statement given by the Employer later, on 13 January 2020, the Deceased had informed the Employer the day before her death, on 3 April 2017, that the Deceased was suffering from headache and dizziness, although she was able to prepare dinner in the evening. At around 7:30 am on 4 April 2017, which was a statutory holiday in Hong Kong, the Employer found that the Deceased was still in her room. At 11 am, the Employer and her husband knocked on the door to the Deceased's room, and on entering the room, found the Deceased lying on her bed with no response. The Employer called emergency service, and the ambulance attendants arrived at around 11:50 am. The Deceased was given cardiopulmonary resuscitation, and then rushed to the Hospital, where she was examined at 12:05 pm and was certified dead.

6. According to the report dated 4 April 2017 which was made to the Coroner by Dr Wong of the Hospital, the Deceased enjoyed "good past health, had complained of headache and dizziness at 5 pm on 3 April 2017, was last seen well at 7 am on 4 April 2017, but was found unresponsive at 11 am". The cause of death was stated to be "uncertain".

7. Police Inspector Tam had attended the Residence at 12:50 pm on 4 April 2017. According to his statement dated 16 October 2017, no will or note was found for the Deceased. The Inspector reported that there was no CCTV at the Residence, and that he had found no sign of struggling, ransacking, fighting, or anything suspicious. Inspector Tam had also examined the body of the Deceased at the Hospital. According to his statement, the Deceased was about 150 to 160 cm tall, 50 kg in weight, and of thin build. No wound or injury was found on her body.

8. The body of the Deceased was also externally examined by Foo Ka-Chung of the Kwai Chung Public Mortuary on 4 April 2017. According to his examination, there was a small abrasion over the front of the middle chest, "TNMs over the front of the left elbow and outer aspect of the right ankle of the deceased", but there was no detection of other recent external injury. These reported findings were included in the Post-Mortem Report dated 12 April 2017.

9. On 13 April 2017, the Applicant arrived in Hong Kong after she was informed of the death of the Deceased. She identified the body of her sister at the Public Mortuary on 13 April 2017, in the company of Mr Li of the Agency. She made a statement to the Police at the Cheung Sha Wan Police Station. In her statement, the Applicant stated, amongst other things, that the Deceased had not suffered from any serious illness, apart from having a benign tumor on her left breast which was diagnosed in 2013. She had headaches before and after her menstruation, but had not received any treatment or operation. The Applicant stated that she had last spoken to her sister in the afternoon of 3 April 2017. Her sister had told her that she would resign, would not work anymore and would return to the Philippines. The Applicant was also informed by her sister that she suffered from back ache and fatigue all over her body.

10. An autopsy was performed on the Deceased on 18 April 2017. According to the report, there was no recent external injury detected. A small amount of partially digested food was found in the Deceased's stomach. Multiple large fibroids were found in her uterus, but her other organs appeared normal and healthy. The remarks of Dr Ng were that the autopsy and toxicological analysis did not reveal any condition that could have accounted for the death. The cause of death was accordingly given as "unknown". Dr Ng further noted that the toxicological analysis detected paracetamol in the blood at sub−therapeutical level.

11. On 21 April 2017, the Coroner certified in the Certificate of the Fact of Death that the precise medical cause of death had yet to be established.

12. The Senior Chemist of the Government Laboratory issued an Examination Report on 23 May 2017. This stated that from a general screening procedure for common drugs and poisons, no significant finding was obtained from the blood and urine samples, apart from the detection of paracetamol at a sub-therapeutic level.

13. On 12 July 2017, the Coroner directed the District Commander of the Cheung Sha Wan Police to report on the death of the Deceased, the apparent cause of which was "unknown". On 1 September 2017, the Consulate General of the Philippines also wrote to the Coroner's Court, requesting for final findings on the death of the Deceased, stating that the family of the Deceased requested an autopsy and a full investigation. The Police issued a report to the Coroner, dated 9 April 2018 ("**Police Report**"). It referred to the statements made by the ambulance attendants, Inspector Tam and the Police Constable who had conducted investigations at the Residence on 4 April 2017, Dr Wong who examined the Deceased at the Hospital, Dr Ng who performed the autopsy, and the Senior Chemist who had issued the Examination Report on 23 May 2017. It concluded that the investigations of the police had revealed no particular sign of suspicion or crime element. It reported that the younger sister of the Deceased (ie the Applicant) had stated that she did not want to make any complaint regarding her sister's death. The Police Report concluded with the statements of opinion that no death inquest should be held, and no death inquest was recommended.

14. On 26 March 2019, the Coroner issued the Death Report, stating her decision that no inquest was required, and that the death should be assigned the classification of "death by unknown causes".

15. In August 2019, the Applicant was able to obtain *pro bono* legal assistance from Justice Without Border, and the solicitors for the Applicant inquired with the Coroner as to the reason for not holding a death inquest. Some time in November 2019, the Coroner issued instructions for a statement to be obtained from the Employer, and for a medical report to be obtained from any hospital, to give an account of the health condition of the Deceased prior to her death. Apparently, the Coroner was then informed that there was no record of the Deceased seeking medical consultation at government hospitals or clinics. Pursuant to the Coroner's request, a statement was obtained by the Police from the Employer, on 13 January 2020 ("**Employer Statement**").

16. In the Employer Statement, the Employer stated that prior to the commencement of her employment, the Deceased had done a medical check-up, and the report had indicated that the Deceased had not suffered from any disease and that her health was normal. The Employer claimed that the Deceased had not mentioned to her that she had any health issue, but on her first day of work, the Deceased had coughed continuously. On the second day of her employment, the Employer had in fact taken the Deceased to see a doctor, and the doctor had indicated that the Deceased's coughing was caused by the weather. Medication was prescribed, but according to the Employer, the Deceased had continued to cough for a week. The Employer had asked the Agency for a change of helper, but her request was declined. She took the Deceased to receive an x-ray on 23 December 2016, and the x-ray did not reveal any abnormality. The Employer stated that the Deceased's coughing had stopped thereafter, and that no other illness had been reported.

17. The Employer confirmed in the Employer Statement that the Deceased had resigned on 19 March 2017, stating that she wished to return to the Philippines. The Employer had accepted the Deceased's resignation, and had agreed to let the Deceased leave after one month.

18. According to the Employer, the Deceased informed her on 3 April 2017 at approximately 3 pm that she was suffering from a headache. She returned to her room to rest, until 5 pm when she prepared dinner for the Employer, indicating that her headache had subsided and that she was well. The Employer claimed that the Deceased informed her at 9 pm that she was suffering from headache again, whereupon she returned to her room to rest.

19. In the Employer Statement, the Employer claimed that at 7:30 am on 4 April 2017, she had noted that the Deceased had not left the Residence after breakfast, as she would normally do on a statutory holiday. When the Employer went to the Deceased's bedroom, she saw the Deceased lying on the bed with her back towards her. According to the Employer, the Deceased only waved to her, with no indication as to whether she was unwell, or not. At approximately 11 am, the Employer noted that the door to the Deceased's bedroom was still closed. She wanted to find out if the Deceased was still at home, and after the Employer's husband had knocked on the door several times and had received no response, the husband opened the door and found the Deceased lying on the bed, with no response. The Employer called for the ambulance and the police, and subsequently accompanied the Deceased to the Hospital, where she was certified dead.

20. The Employer stated that she had been satisfied as to the work performance of the Deceased.

The application to the Court for inquest

21. The Applicant issued the Originating Summons under section 20 (1) (a) of the Ordinance on 10 March 2020. This provides that where the Court, upon the application of a properly interested person or the Secretary for Justice, is satisfied that a coroner has failed to hold an inquest which ought to be held, the Court may order an inquest to be held into the death of a person.

22. The application is made by the younger sister of the Deceased on behalf of the family of the Deceased, who are parties interested in the cause of and the circumstances connected with the death of the Deceased, and how she came by her death. The Applicant has also been authorized by her mother to process the Deceased's claims for employees compensation and other benefits due to the Deceased under her employment in Hong Kong, and in that regard, the Applicant is a person properly interested in the cause and circumstances connected with the death of the Deceased. The application is supported by the Applicant's affidavits, made on 29 April 2020 and 27 May 2020. These affidavits set out the personal circumstances of the Deceased, as well as what the Deceased had informed the Applicant as to the conditions of her employment by the Employer and of her health prior to her death in April 2017.

23. The Deceased's employment with the Employer in Hong Kong was not her first job as a domestic helper. Prior to working in Hong Kong, the Deceased had in fact worked as a domestic helper in Bahrain from August 2002 to August 2004, and then in Singapore from March 2007 to November 2011.

24. According to the Applicant, the Deceased had enjoyed reasonably good health prior to her employment in Hong Kong. She referred to the Deceased's medical condition, of having a benign tumor on her breast, and of her complaints of headache before and after her menstruation periods. She claimed that after having been examined in a hospital in the Philippines in 2013, no treatment or medical care was prescribed as necessary for the Deceased.

25. According to the receipts which the Applicant found amongst the possessions of the Deceased after her death, the Deceased had been prescribed with medication for the coughing she experienced in December 2016 upon her arrival in Hong Kong.

26. The Applicant stated that shortly after the commencement of the Deceased's employment in Hong Kong, the Deceased had started to complain to her of having back pain and general fatigue every day. Throughout February and March 2017, the Applicant had been informed by the Deceased, when they talked on the telephone, that the Employer had demanded the Deceased to work long hours, and that she had been overworked. She was instructed to do the laundry late at night, after the Employer's family had finished dinner, and could only sleep very late after midnight. She was so deprived of sleep that she would fall asleep in odd positions and noisy surroundings on her days off. The Deceased could only rest discreetly during her working hours, and only for a very short time, because she would be reprimanded by the Employer if she was seen not working.

27. According to what the Deceased had informed the Applicant, the Deceased was not provided with sufficient food by the Employer. She had to purchase extra food for herself, and had expressed concern to the Applicant as to her food intake. The Deceased also told the Applicant that she was only permitted to eat after she had finished her long list of household chores, and that she often had to work with an empty stomach for extensive hours. The Deceased told the Applicant that she could only eat and drink very discreetly, when the Employer was not watching, or when she was picking up the children from school, because there was CCTV installed in the Residence. The Deceased said she had to hide a biscuit in her pocket and nibble on it gradually to suppress her hunger.

28. The Applicant further pointed to instances of the Employer abusing the Deceased, verbally, and physically by pushing and poking the Deceased. The Deceased was not even permitted to use the toilet in the Residence for her own sanitary needs. The Applicant expressed her belief that the back pain and general fatigue of which the Deceased had complained was the combined effect of overwork, malnourishment and enormous stress suffered during the Deceased's employment by the Employer.

29. The Applicant's evidence is that since January 2017, the Deceased had in fact tried many times to seek help from the Agency, complaining about her work conditions. Mr Li had informed the Deceased at first to be more accommodating towards the Employer, and to make adjustments even if the Employer was unkind. However, as the situation deteriorated over time, and the Employer started scolding the Deceased with offensive language, the Applicant stated that the Deceased had visited the office of the Agency since the last week of February, to seek help. In March 2017, the Deceased was told by Mr Li that the Employer had a track record of mistreating all her former domestic helpers, and that the Deceased was the third helper who did not remain in employment due to the bad attitude of the Employer. According to the Applicant, Mr Li told the Deceased that the Agency was going to blacklist the Employer and would stop introducing domestic helpers to the Employer after the Deceased.

30. The Applicant has been fortunate in that solicitors and Counsel have acted for her on *pro bono* basis, such that legal submissions have been made on her behalf, in support of the application. The Department of Justice acting for the Coroner indicated that the Coroner adopts a neutral stance in the proceedings, and at the Court's request, confirmed that no issue is taken in relation to the submissions on law made on behalf of the Applicant. Having accepted that the application for inquest should be considered *de novo* (*Secretary for Justice v William Ng Esq, a Coroner* [2011] HKLRD 283), the Department of Justice did not attend Court to make any further submissions.

31. At the end of the hearing on 8 April 2021, I allowed the application, and ordered an inquest to be held under section 20 (1) (a) of the Ordinance. The following sets out the reasons for my decision.

The purpose of an inquest and the applicable legal principles

32. Section 14 (1) of the Ordinance provides that a coroner may, if he considers that an inquest is necessary, hold an inquest into the death, where (*inter alia*) a person dies: (i) suddenly; (ii) by accident or violence; or (iii) under suspicious circumstances.

33. In this case, the Deceased died suddenly, aged 46, without any serious disease detected prior to her death. The sudden death falls within the situation when an inquest may be held under section 14 (1), irrespective of whether or not the Deceased had died under suspicious circumstances, or by accident or violence.

34. Not every sudden death warrants an inquest, and in deciding whether an inquest should be held, it is of course relevant to consider the purpose of inquests as set out in Section 27 of the Ordinance. This states:

> "The purpose of an inquest into the death of a person shall be to inquire into the cause of and the circumstances connected with the death and, for that purpose, the proceedings and evidence at the inquest shall be directed to ascertaining the following matters in so far as they may be ascertained –
>
> (a) the identity of the person;
>
> (b) how, when and where the person came by his death;
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> (c) the particulars for the time being required by the Births and Deaths Registration Ordinance (Cap 174) to be registered concerning the death; and
>
> (d) the conclusion of –
>
> (i) where the inquest was held without a jury, the coroner who held the inquest;
>
> (ii) in any other case, the jury concerned,
>
> as to the death."

35. Of the matters which fall to be ascertained in an inquest, the material ones in the present case are those identified in section 27 (b).

36. As highlighted in *Secretary for Justice v William Ng Esq, a Coroner* [2011] 1 HKLRD 283, the Court is not concerned with fault finding, nor with reviewing the merits of the original decision of the Coroner not to hold an inquest. Under section 20 (1) (a) of the Ordinance, the Court is only required to consider, *de novo*, whether an inquest "ought to be held", and not whether the Coroner has made any particular error in reaching his decision not to hold an inquest.

37. The inquest is inquisitorial in nature, for the purpose of establishing facts. The function of the Coroner is to determine facts about the deceased: the cause of death, and the circumstances surrounding the death and the cause. The learned authors of *Jervis on the Office and Duties of Coroners* (14th Ed) observed at paras 1-18 to 1-23 that an inquest is to seek out and record as many of the facts concerning the death as public interest may require.

38. Section 27 (b) identifies the matters to be ascertained as to include "how" the person came by his death. As Counsel for the Applicant submitted, this is wider than ascertaining the medical cause of the death, and the Coroner should inquire into acts and omissions which are directly responsible for the death (*R v HM Coroner for North Humberside and Scunthorpe, ex p Jamieson* [1995] QB 1; para 6-08, *Jervis*).

39. The approach in *Jamieson* was adopted by the Hong Kong Court in *Tien v Lam Esq* [2004] 2 HKLRD 719, and *Tien* was followed in *Secretary for Justice v William Ng Esq, a Cornoner* [2011] 1 HKLRD 283. In *William Ng*'s case, the Court was of the view that the ascertainment of how the person came by his death was a limited factual question, not extending to the broad circumstances in which the deceased died.

40. Counsel pointed out that in *Sony Rai v Coroner* [2011] 2 HKLRD 245, Reyes J broadened the meaning of "how" under section 27 (b), to extend to "by what means and in what circumstances" a person came by his death. This was upon consideration of the fundamental importance of the right to life under Article 28 of the Basic Law, and the right under Article 2 (1) of the Hong Kong Bill of Rights, not to be subjected to cruel, inhuman or degrading treatment or punishment under Article 3 of the Bill of Rights. The duty of the Government and all public authorities in Hong Kong to safeguard and guarantee the individual's right to life justifies the need for a coroner to give due consideration to these rights when deciding on the need to hold an inquest under the Ordinance.

41. In *Sony Rai v Coroner* [2011] 2 HKLRD 245, Reyes J pointed out that Article 28 of the Basic Law and Article 2 (1) on the Hong Kong Bill of Rights, and their implications on the construction of "how" in section 27 (b) of the Ordinance, had not been drawn to the attention of the Court in *Tien v Lam Esq* [2004] 2 HKLRD 719 and *Secretary for Justice v William Ng, Esq* [2011] 1 HKLRD 283, and that the decision in *R (Middleton) v West Somerset Coroner* [2004] UKHL 10 had not been cited to the Court. At paragraphs 33-35 of his judgment, Reyes J explained:

> "In my judgment, the reasoning in *R (Middleton) v West Somerset Coroner* on the UK's obligations arising from art 2 of the ECHR and the implications of those obligations on the proper scope of a coroner's inquest, must be equally applicable here. This must be so in light of art 28 of the Basic Law, art 2 (1) of the Hong Kong Bill of Rights and the incorporation into Hong Kong law of art 6 of the ICCPR. Reading the word 'how' in s 27 (b) of the Coroners Ordinance as requiring in all situations a limited factual investigation into the immediate means (as opposed to broader circumstances) in which a deceased died, would mean that in some situations the Government would not be fulfilling its procedural obligation in connection with the right to life.
>
> Obviously, as the House of Lords itself noted in *R (Middleton) v West Somerset Coroner*, it will not be in all situations that an inquiry into the broad circumstances of the death will be required. In many, possibly a majority of instances, it will be readily apparent how a person died and there will be nothing in the evidence suggested of some systematic problem which caused or contributed to the death. But to be compliant with the procedural obligations arising from the guarantee of the right to life in the Basic Law and Hong Kong Bill of Rights, a coroner must retain the power or discretion, where circumstances warrant, to investigate inappropriate cases whether systemic factors (broad circumstances) caused or contributed to a death. Thus, in light of the Basic Law and Hong Kong Will of Rights, I do not believe that a narrow reading of 'how' in s 27 (b) of the Coroners Ordinance can be justified.
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> Following the coming into effect here of the Basic Law and Hong Kong Bill of Rights, the Court has the duty to interpret legislation in a manner which is consistent with the obligations arising from those two documents. It seems to me therefore that, consistently with the Basic Law and Hong Kong Bill of Rights, I should construe the word 'how' in s 27(b) of the Coroners Ordinance to permit a wider range of inquiry. In other words, much as suggested in *R (Middleton) v West Somerset Coroner* in relation to the corresponding UK legislation, the word 'how' in s 27 (b) of the Coroners Ordinance should he read as empowering an inquest where appropriate, to investigate not just the means by which a person has died, but also the broad circumstances in which one has lost one's life." (Emphases added)

42. I fully agree with the reasoning of Reyes J, and adopt the approach he held to be applicable to the construction of section 27 (b) of the Ordinance.

Ought an inquest be held in the present case?

43. On the evidence presently available in this case, the Deceased was still relatively young and did not suffer from any serious illness which could have caused her death. Her coughing had stopped and the x-ray had revealed no abnormality in her lungs. The benign tumor had been found in 2013 and had not given cause for any treatment or surgery. According to the report of Doctor Alan Worsley of the Department of Pharmacology and Pharmacy, of the University of Hong Kong, the investigation reports and the toxicological examination on the Deceased had found no signs of alcohol, therapeutic agents or medication, and that other drugs were at undetectable levels. Further, the autopsy report found the cause of death to be unknown, which suggests that there was no pathological or toxicological basis to account for the means by which the Deceased came by her death.

44. On behalf of the Applicant, Counsel submitted that there was evidence of possible neglect and failure to provide adequate nourishment for the Deceased. In this case, the Deceased as a foreign domestic helper working in Hong Kong and residing with her employer was dependent on the Employer to provide her with proper nourishment and care, including medical treatment as may be required. On the Applicant's evidence, the Deceased had been required to work long hours, late into the night, but had not been given sufficient food, and was not allowed to eat and drink as and when the Deceased had the need. I have borne in mind the fact that the Deceased had, before taking up employment with the Employer in Hong Kong, worked for 6 years in Bahrain and Singapore. She was not a novice to the demands on a domestic helper, and her complaints of long hours of work cannot simply be dismissed as lethargy. Further, according to the Applicant, Mr Li of the Agency had coorborated the substance of the Deceased's complaints against the Employer, as Mr Li had told the Deceased that the Employer had a history of mistreating her former domestic helpers, and that the Agency had intended to put the Employer on a blacklist.

45. As Counsel pointed out, if an inquest was held, the Coroner may subpoena the relevant witnesses to give evidence as to the events of 3 April and 4 April 2007 and on the entire circumstances of how the Deceased had been affected by her headache and any other ailments on the day before and in the morning up to her being certified dead. On the evidence, the Deceased had already complained of suffering from a headache in the afternoon of 3 April 2017 and had to return to her room to rest until the evening. As apparent from the Deceased's mobile telephone, a call had been made to the Deceased at 9:55 am on 4 April 2017, from Madam Rio Mananuih a friend of the Deceased ("**Rio**"), but such call had not been answered. The Employer claimed that she had cause to check on the Deceased at 7:30 am on 4 April 2017, and that she had found the Deceased to be unresponsive at 11 am, but it was not until 11:42 am that the emergency service received the call for assistance. The Employer must have contacted Rio before 12 noon, since Rio had travelled in the same ambulance as the one which took the Employer and the body of the Deceased to the Hospital.

46. I accept the submissions of Counsel, that there are public interest considerations in this case, where a person in a vulnerable and dependent situation dies whilst in the care and custody of her employer, and the death is unaccounted for and cannot be explained. Mr Chan pointed out that the Coroner is empowered under section 44 (2) of the Ordinance to make recommendations designed-

> (a) to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held;
>
> (b) to prevent other hazards to life disclosed by the evidence at the inquest;
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> (c) to bring to the attention of the person who may have power to take appropriate action any deficiencies in a system or method of work which are disclosed by the evidence at the inquest and which are of public concern.

47. In *Secretary for Justice v William Ng, Esq*, the Court noted that where it is said that an inquest ought to be held because the jury or coroner might make useful recommendations, it is for the applicant to identify at least broadly the areas in which useful recommendations might be made, and to point to some evidential basis for suggesting that the coroner or jury would be likely to make such recommendations. In the present case, Mr Chan referred to the Applicant's evidence that the Deceased had complained a number of times to the Agency about the ill−treatment she had received from the Employer, and that according to Mr Li, the Employer had a record of mistreating her domestic helpers. Counsel pointed out that if this was true, it had not deterred the Agency from arranging for domestic helpers to work for the Employer, and the Immigration Department had not apparently been notified of the Employer's alleged record. In this unfortunate case, if what Mr Li is reported to have said about the Employer's bad record was true, and the matter had been reported to the Immigration Department, the Contract might not have been approved, the Deceased would not have worked for the Employer and her death might not have occurred. An inquest should be held to obtain evidence from Mr Li and the Employer, and other witnesses such as Rio who may have had contact with the Deceased whilst she was working in Hong Kong, to obtain evidence as to the Deceased's working conditions, and on the basis of such evidence, to consider whether useful recommendations can be made to employment agencies, the Immigration Department and employers, on the system of approving contracts of employment of foreign domestic helpers, and to implement safeguards for the protection of foreign domestic helpers employed to work in Hong Kong.

48. Mr Chan also highlighted the facts in the present case which show a systemic deficiency in the way in which investigations are made by the police, when foreign domestic helpers or their family members seek help in Hong Kong. When the Applicant came to Hong Kong on 13 April 2017 to deal with the affairs of the Deceased, she was accompanied by Mr Li to the Cheung Sha Wan Police Station, where she was interviewed and a statement was taken from her. There was no Tagalog interpreter, and the Applicant was not told that she had the option of asking for such an interpreter. There was only a police officer who spoke English and Chinese and acted as interpreter. When the Applicant asked questions, the policeman taking the statement only spoke to Mr Li in Chinese. The Applicant could not follow everything that was exchanged between the policeman and Mr Li.

49. The Applicant's statement to the police was produced in Chinese and in English. She was given the statements to read and sign, and although the Applicant had noticed that many things which she had stated had not been recorded, she was too confused and overwhelmed to ask why the details were left out. The Applicant was not given a copy of the statement until more than 2 years later, in November 2019, when Justice Without Borders contacted the police for her. The Applicant found out then that the statement she had signed was not a true reflection of what she had said or had meant. Amongst other things, the Applicant claims that the statement omitted what she had said about the Deceased having been deprived of food and proper rest. The English version of the Applicant's statement contained the sentence: "I do not lodge any complaint." The Applicant claims that she had never said that. According to the Applicant, she had asked the police why her sister had suddenly died.

50. It was only after Justice Without Borders made inquiries with the Coroner that the police were directed, in about November 2019, to obtain a statement from the Employer. Counsel pointed out that this delay and initial inaction was totally unsatisfactory, as the Employer was obviously the person who had the most direct and relevant information as to the circumstances connected with and leading to the death of the Deceased on 4 April 2017. Members of the family of the Deceased obviously would have cause to doubt, whether the authorities in Hong Kong had paid due heed to the procedural obligations arising from the guarantee of the right to life, provided for in the Basic Law and Hong Kong Bill of Rights.

51. Whether or not the Applicant's complaints and reports of what the Deceased had told her about her conditions of work were true, and whether or not there were exaggerations in the claims made, can be examined in the process of the inquest. On the evidence presented at this stage, there are sufficient facts to suggest that the inquisitorial powers and functions of the Coroner at an inquest should be exercised to investigate the circumstances in which the Deceased lost her life, and that recommendations can be made in the areas outlined by Counsel.

52. In all the circumstances of this case, I am satisfied that an inquest ought to be held, to inquire into the cause of and the circumstances connected with the death of the Deceased, and to ascertain in what circumstances the Deceased came by her death.

53. I am grateful for the assistance offered by the solicitors and Counsel in this case, both to the family of the Deceased and to the Court, particularly when the Department of Justice had failed to make any submissions.

(Mimmie Chan)
Judge of the Court of First Instance
High Court

Mr Benjamin Chan, instructed by TH Koo & Associates, for the applicant (*pro bono*)

The Respondent was represented by Department of Justice but no appearance was made