香港醫務委員會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr SIT Sou Chi (薛守智醫生) (Reg. No.: M10748)

Dates of hearing: 17 and 28 October 2025 (Friday and Tuesday)

Present at the hearing

Council Members/Assessors:	Prof. TANG Wai-king, Grace, SBS, JP (Chairperson of the Inquiry Panel) Dr KWOK Wang-chun Dr CHENG Wai-tsoi, Frankie Ms LIU Lai-yun, Amanda Mr Calvin K CHENG
Legal Adviser:	Mr Edward SHUM
Defence Counsel and Solicitor representing the Defendant:	Ms Catrina LAM SC as instructed by Messrs. Howse Williams (Day 1) Mr Chris HOWSE of Messrs. Howse Williams (Day 2)
Legal Officer representing the Secretary:	Ms Carol LEE as instructed by Department of Justice

The Charge

1. The charge against the Defendant, Dr SIT Sou Chi, is:

> *"That on or about 22 December 2009, he, being a registered medical practitioner, disregarded his professional responsibility to his patient* [redacted] *("the Patient"), a new born, in that, he failed to carry out all necessary and immediate investigations on the Patient after the Patient developed 1st episode of neonatal seizure at 3:31 a.m.*

In relation to the facts alleged, he has been guilty of misconduct in a professional respect."

Facts of the case

2. The name of the Defendant has been included in the General Register from 22 July 1996 to the present. His name has been included in the Specialist Register under the specialty of Paediatrics since 4 August 2004.

3. The Patient was born by spontaneous vaginal delivery at 09:19 hours on 19 December 2009 with a birth weight of 3.1 kg at gestation 37 weeks and 4 days at the Hong Kong Baptist Hospital ("BH").

4. The Patient was first seen by the Defendant for neonatal assessment after delivery. Newborn examination was unremarkable and the Patient was described as normal by the Defendant.

5. When the Patient was admitted after birth to the Nursery of BH, he was afrebile with normal breathing and apical rate. Physical examination results were normal except some "*red lines*" noted over his scalp. His body temperature, respiration and heart rate were monitored regularly.

6. On 20 December 2009, the Patient was seen by the Defendant at the Nursery. The Patient was described in the History, Physical & Progress Record as well with no jaundice. Physical examination revealed no abnormality.

7. On 21 December 2009, the Patient was seen by the Defendant again. The Patient was described in the History, Physical & Progress Record as well with query jaundice. Physical examination revealed no abnormality. Transcutaneous bilirubinometer (TCB) reading was 9.4mg/dL and no treatment was offered.

8. Redness was noted over the Patient's chin and this finding was documented in the Nursing Kardex at 11:45 and 19:00 hours on 21 December 2009.

9. At 03:00 hours on 22 December 2009, the night duty nurse at the Nursery, Nurse HO Kit Ha ("Nurse HO") documented in the Nursing Kardex for the Patient that he was

"*irritable with high pitch crying*" at around 02:30 hours after feeding. Nurse HO also found the Patient to be "*four limbs rigid, sweating & choking persisted*". The Patient was "*put... into incubator [with] oximeter to keep observation*". Oxygen saturation (SaO2) was 94%; H'stix was 5.4mmol/L. Nurse HO also noted ectopic heartbeat. It was however not documented in the Nursing Kardex whether she had reported this clinical event to the Defendant.

10. The Patient's oxygen saturation dropped to 80% at 03:30 hours on 22 December 2009. According to Nurse HO, the Patient developed "*contraction of four limbs [and] abnormal movement of eyeball*" for 15 seconds with "*sweating persisted*" at 03:31 hours. The Patient also had "*coldness of body & 4 limbs but redness on upper part of body pale looking on lower limbs* [and] *[t]hen resume[d] normal colour spontaneously in a short period*". "*Suction [was] done once due to choking persisted*" and oxygen supplementation of 2L/minute was given to the Patient via incubator.

11. According to Nurse HO, she reported to the Defendant by phone at 04:20 hours on 22 December 2009 on what happened to the Patient. There is conflicting evidence on precisely what Nurse HO had told the Defendant and how he responded.

12. Subsequent hourly monitoring revealed the Patient's condition was stable with apical rate of 124-130/min; respiratory rate of 40-50/min; and SaO2 of 96%.

13. At 05:00 hours on 22 December 2009, Nurse HO documented in the Nursing Kardex the clinical event which happened to the Patient at 03:30 hours.

14. Nurse HO also documented in the Nursing Kardex that the Patient's SaO2 fell down to 67% despite oxygen supplementation at 06:40 hours on 22 December 2009. The Patient had "*contraction of 4 limbs*" for 15 seconds. Suction was performed and reddish fluid was noted in oral region. At 06:50 hours, the Patient developed "*blinking of eyes*", "*contraction of 4 limbs*" for 15 seconds and oxygen desaturation with SaO2 down to 87%.

15. The clinical event which happened at 03:30 hours on 22 December 2009 was also recorded as the first event in the Convulsion Chart of the Patient. This was followed by the two clinical events which happened at 06:40 and 06:50 hours respectively on 22 December 2009.

16. However, the Defendant was only informed by Nurse HUI at 07:30 hours on 22 December 2009 of the latter two clinical events.

17. At 08:00 hours on 22 December 2009, the Patient was seen by the Defendant at the Nursery. In the History, Physical & Progress Record, the Patient was described as having increased heart rate and desaturation. There was no rash. His chest, abdomen and heart were normal. However, two more episodes of limb contraction and eye blinking were noted at 08:00 and 08:40 hours on 22 December 2009.

18. The Defendant suspected the Patient was suffering from neonatal seizure. The Patient was kept nil by mouth and put on intravenous dextrose infusion. Blood tests including complete blood picture, C-reactive protein, blood culture, blood gases, glucose, sodium, potassium, calcium, ammonia and clotting profile were checked. Lumbar puncture was not performed because of the unstable condition of the Patient.

19. Initially, arrangement was made for the Patient to be transferred to the Queen Elizabeth Hospital ("QEH") for further management. However, the Patient developed 2 episodes of "*blinking of eyes*" and "*contraction of 4 limbs*" with desaturation at 11:40 and 11:52 hours on 22 December 2009 and required higher oxygen supplementation to maintain a SaO2 of 95%.

20. The Patient had a further episode of convulsion at 13:00 hours on 22 December 2009 and developed "*respiratory cardiac arrest*" with bradycardia down to 49/min with SaO2 of 39%. The Patient was resuscitated with chest compression and manual Ambu-bagging by the nurse.

21. The Patient developed another episode of bradycardia (78/min) and oxygen desaturation with SaO2 of 46% at 13:25 hours on 22 December 2009. Intravenous injection of Adrenaline was given at 13:26 hours after chest compression and manual Ambu-bagging commenced.

22. The Patient was later escorted by the Defendant and left BH for QEH at 13:45 hours on 22 December 2009.

23. Meanwhile, the results of laboratory tests done at BH revealed that both the Patient and his mother were suffering from Streptococcal agalactiae (Group B streptococuss).

24. After his admission to QEH, lumbar puncture was performed later in the afternoon of 22 December 2009 and the cerebrospinal fluid was found to contain Streptococcal agalactiae. A diagnosis of Group B Streptococcal meningitis, septicemia and pneumonia was made. The Patient remained afebrile after admission to QEH except

for one kick fever on 27 December 2009. The Patient was treated by intravenous penicillin and phenobarbitone.

25. The Patient was discharged from QEH on 29 January 2010. After discharge from QEH, the Patient was followed up at the Neonatal Clinic of QEH. The Patient was also referred to the Child Assessment Centre for formal developmental assessment.

26. The Patient's father subsequently lodged this complaint against the Defendant with the Secretary of the Medical Council (the "Council").

Application for Permanent Stay of Proceedings

27. At the beginning of this Inquiry, the Defendant applied through his Counsel to us for permanent stay of the disciplinary proceedings against him. The Defendant complained that the "*delays and resulting prejudice to [him] constitute an abuse of process such that [this] Inquiry should not be allowed to proceed*". Firstly, it took "*almost 3.5 years [for the case] to be referred from the Chairman of the PIC to the full PIC for consideration*". Secondly, "*the Secretary only served the witness statements of Nurse HO and Nurse HUI on [the Defendant] more than six years after the relevant events and just 7 days before the [original scheduled hearing date of] 13/7/2016 Hearing*". Thirdly, "*the Secretary failed to take any action for over 8 years after the adjournment before resurrecting the case out of the blue*".

28. Counsel for the Defendant sought to rely on the English cases of *R v Chief Constable of the Merseyside Police, ex parte Merrill* [1989] 1 WLR 1077 and *R (on the application of the Independent Police Complaints Commission) v The Chief Constable of West Mercia & Another* [2007] EWHC 1035 (Admin) and argued that a disciplinary tribunal should exercise its power to stay the disciplinary proceedings if "*it would be unfair to proceed further*" [per Lord Donaldson MR at 1085F-G]. "*[W]hether unfairness in this context is a free-standing concept or an example of abuse of power does not really matter. These are only labels after all*" [per Keith J at paragraph 21]. We do not agree. In our view, Counsel for the Defendant has taken these quotations out of context.

29. In *R (on the application of the Independent Police Complaints Commission) v The Chief Constable of West Mercia & Another*, the claimant i.e. the Independent Police Complaints Commission, directed the Chief Constable of West Mercia to bring disciplinary proceedings against the interested party, Police Constable Walton, in

respect of use of excessive force in effecting arrest of a person who subsequently died from head injury. However, the panel of officers appointed by the Chief Constable to hear the case decided that the disciplinary proceedings should be stayed because the jury at the death inquest of the arrested person had already expressed the views that the force used to effect the arrest was reasonable; and continuance of the disciplinary proceedings constituted an abuse of process.

30. At the heart of the judicial review application before Keith J was the question whether the disciplinary panel was under any duty to stay the disciplinary proceedings on the basis upon which it purported to do so. Keith J was not breaking new ground. Indeed, Keith J emphasized in paragraph 20 of his judgment that:-

"*The power to stay proceedings as an abuse of process is one which the law has long recognised. It was described by Lord Diplock in Hunter v Chief Constable of the West Midlands Police [1982] AC 529 at p.536B-C as an*

"... inherent power which any court of justice must process to prevent misuse of its procedure in a way which, although not inconsistent with the literal application of its procedural rules, would nevertheless be manifestly unfair to a party to litigation before it, or would otherwise bring the administration of justice into disrepute among right-thinking people."

The jurisdiction is one which must be exercised with the greatest of caution... but Lord Diplock articulated the two instances in which it might be appropriate to stay proceedings as an abuse of process. The first is where the proceedings would be "manifestly unfair to a party to the litigation". The second is where the proceedings would "bring the administration of justice into disrepute among right-thinking people"."

31. In *R v Chief Constable of the Merseyside Police, ex parte Merrill*, Lord Donaldson MR also cautioned against over-generalization of reasons for judicial decisions and thus he said:-

(at 1084H-1085A):-

"*...Judgments apply specifically to the facts of the case under consideration and only incidentally may have more general application*"; and

(at 1085C-F):-

"*... the introduction of the concept of "abuse of process" as being the test which the Chief Constable had to apply in deciding whether or not to allow the proceedings to continue could result in creating a greater hurdle for Detective Constable Merrill to surmount than was justified...*"

32. It was in this context that Lord Donaldson MR went on to hold (at 1085F-G):-

"*The Chief Constable had no need to concern himself with "abuse of process". As a judicial tribunal, he had a discretionary power to dismiss the charge without hearing the full evidence if he was satisfied that, whatever the evidence might reveal, it would be unfair to proceed further...*"

33. It is well established that "*there are two limbs for granting a stay [of proceedings] at common law. The first limb is when it is impossible to ensure a fair trial; the second is that even if a fair trial is possible, the integrity of the judicial system will be compromised if the [proceedings] is allowed to proceed*" [see: *Archbold Hong Kong 2025* Vol. 2 at 19-34B].

34. In *R v Maxwell* [2010] UKSC 48, Dyson JSC further explained at paragraph 13 of the Judgment of the House of Lords that:-

> "*In the first category of case, if the court concludes that an accused cannot receive a fair trial, it will stay the proceedings without more. No question of the balancing of competing interests arises. In the second category of case, the court is concerned to protect the integrity of the criminal justice system. Here a stay will be granted where the court concludes that in all the circumstances a trial will offend the court's sense of justice and propriety (per Lord Lowry in R v Horseferry Road Magistrates' Court, Ex p Bennett [1994] 1 AC 42, 74G) or will undermine public confidence in the criminal justice system and bring it into disrepute (per Lord Steyn in R v Latif [1996] 1 WLR 104, 112F)*"

35. In order to stay under the first limb, the applicant for stay of proceedings "*needs to show on the balance of probabilities that a fair trial could not be held*" [see: *Archbold Hong Kong 2025* Vol. 2 at 19-34B]. Even if there is a long period of delay, "*its cause and effect must be examined*" [see: *Cheung Hin Kwan v Commissioner of Police & Another* [2006] 2 HKC 278 per Woo VP at paragraph 37]. "*The determination of stay applications is case and fact specific*" [see: *Archbold Hong*

Kong 2025 Vol. 2 at 19-43B]. Whilst "*the right is to trial without undue delay[,] it is not a right not to be tried after undue delay*" [see: *HKSAR v Lee Ming Tee*; HCCC 191/1999; 8 June 2004; per Tang J at paragraph 70].

36. Counsel for the Defendant submits that the legal principles concerning stay of criminal and disciplinary proceedings are different. The wider public interest that criminals would not be allowed to walk free without punishment is not apposite to disciplinary proceedings brought under the Medical Registration Ordinance ("MRO").

37. Counsel for the Defendant is however unable to provide us with any local case authority in support of this novel proposition. To the contrary, in *Professional Standards Authority for Health & Social Care v General Pharmaceutical Council & Another*; [2024] EWHC 3005 (Admin), which is one of the cases in the Defendant's List of Authorities, Lang J quoted with approval the legal principles summarized in *Disciplinary & Regulatory Proceedings* (10th ed.) by Foster et. al., where the authors specifically referred to the above quoted passage of Dyson SJC in *R v Maxwell*, and held at paragraph 105 that:-

"*A stay for abuse of process is an exceptional step. It is a final step in disciplinary proceedings, and means that the case against R2 can never be considered on its merits and no action can be taken against him even if the allegation are well-founded. The public interest in the overarching statutory objectives of protecting the public and maintaining professional standards and public confidence in the profession has to be weighed in the balance, together with the public interest in the integrity of the disciplinary process*".

38. In our view, the legal reasoning expounded by Dyson SJC is equally apposite to disciplinary proceedings brought under the MRO.

39. There is no doubt a long period of delay in the present case but its cause and effect must be examined. We agree with the Legal Officer that even where the delay can be said to be unjustifiable, the imposition of a permanent stay should be the exception rather than the rule.

40. By a Notice of Meeting of the PIC dated 21 January 2014, the Secretary notified the Defendant that the particulars of the complaint against him were that:-

"*on or about 22 December 2009, [he], being a registered medical practitioner,*

disregarded [his] professional responsibility to [his] patient [redacted] *("the Patient"), a new born, in that, [he] failed to carry out all necessary and immediate investigation on the Patient after the Patient developed 1st episode of neonatal seizure at 3:31am."*

41. In his medical report, which was submitted to the Preliminary Investigation Committee ("PIC") of the Council under the cover of his solicitors' letter dated 21 May 2014, the Defendant explained that:-

"*5. I was not informed that the Baby's mother had a fever following delivery.*

6. My intention was to examine the Baby again during the morning of 22 December 2009.

...

7. Before my planned review took place, I received a telephone call when I was at home... from a nurse at about 4:30 a.m. on 22 December 2009.

8. The nurse advised me that, at 3:30 am, the Baby had slight choking of milk and there was slight stiffening, and staring of eyes...; oxygen saturation was 80%; she performed suctioning of airway and the Baby returned to normal after 15 seconds.

9. I enquired with nurse whether the Baby presented with any abnormality before the episode at 3:30 am. The nurse advised the following:-

a. The Baby was "okay" and there was no problem;
b. The Baby was unremarkable over the past few days and would be discharged the next day.

10. I further asked the nurse regarding the Baby's condition at 4:30 a.m. The nurse confirmed that the Baby was stable and that saturation and other vital signs were "okay".

11. I considered and said to the nurse that if the Baby suffered convulsion, then full workup would be required; however, given that the Baby had one choking episode only, I instructed the nurse to:-

a. *implement hourly observations for the Baby's vital signs including apical rate, respiration rate and saturation and also for any abnormal body movement together with continuous oxygen saturation monitoring by connecting the Baby to an oximeter;*
b. *omit the 4 a.m. feed, which had not been given; and*
c. *put the Baby in an incubator (if there was any change of colour, shortness of breath, abdominal distention or abnormal movement, it could be easily noticed when the Baby is in the incubator).*

12. *I clearly instructed the nurse to inform me immediately if there was recurrence of abnormal movement or if the Baby suffered a convulsion, as I would then arrange a number of further investigations.*

13. *The nurse did not inform me that the Baby's limbs were rigid, that he was sweating or that he had a high-pitched cry at 2:30 a.m. Neither did the nurse inform me that there was redness on the upper part of the body or any abnormality in the Baby's colour.*

14. *At no stage did I advise the nurse to put the Baby on continuous oxygen nor did the nurse discuss this with me. I did not know that the Baby was already put on continuous oxygen and placed inside an incubator. If the nurse had informed me that the Baby was on continuous oxygen, I would have instructed the nurse to gradually wean off the oxygen supply and further monitored the Baby once the oxygen supply had been withdrawn. The fact that the Baby was on continuous oxygen could have distorted the saturation level.*

15. *I suspected that this was a choking event (related to gastroesophageal reflux) and wanted to monitor the situation to review whether there was any abnormality after 4:30a.m.*"

42. In the said letter to the PIC, the Defendant's solicitors further submitted that:-

"9. *We have reviewed the CD voice recording attached to the PIC Notice concerning a meeting with the baby's family at the hospital following the incident. At 10 minutes of the recording in the computer file named 09.12.30(2), it was recorded that:-*

...

"Nurse Lau: We informed doctor by telephone, and the doctor told us that you could continue observation to ascertain whether or not it was genuine

[convulsion], since [the patient's] condition was unlike the appearance of convulsion, his condition was serious choking, if it was genuinely a convulsion that should have been easily spotted, but it was different from convulsion; when babies suffer convulsion, it could be very serious.' (our English translation).

10. According to the above extract from the discussion, the hospital accepts that the condition of the baby at the relevant time (at 3:31am on 22 December 2009) was not consistent with a neonatal seizure. It was more consistent with a choking/vomiting episode."

43. By a letter dated 24 June 2016, solicitors for the Defendant wrote to the Secretary of the Council seeking clarification on the scope of the disciplinary charge against the Defendant.

44. The then Legal Officer replied by letter on 30 June 2016 and confirmed that:-

"As to your enquiry on the scope of our charge regarding "all necessary and immediate investigations", it is the Secretary's case that after the Defendant received the call from nurse Ho at around 4 am on 22 Dec 2009, the Defendant should have attended the hospital to assess the patient immediately, instead of delaying till around 7:45 a.m. on the same day."

45. Despite the Legal Officer's clarification on the scope of the disciplinary charge, the Secretary continued to engage in protracted correspondence with solicitors for the Defendant over "*missing documentation*", in particular, "*all radiological films... taken of the [P]atient... during the hours of 8:00 to 14:00 on 22 December 2009*"; and "*the identity of the person who wrote the handwritten words on page 2 of the Report of a Neonatal Fit on 22 December 2009*".

46. During her oral submission, Counsel for the Defendant also complained that the words "*of eye*" were deleted from the entry on the Patient's Convulsion Chart at 3:31 a.m. on 22 December 2009; and the words "*blinking of eyes*" were squeezed in between the entries on the Patient's Convulsion Chart at 6:04 a.m. and 6:50 a.m. In our view, these are mere speculations. Be that as it may, the complaint about the deletion of the words "*of eye*" is red herring. We fail to see how it may possibly prejudice the defence case that Nurse HO did not tell the Defendant over the phone that the Patient had "*blinking of eyes*" during the episode at 3:31 a.m.

47. Counsel for the Defendant contends that serious prejudice to the defence case has resulted from the delay. In particular, "*this late disclosure [of Nurse Ho's evidence] deprived [the Defendant] of the opportunity to investigate or challenge her account while memories were still fresh and relevant evidence was still available*"; and the Defendant "*was only able to set out his best recollection of the events when preparing his [medical] report on 21 May 2014... without the benefit of timely access to the Neonatal Nursing Reports and other critical medical records. The delay severely impaired his ability to provide a detailed and contemporaneous account, resulting in serious procedural unfairness.*"

48. It is pertinent in our view to note at the outset that the burden of proof is always on the Secretary and the Defendant does not have to prove his innocence. In our view, the truthfulness or otherwise of any part of a witness' testimony is essentially a question of fact to be decided by looking at the whole evidence. Generally speaking, contemporaneous written documents are of the greatest importance in assessing credibility. Importance should be attached to the inherent likelihood or unlikelihood of an event having happened, or the apparent logic of events. It is essential to have regard to the entirety of a witness' evidence. A witness can make mistakes, but the mistakes do not necessarily affect other parts of his evidence. It is open to us, as a tribunal of fact, to decide in respect of any witness whether we can accept all the evidence of that witness, none of it or only some of it.

49. The Defendant never mentioned in his medical report dated 21 May 2014 that he had any difficulty in recollecting the relevant events. Indeed, the Defendant was able to give a detailed narrative of his telephone conversation with Nurse HO at around 4:30 a.m. on 22 December 2009.

50. Insofar as the "*Report of a Neonatal Fit on 22/12/2009*" is concerned, it was not written by Nurse HO or Nurse HUI, who were on duty at the Nursery. There is nothing in the evidence which indicates that the author(s) of this Report had firsthand knowledge of what happened. Indeed, Nurse HO cautioned in her witness statement dated 22 January 2010 that this Report was not her narrative and she had never seen it before submission to the Department of Health. It follows in our view that "*the identity of the person who wrote the handwritten words on page 2 of the Report*" had nothing to do with the credibility of Nurse HO.

51. Counsel for the Defendant also complained about prejudice to the Defendant's health, practice and reputation. We appreciate that the present disciplinary

proceedings have been hanging over the head of the Defendant for a long time. However, when being informed by email of 24 February 2025 that the Secretary was "*going to schedule the hearing for 15 and 16 September 2025*", the Defendant asked through his solicitors by email dated 28 February 2025 "*whether it is possible to schedule the inquiry in October or beyond, as he is studying a master's degree course... [and] [h]e is concerned that the date of his viva examination [in September] may clash with the dates [the Secretary] provided.*"

52. In our view, the Defendant fails to show on the balance of probabilities that he has been so prejudiced by the delay that he can no longer receive a fair trial.

53. It is however not the end of the matter. We still need to consider the second limb and that is whether continuance of the present disciplinary proceedings will "*offend the [disciplinary tribunal's] sense of justice and propriety*"; and whether "*public confidence in the proper administration of justice, is or would be offended*" *if [the disciplinary tribunal] is asked to try the [Defendant] in the particular circumstances of the case*" [see: *Archbold Hong Kong 2025* Vol. 1 at paragraph 4-50].

54. We agree with the Legal Officer that late disclosure of the witness statement of Nurse HO would be remedied by adjournment of the disciplinary inquiry originally scheduled to be held on 13 July 2016. However, the real point is that another 8.5 years had elapsed before the Secretary sought to restore the hearing of the disciplinary inquiry. Presumably, the Secretary was labouring under the misguided belief about the relevancy of the "*missing documentation*" and "*the identity of the person who wrote the handwritten words on page 2 of the Report of a Neonatal Fit on 22 December 2009*". Be that as it may, the burden is on the Secretary "*to explain and justify any lapse of time which appears to be excessive*" [see: *HKSAR v Lee Ming Tee* per Tang J at paragraph 18]. However, the Secretary is unable to provide us with any reasonable explanation and let alone justification for the further delay after July 2016.

55. As Tang J vividly described in *HKSAR v Lee Ming Tee* at paragraph 82, "*[i]n a suitable case the court will say enough is enough and grant a permanent stay*". Given the peculiar circumstances of this exceptional case, we accept that the further delay after July 2016, when taken together with the events that had happened before July 2016, is such that the disciplinary proceedings against the Defendant had by itself become oppressive and abusive and must be halted.

56. For these reasons, the Defendant's application for a permanent stay of the disciplinary proceedings against him is allowed; and we shall make an order prohibiting the Secretary from proceeding with the disciplinary inquiry against the Defendant in this case.

Prof. TANG Wai-king, Grace, SBS, JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong

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DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr SIT Sou Chi (薛守智醫生) (Reg. No.: M10748)

Date of hearing: 22 November 2025 (Saturday)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP (Chairperson of the Inquiry Panel)
Dr KWOK Wang-chun
Dr CHENG Wai-tsoi, Frankie
Ms LIU Lai-yun, Amanda
Mr Calvin K CHENG

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Mr Jin PAO SC as instructed by Messrs. Howse Williams

Legal Officer representing the Secretary: Mr Mike LUI SC as instructed by Department of Justice

Decision on Review of Order for Stay

1. After we made an order on 28 October 2025 for stay of the disciplinary proceedings against the Defendant in this case (the "Order"), there were voices in the community that our consideration for stay might have been incomprehensive. With the assistance of our legal adviser, it came to our notice that it was held by Goldring J in *Council for the Regulation of Health Care Professionals v General Medical Council and Saluja* [2007] 1 WLR 3094 at 3110E-3111B that:-

> "*79 First, to impose a stay is exceptional.*
>
> *80 Second, the principle behind it is the court's repugnance in permitting its process to be used in the face of the executive's misuse of state power by its agents. To involve the court in convicting a defendant who has been the victim of such misuse of state power would compromise the integrity of the judicial system.*
>
> *81 Third, as both domestic and European authority make plain, the position as far as misconduct of non-state agents is concerned, is wholly different...*

...

83 Fourth, in the present disciplinary hearing there is no state involvement in the proceedings being brought. These are proceedings brought against a doctor by his regulator in order to protect the public, uphold professional standards and maintain confidence in the profession. These are to a significant degree different considerations from those that apply to criminal prosecution and misuse of executive powers by the state's agents.

84 Fifth, it would be an error of law in considering any application for abuse of process for the tribunal not to have well in mind the differences to which I have referred..."

2. Pursuant to section 21(4B) of the Medical Registration Ordinance ("MRO"), we decided on our own initiative to review the Order. Through the Chairperson, we then directed the Secretariat to notify the Secretary and the Defendant in writing of our decision and invited them to make representations and to appear before us today for holding a review.

3. In *Hong Kong Medical Association v Medical Council of Hong Kong* [2014] 3 HKLRD 664, Zervos J (as he then was) had this to say of the power and purpose of a review under section 21(4B) of the MRO:-

"*34. I will discuss in greater detail the review provision but it is worth noting at this stage that there is a separate right of appeal by a registered medical practitioner who is aggrieved by a disciplinary order...*

...

42. Professor Chan argues that the purpose of the review under s.21(4B) is to provide a prompt and simple means to remedy or revisit any of the decisions or orders of the Council in its inquiry without recourse to the full appellate process of the Court of Appeal under s.26, which could be both costly and time consuming. He further argues that it was intended to correct patent mistakes rather than to have a protracted rehearing and deal with complicated factual or legal issues which should be reserved for an appeal. With this I agree. But the review power is only available to the Council and the right of appeal is only available to an aggrieved registered medical practitioner. This indicates that the review power is limited both in terms of who can exercise it and the nature of the matters to be considered..."

4. Although sections 21(4B) and 26 of the MRO were amended in 2018 by replacing "the Council" with "an inquiry panel", the legal principles enunciated by Zervos J are equally apposite and binding on us.

5. Neither the Secretary nor the Defendant questioned the correctness of the legal principles summarized by Goldring J in paragraphs 79 to 84 of the Judgment in the *Saluja* case.

6. In considering the Defendant's application for stay of disciplinary proceedings against him, it would therefore be "*an error of law*" for us not to bear in mind the significant difference in consideration for disciplinary proceedings when exercising our discretion for granting a stay under the second limb of the test in *R v Maxwell* [2010] UKSC 48.

7. We agree with the Legal Officer the purpose of this review hearing is not to allow the Defendant to "*reopen or relitigate*" the granting of a stay under the first limb of the test in *R v Maxwell*.

8. As Lord Dyson JSC aptly pointed out in *Warren v Attorney General of Jersey* [2011] UKPC 10:-

> "*35. ...The second category case where the court has the power to stay proceedings as an abuse of process is... one where the court's sense of justice and propriety is offended if it is asked to try the accused in the particular circumstances of the case. It is unhelpful and confusing to say that this category is founded on the imperative of avoiding unfairness to the accused. It is unhelpful because it focuses attention on what is fair to the accused, rather than on whether the court's sense of justice and propriety is offended or public confidence in the criminal justice system would be undermined by the trial. It is confusing because fairness to the accused should be the focus of the first category of case. The two categories are distinct and should be considered separately.*

9. The Legal Officer sought to adduce a "*witness statement*" of the Secretary to explain the delay in the disciplinary proceedings against the Defendant. We appreciate that unlike the Court of Appeal, we may take a more flexible approach for receiving new evidence on review [see: *Phipson on Evidence* (20th ed) paras 13-01 & 13-02]. We agree with Counsel for the Defendant that the Secretary does not provide any satisfactory explanation why the new evidence has not been adduced in the first place.

10. In any event, the new evidence is in our view unlikely to have "*an important influence on the result*" [see: *Phipson on Evidence* (20th ed) paras 13-07 to 13-09]. Indeed, the Secretary conceded in her "*witness statement*" that:-

> "*21. In this regard, I also confirm that my colleagues at the Secretariat have enquired with the then Deputy Secretary (Medical Council) who handled this case at the material time (who... has already been posted out from the Secretariat in September 2023) and I have been informed that she has confirmed that she no longer has any recollection about the matters relating to this case years ago independently from what the records show.*"

11. The upshot is that the Secretary would still be unable to show from the records any satisfactory explanation or justification for the delay after the original inquiry was adjourned in August 2016.

12. For these reasons, we refuse to admit the Secretary's "*witness statement*" as new evidence in the review hearing.

13. We agree with the Legal Officer that "*in cases where a fair trial remains possible...[t]he discretion to stay... ought not be exercised in order to express [our] disapproval of official [mis]conduct*" [see: *HKSAR v Lee Ming Tee & Another* (2001) 4 HKCFAR 133 at 151D-G].

14. We disagree with the Counsel for the Defendant that the distinction between misconduct of state agents and non-state agents in the *Saluja* case was confined to the context of entrapment.

15. It is clear to us from the case authorities cited by the Legal Officer and Counsel for the Defendant that to stay disciplinary proceedings against a registered medical practitioner on the ground of abuse of process is a rare step only to be taken in exceptional cases. There is undoubtedly an important countervailing public interest that allegations of a serious nature against a registered medical practitioner should be heard and determined rather than stayed.

16. Counsel for the Defendant argues that the Defendant has suffered significant prejudice as a result of the inordinate delay. It is however pertinent to note that by referring the Defendant to inquiry, the Preliminary Investigation Committee was satisfied on the evidence before it that there would be a reasonable prospect of his being found guilty of misconduct in a professional respect in this case. Indeed, the Defendant never challenges the decision to refer him to inquiry.

17. We gratefully agree with the majority Judgment of the High Court of Australia in *Walton v Gardiner* (1993) 177 CLR 378 at 395-6 that:-

> "*In its application to the Tribunal, the concept of abuse of process requires some adjustment to reflect the fact that the jurisdiction of the Tribunal, which is not a court in the strict sense, is essentially protective – i.e. protective of the public – in character...*
>
> *...The question whether disciplinary proceedings in the Tribunal should be stayed by the Supreme Court on abuse of process grounds should be determined by reference to a weighing process similar to the kind appropriate in the case of criminal proceedings but adapted to take account of the differences between the two kinds of proceedings. In particular, in deciding whether a permanent stay of disciplinary proceedings in the Tribunal should be ordered, consideration will necessarily be given to the protective character of such proceedings and to the importance of protecting the public from incompetence and professional misconduct on the part of medical practitioners...*"

18. We wish to add that in considering the important countervailing public interest that allegations of a serious nature against a registered medical practitioner should be heard and determined rather than stayed, we should also take into consideration the maintenance of public confidence in the medical profession by upholding its high standards and good reputation.

19. As Choudhury J explained in *R(on the application of Clinton) v General Medical Council* [2017] EWHC 3304 (Admin) at paragraph 32:-

> "*...if all that was required to grant a stay was a finding of serious failing in procedure then the balancing exercise to which all the authorities refer would be otiose. The tribunal could simply find that there were defects in procedure and proceed to a stay. But that is not all that is required. The tribunal must go to consider whether, in the light of those defects, the public interest in ensuring that standards are upheld... is outweighed by the public interest in the integrity and fairness of the process...*"

20. Applying these legal principles to the particular circumstances of this case and bearing in mind that a fair trial remains possible, we are convinced upon review that the countervailing public interest in protection of the public and to maintain public confidence in the medical profession is not outweighed by the public interest in the integrity and fairness of the process.

21. We therefore decide to revoke our previous order for stay of the disciplinary proceedings against the Defendant.

Prof. TANG Wai-king, Grace, SBS, JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong

香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr SIT Sou Chi (薛守智醫生) (Reg. No.: M10748)

Dates of hearing: 24 April 2026 (Friday) (Day 4)
26 April 2026 (Sunday) (Day 5)
7 June 2026 (Sunday) (Day 6)
5 July 2026 (Sunday) (Day 7)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP
(Chairperson of the Inquiry Panel)
Dr KWOK Wang-chun
Dr CHENG Wai-tsoi, Frankie
Ms LIU Lai-yun, Amanda
Mr Calvin K CHENG

Legal Adviser: Mr Stanley NG

Defence Counsel representing the Defendant: Mr Anthony ISMAIL as instructed by Messrs. Howse Williams

Legal Officer representing the Secretary: Mr Mike LUI, SC, Outside Counsel, as instructed by Department of Justice

The Charge

1. The charge against the Defendant, Dr SIT Sou Chi, is:

> *"That on or about 22 December 2009, he, being a registered medical practitioner, disregarded his professional responsibility to his patient*

[redacted] *("the Patient"), a new born, in that, he failed to carry out all necessary and immediate investigations on the Patient after the Patient developed 1st episode of neonatal seizure at 3:31 a.m.*

In relation to the facts alleged, he has been guilty of misconduct in a professional respect."

Facts of the case

2. The name of the Defendant has been included in the General Register from 22 July 1996 to the present. His name has been included in the Specialist Register under the Specialty of Paediatrics since 4 August 2004.

3. The Patient was born at Baptist Hospital ("BH") on 19 December 2009 at 09:19 hours by vaginal delivery with a birth weight of 3.1 kg at gestation 37 week and 4 days.

4. The Patient was first seen by the Defendant for neonatal assessment after delivery. Newborn examination was unremarkable and the Patient was described as normal by the Defendant.

5. The Patient was admitted to the Nursery of BH after birth. He was afebrile with normal breathing and apical rate. Physical examination results were normal except some *"red lines"* noted over the scalp. His body temperature, respiration and heart rates were monitored regularly.

6. On 20 December 2009 at 10:30 hours, the Patient was seen by the Defendant at the Nursery. In the History, Physical and Progress Record of the Patient, he was described as well and not jaundiced. Physical examination revealed no abnormality.

7. On 21 December 2009 at 08:00 hours, the Patient was seen by the Defendant again. In the History, Physical and Progress Record of the Patient, he was described as well with query jaundice. Transcutaneous bilirubinometer reading was 9.4 mg/dL and no treatment was offered.

8. Redness was noted over the Patient's chin and this finding was documented in the Nursing Kardex at 11:45 and 19:00 hours on 21 December 2009.

9. On 22 December 2009 at 03:00 hours, the night duty nurse at the Nursery, Nurse HO Kit Ha ("Nurse HO"), a registered nurse, documented in the Nursing Kardex for the Patient that he was *"irritable & high pitch crying"* at around 02:30 hours. Nurse HO also found the Patient to be *"four limbs rigid, sweating & choking*

persisted". The Patient was *"put ...into incubator [with] oximeter to keep observation"*. Oxygen saturation (SaO_2) was 94% in air; H'stix was 5.4 mmol/L. Nurse HO also noted ectopic heartbeat.

10. The Patient's oxygen saturation dropped to 80% at 03:30 hours. According to Nurse HO, the Patient developed *"contraction of four limbs [with] abnormal movement of eyeball & sweating persisted"* for 15 seconds. The Patient had *"coldness of body & 4 limbs but redness on upper part of body pale looking on lower limbs [and] [t]hen resume[d] normal colour spontaneously in a short period"*. *"Suction [was] done once due to choking persisted"* and oxygen supplementation of 2L/minute was given to the Patient via incubator.

11. The clinical event which happened at 03:31 hours was recorded as the first event in the Convulsion Chart of the Patient by Nurse HO. Nurse HO recorded *"contraction of 4 limbs"* for 15 seconds, and *"↓SaO_2 80%"*.

12. Nurse HO reported to the Defendant by phone at 04:20 hours on what happened to the Patient. The telephone conversation lasted for around 10 minutes till 04:30 hours. There is conflicting evidence on precisely what Nurse HO had told the Defendant and how he responded.

13. Subsequent hourly monitoring revealed the Patient's condition was stable with apical rate of 124-130/min; respiratory rate of 40-50/min, and SaO_2 of 96%.

14. At 05:00 hours, Nurse HO documented in the Nursing Kardex the clinical event happened at 03:30 hours.

15. At 06:04 hours, Nurse LAI Yee Fong ("Nurse LAI") found the Patient had "contraction of 4 limbs" for 15 seconds. His SaO_2 dropped to 67% but immediately returned to normal. She conducted sputum suction for him, and reddish fluid was noted in oral region. She recorded the incident in the Convulsion Chart, and reported them to Nurse HO. Nurse HO then checked the Patient, whose SaO_2 remained above 95%.

16. At 06:40 hours, Nurse HO documented the clinical event that happened at 06:04 hours in the Nursing Kardex.

17. At 06:50 hours, Nurse LAI informed Nurse HO that the Patient had *"blinking of eyes*", *"contraction of 4 limbs"* for around 15 seconds and oxygen desaturation with SaO_2 down to 87%. Nurse LAI recorded the incident in the Convulsion Chart.

18. Nurse HUI Suk Kuen ("Nurse HUI") was the morning duty nurse of the Nursery of BH. Nurse HUI arrived at the Nursery before 07:00 hours to change shift

with Nurse HO. Nurse HUI was told by Nurse HO about the clinical event that happened at 06:50 hours. Nurse HUI was also told by Nurse HO that there was another similar incident that happened in the early morning, which Nurse HO had already informed the Defendant. Nurse HUI documented the clinical event that happened at 06:50 hours in the Nursing Kardex.

19. At 07:30 hours, Nurse HUI called the Defendant and informed him about the two clinical events that happened at 06:04 and 06:50 hours.

20. At 08:00 hours, the Patient was seen by the Defendant at the Nursery. In the History, Physical & Progress Record, the Patient was described as having increased heart rate and desaturation. There was no rash. His chest, abdomen and heart rate were normal. However, two more episodes of limb contraction and eye blinking were noted at 08:00 (when the Defendant saw the baby) and 08:40 hours.

21. The Defendant suspected the Patient was suffering from neonatal seizure. The Patient was kept nil by mouth and put on intravenous dextrose infusion. Blood tests including complete blood picture, C-reactive protein, blood culture, blood gases, glucose, sodium, potassium, calcium, ammonia and clotting profile were checked. Lumbar puncture was not performed because of the unstable condition of the Patient. Phenytoin 45mg intravenous infusion over 1 hour was given at 09:34 hours to control the seizure. Ampicillin 200mg (65 mg/kg) and Cefotaxime 200mg (65 mg/kg) were given intravenously at 10:00 hours.

22. Initially, arrangement was made for the Patient to be transferred to the Queen Elizabeth Hospital ("QEH") for further management. However, the Patient developed 2 episodes of *"blinking of eyes"* and *"contraction of 4 limbs"* with desaturation at 11:40 and 11:52 hours and required higher oxygen supplementation to maintain a SaO_2 of 95%.

23. The Patient had a further episode of convulsion at 13:00 hours and developed *"respiratory cardiac arrest"* with bradycardia down to 49/min with SaO_2 of 39%. The Patient was resuscitated with chest compression and manual Ambu-bagging by the nurse.

24. The Patient developed another episode of bradycardia (78/min) and oxygen desaturation with SaO_2 of 46% at 13:25 hours. Intravenous injection of Adrenaline was given at 13:26 hours after chest compression and manual Ambu-bagging were commenced.

25. The Patient was later escorted by the Defendant and left BH for QEH at 13:45 hours.

26. Meanwhile, the results of laboratory tests done at BH revealed that both the Patient and his mother were suffering from Streptococcal agalactiae (Group B streptococcus).

27. After his admission to QEH, lumbar puncture was performed later in the afternoon of 22 December 2009 and the cerebrospinal fluid was found to contain Streptococcal agalactiae. A diagnosis of Group B Streptococcal meningitis, septicemia and pneumonia was made. The Patient remained afebrile after admission to QEH except for one kick fever on 27 December 2009. The Patient was treated by intravenous penicillin and phenobarbitone.

28. The Patient was discharged from QEH on 29 January 2010. After discharge from QEH, the Patient was followed up at the Neonatal Clinic of QEH. The Patient was also referred to the Child Assessment Centre for formal developmental assessment. On 16 August 2010, the Patient was assessed by the Fanling Child Assessment Centre at the age of 8 months. There he was diagnosed to have cerebral palsy with global delayed development and could only achieve developmental milestones for less than 3 months old.

29. The Patient's father subsequently lodged this complaint against the Defendant with the Secretary of the Medical Council (the "Council").

Burden and Standard of Proof

30. We bear in mind that the burden of proof is always on the Secretary and the Defendant does not have to prove his innocence. We also bear in mind that the standard of proof for disciplinary proceedings is the preponderance of probability. However, the more serious the act or omission alleged, the more inherently improbable must it be regarded. Therefore, the more inherently improbable it is regarded, the more compelling the evidence is required to prove it on the balance of probabilities.

31. There is no doubt that the allegation against the Defendant here is a serious one. Indeed, it is always a serious matter to accuse a registered medical practitioner of misconduct in a professional respect. Therefore, we need to look at all the evidence and to consider and determine the disciplinary charge against him carefully.

Findings of the Inquiry Panel

32. The crux of the matter lies in what was reported by Nurse HO to the Defendant

during the telephone conversation at 04:20 hours on 22 December 2009, and how the Defendant responded.

33. Nurse HO gave evidence. She relied on a statement made by her dated 22 January 2010 ("Statement"), which was one month after the incident. In her Statement, Nurse HO set out, according to her memory, the telephone conversation she had with the Defendant at 04:20 hours on 22 December 2009, as follows:

"22-12-09 約4:20AM始，本人與薛醫生之對話如下：

我： *薛醫生，浸會 Nursery，已經報了早出院的 B203-6 床 -- 彭紅英之子好扭計，2 點半嗰時發現佢在床仔大喊，成頭出晒汗，有啲Choking。我打開佢張被睇到佢手手腳腳有啲伸直，但好快無嘢，聽埋Heart Rate 好似有啲Ectopic，先係快快快，然後有幾吓慢咗， 跟住又快番，我放咗佢入箱，駁咗 SaO_2-94%，再做埋 H'stix -5.4。*
（其間薛醫生有用"係"… "係"作回應）

薛醫生： *（停頓一陣）嗰Heart Rate 跳番快即係無嘢喇！*

我： *到了3點半見到佢 SaO2 跌到80%，手腳 Contract 屈起好快鬆番，但無抽抽吓，維持咗大約15秒，我俾咗 O2 2L.through incubator, SaO2 resume 番96%，佢一樣有出汗，顏色上半身紅啲，下半身白啲，但好快變番正常。腳仔有啲凍，所以我幫佢Take咗 Temp 同 BP, Temp - 37°C，而BP係76/57，個Mean係62，佢好似想作抽筋喎！*
（其間薛醫生仍然有用"係" …"係"作回應）

薛醫生： *咁而家用緊 O2，SaO2 上返96%，抖氣快唔快？*

我： *唔快。*

薛醫生： *咁而家BB 有無嘢？*

我： *暫時OK。*

薛醫生： *（停頓一陣）*

我：　　不如4點呢餐奶唔好餵佢？

薛醫生：　好，咁繼續攞住佢係箱睇住先，我聽朝早啲到啦！

【完成整段對話時間約為零晨4時30分】”

34. The Defendant's version of the telephone conversation at around 04:30 hours on 22 December 2009 with Nurse HO as set out in his medical report dated 21 May 2014, which was four and a half years after the incident, was as follows:

“7. Before my planned review took place, I received a telephone call when I was at home in Kowloon (Parc Palais, King's Park, 18 Wylie Road, Kowloon) from a nurse at about 4:30 a.m. on 22 December 2009.

8. The nurse advised me that, at 3:30 a.m., the Baby had slight choking of milk and there was slight stiffening, and staring of eyes (“有啲「濁」奶、個人有啲緊、眼定定); oxygen saturation was 80%; she performed suctioning of airway and the Baby returned to normal after 15 seconds.

9. I enquired with the nurse whether the Baby presented with any abnormality before the episode at 3:30 a.m. The nurse advised the following:-

a. The Baby was “okay” and there was no problem.

b. The Baby was unremarkable over the past few days and would be discharged the next day.

10. I further asked the nurse regarding the Baby's condition at 4:30 a.m. The nurse confirmed that the Baby was stable and that saturation and other vital signs were “okay”.

11. I considered and said to the nurse that if the Baby suffered convulsion, then full workup would be required; however, given that the Baby had one choking episode only, I instructed the nurse to:-

a. implement hourly observations for the Baby's vital signs including apical rate, respiration rate and saturation and also for any abnormal body movement together with continuous oxygen saturation monitoring by connecting the Baby to an oximeter;

b. omit the 4 a.m. feed, which had not been given; and

c. *put the Baby in an incubator (if there was any change of colour, shortness of breath, abdominal distention or abnormal movement, it could be easily noticed when the Baby is in the incubator).*

12. *I clearly instructed the nurse to inform me immediately if there was recurrence of abnormal movement or if the Baby suffered a convulsion, as I would then arrange a number of further investigations.*

13. *The nurse did <u>not</u> inform me that the Baby's limbs were rigid, that he was sweating or that he had a high-pitched cry at 2:30 a.m. Neither did the nurse inform me that there was redness on the upper part of the body or any abnormality in the Baby's colour.*

14. *At no stage did I advise the nurse to put the Baby on continuous oxygen nor did the nurse discuss this with me. I did not know that the Baby was already put on continuous oxygen and placed inside an incubator. If the nurse had informed me that the Baby was on continuous oxygen, I would have instructed the nurse to gradually wean off the oxygen supply and further monitored the Baby once the oxygen supply had been withdrawn. The fact that the Baby was on continuous oxygen could have distorted the saturation level.*

15. *I suspected that this was a choking event (related to gastroesophageal reflux) and wanted to monitor the situation to review whether there was any abnormality after 4:30 a.m."*

35. In this case, we have to decide on whether Nurse HO or the Defendant is the more believable one. In our view, the truthfulness or otherwise of any part of a witness' testimony is essentially a question of fact to be decided by looking at the whole evidence. It is open to us, as a tribunal of fact, to decide in respect of any witness whether we can accept all the evidence of that witness, none of it or only some of it.

36. We gratefully adopt as our guiding principles the following approach for assessing witness credibility as set out by Deputy High Court Judge H. Au-yeung (as he then was) in *High Fashion New Media Corporation Ltd. v Leong Ma Li* [2022] HKCFI 2234 at para. 14:-

"(1) Generally speaking, contemporaneous written documents and documents which came into existence before the problems in question emerged are

of the greatest importance in assessing credibility;

(2) Importance should be attached to the inherent likelihood or unlikelihood of an event having happened, or the apparent logic of events;

(3) The court will also attach importance to the consistency of the witness' evidence with undisputed or indisputable evidence, and the internal consistency of the witness' evidence. The latter type of consistency is often tested by a comparison between the witness' oral testimony and his or her witness statement;

(4) The court should consider a witness' motive for deliberately not giving truthful testimony. For example, telling the truth may prejudice his interest, or a just determination of the litigation may affect his interest;

(5) It is essential to have regard to the entirety of a witness' evidence. A witness can make mistakes, but the mistakes do not necessarily affect other parts of his evidence. Likewise, a witness may lie. However, lies themselves do not mean necessarily that the entirety of that witness' evidence is to be rejected. A witness may lie in a stupid attempt to bolster his case, but the actual case nevertheless remains good irrespective of the lie;

(6) On the other hand, where it is shown that a witness has been discredited over one or more matters to which he has testified, this fact is relevant to the assessment of his overall credibility;

(7) While the court is entitled to take demeanour into account when assessing testimony, it should be borne in mind that demeanour can be deceptive and is therefore to be approached with care."

37. Nurse HO told us that the purpose of her Statement was to record the events in a greater detail to supplement the information not recorded in the Nursing Kardex as she knew there might be developments or other needs. Her Statement was dated 22 January 2010 with preparation starting some time before that date. Her Statement was prepared a month or less than a month after the incident, when her memory was relatively fresh in her mind. As her memory was fresh at the time she prepared the Statement, we do not see there is anything to be criticized with the way she presented in her Statement of the telephone

conversation she had with the Defendant at 04:20 hours on 22 December 2009.

38. Nurse HO told us that her Statement was prepared without seeking and having professional advice. Her evidence was unshaken on cross-examination. Nurse HUI had also prepared a statement dated 22 January 2010. Nurse HUI's statement was also in the form of a table like Nurse HO's – it was compiled and typed out for her by Nurse LAI, who was good at computers. Nurse HUI told us that when drafting her statement she had never communicated with Nurse HO. Nurse HUI's evidence was not shaken on cross-examination. We believe in what both Nurse HO and Nurse HUI told us that they had prepared their statements independently. There is no evidence to suggest that they had collaborated or crafted their evidence against the Defendant or that they had been asked by their superiors to craft their evidence against the Defendant. We do not see there is any valid basis to suggest that Nurse HO and/or Nurse HUI had lied in making their statements.

39. At the Inquiry, the Secretary relied on three pieces of material contemporaneous records, namely the Nursing Kardex, the Convulsion Chart and the Nursery Observation Chart. The Defendant did not dispute the authenticity of these records. The Defendant did not positively claim that the information in these records was inaccurate. The Defendant himself only said that he was unsure whether the Nursing Kardex was accurate.

40. Nurse HO was however questioned by the Defence Counsel as to why it took her quite some time afterwards to post-record in the Nursing Kardex some clinical events of the Patient. Nurse HO explained that she had to closely attend to many newborns with various needs at the same time, and as inputting details in Nursing Kardex was more time-consuming than writing an entry in the Convulsion Chart, her priority was to take care of the newborns, after which she would input in the Nursing Kardex. We accept what Nurse HO told us. In fact, it is quite common that nurses at hospital nurseries will not write or input details into Nursing Kardex in real time. It is also quite common that different nurses have different approaches of writing or inputting into Nursing Kardex.

41. Nurse HO was also questioned by the Defence Counsel why there were 3 versions of record of the Patient's eyes for the clinical event at 03:30 hours, namely (i) the Nursing Kardex entry of *"abnormal movement of eyeball"*; (ii) crossing-out *"of eye"* in the first entry of the Convulsion Chart; and (iii) Nurse Ho's Statement (p.2) describing *"opened both eyes"*. We have

looked at Nurse HO's Statement (p.2), which remarked in the *"Record"* column for the *"Around 3:30 AM"* entry, that *"These conditions were recorded in the Kardex 5 AM section"*. In our view, the words *"opened both eyes"* in the Statement are only descriptions and should fairly be understood in conjunction with the Nursing Kardex entry. There is also no inconsistency between the Nursing Kardex entry and the first entry in the Convulsion Chart. Nurse HO told us that she could not recall why she had deleted *"of eye"* in the Convulsion Chart. We accept that Nurse HO told us the truth. It was never suggested to her that she had been untruthful in saying that she had no recollection about this.

42. In our view, none of the Defendant's challenges could undermine the accuracy of the information contained in the Nursing Kardex, the Convulsion Chart and Nursery Observation Chart. We will rely on these documents.

43. According to the Nursing Kardex entry inputted by Nurse HO at 03:00 hours, at around 02:30 hours, Nurse HO found the Patient to be *"four limbs rigid, sweating & choking persisted"*. The Patient was *"put …into incubator [with] oximeter to keep observation"*. Oxygen saturation (SaO_2) was 94% in air; H'stix was 5.4 mmol/L. Nurse Ho also noted ectopic heartbeat.

44. According to the Nursing Kardex entry inputted by Nurse HO at 05:00 hours, the Patient's oxygen saturation dropped to 80% at 03:30 hours. The Patient developed *"contraction of four limbs [with] abnormal movement of eyeball & sweating persisted"* for 15 seconds. The Patient had *"coldness of body & 4 limbs but redness on upper part of body, pale looking on lower limbs [and] [t]hen resume[d] normal colour spontaneously in a short period"*. *"Suction [was] done once due to choking persisted"* and oxygen supplementation of 2L/minute was given to the Patient via incubator.

45. According to the first entry of the Convulsion Chart inputted by Nurse HO at 03:31 hours, the Patient had *"contraction of 4 limbs"* for 15 seconds, and SaO_2 dropped to 80%.

46. The Defendant did not order the opening of the Convulsion Chart. The fact that Nurse HO opened the Convulsion Chart on her own initiative at 03:31 hours without the Defendant's order and inputted *"contraction of 4 limbs"* for 15 seconds suggested that she must be suspecting convulsion and was concerned with the Patient's condition.

47. In our view, it was not normal, and in fact unusual, for nurses to call and report to doctors past midnight if it was only a choking incident. Choking incidents

were not uncommon in babies and nurses could easily handle choking incidents themselves without calling the doctors. In our view, if Nurse HO was not concerned about the suspected convulsion, there was no reason why she would have to call the Defendant in the early morning at 04:20 hours. It was unreasonable that Nurse Ho had to call the Defendant only because of choking. There must be something of concern to Nurse HO. It is unreasonable and illogical to suggest that Nurse HO informed the Defendant of slight choking of milk, slight stiffening, and staring of eyes ("有啲「濁」奶、個人有啲緊、眼定定); oxygen saturation was 80%; and suctioning of airway was done and the baby returned to normal after 15 seconds, as this would be contrary to what she inputted in the Nursing Kardex and the Convulsion Chart for the clinical event at 03:30 hours. We believe that Nurse HO had reported to the Defendant what she said in her Statement about the 03:30 clinical event. We also believe that Nurse HO had told the Defendant that she suspected convulsion ("佢好似想作抽筋喎！").

48. The Defendant said that Nurse HO did not inform him that the Patient's limbs were rigid and that he was sweating or that he had a high-pitched cry at 02:30 hours. The Defendant said that Nurse HO did not inform him that there was redness on the upper part of the body or any abnormality in colour. The Defendant also said that he had enquired with Nurse HO whether the Patient presented with any abnormality before the episode at 03:30 hours, and Nurse HO told him that the baby was "okay" and "there was no problem, and the baby was unremarkable over the past few days and would be discharged the next day". The Defendant's alleged question to Nurse HO was whether there was any abnormality before the episode at 03:30 hours. The alleged question was not directed to what happened over the past few days and when the Patient would be discharged. We find it illogical and unreasonable why Nurse HO had to withhold from the Defendant about what happened before the episode at 03:30 hours, and had to say something totally irrelevant. We do not find the Defendant credible. Further, Nurse HO wrote down in the Nursing Kardex the episode at 02:30 hours at 03:00 hours, before she called the Defendant at 04:20 hours. There is no reason why she had to withhold this information from the Defendant. We find it more likely the case that Nurse HO had informed the Defendant of what she wrote in her Statement about the episode at 02:30 hours.

49. The Defendant also told us that Nurse HO never told him that the Patient was already placed in the incubator. The Nursing Kardex entry for the episode at 03:30 hours clearly reads "O_2 given ~2L via incubator". The entry of the Nursery Observation Chart showing oxygen of 2L was given at 03:45 hours. Although there was no entry for incubator temperature, Nurse HO explained that she had omitted to record the temperature. The contemporaneous evidence shows that the Patient was placed in the incubator and oxygen of 2L was given at 03:45 hours. There is no reason why Nurse HO had to withhold this

information from the Defendant. We do not accept the Defendant's contention that Nurse HO had not told the Defendant that the Patient was placed in incubator and oxygen of 2L was given. Even if it was the case that Nurse HO had not so informed the Defendant, but which we had already found otherwise, the Defendant should have in our view made enquiry with Nurse HO and he could have found out easily. The Defendant knew that the Patient's SaO_2 was 80%, which was abnormally low. He could have asked the simple question if the Patient was on continuous oxygen. In fact, it is a common practice in neonatal unit for nurses to administer oxygen immediately if a baby desaturates. The Defendant's assertion that Nurse HO had not told him, but without himself finding out the same, is in our view unbelievable.

50. Nurse HO was questioned by the Defence Counsel why she called the Defendant at 04:20 hours, almost an hour after the 03:30 episode. Nurse HO explained that she had to closely attend to the Patient on various things and she called the Defendant after she was settled. Further, Nurse HO was questioned why she did not call the Defendant after the 06:04 episode and/or the 06:50 episodes, but had to wait till 07:30 hours for Nurse HUI to make the call. Nurse HO explained that during the telephone call she had with the Defendant at 04:20 to 04:30 hours, the Defendant told her that he would come back to the Nursery early that morning. Nurse HO said she was expecting the Defendant to be back any time soon, and she was attending to the Patient and other newborns, so she did not call the Defendant. We find Nurse HO's explanations reasonable.

51. The Secretary also relied on an audio recording (Recording No. 6) of a meeting held in the afternoon on 30 December 2009 between the Defendant and members/friends of the Patient's family. The Defendant accepted in cross-examination that he as a responsible doctor *"would tell the parents the truth"* and *"would tell them the truth and nothing but the whole truth and without even half-truth"*. The Defendant also accepted in cross-examination that his *"recollection on the 30th December 2009 when [he] saw the parents ... would be more accurate and complete than [his] recollection in February 2010."*

52. At the inquiry, part of Recording No. 6 was played, as follows:

> *"我都係嗰句 ….OK 嗱我都係講返俾你聽，嗱，我（聽不清）**4點半話俾我聽懷疑抽筋**，（深圳張醫生：嗯）我，唔知係唔係，（B：抽筋還要懷疑嗎？〕嗱，佢咪就係話硬，**（B：你的護士、你的姑娘，不知道是抽筋嗎？）佢就懷疑**，同埋呢，佢就話，而家無野啦嘛，咁佢（聽不清）頭先話仗僧，跟住啦就懷疑好似硬過，咁佢話俾我聽，話俾我聽我就話，咦，咁而家有無硬？無硬，停咗，而家無野，**放咗係箱觀***

<u>察住</u>，咁我嘅 instruction，我嘅指引呢就係話你放係箱嗰度…深圳張醫生：你觀察了… 薛守智醫生：不如你….不如俾我講埋好無呀？深圳張醫生：嗯嗯嗯…薛守智醫生：下，咁呢，我地就觀察咗，咁佢如果再話俾我聽嘅時候就肯定喇（深圳張醫生：嗯。）7點鐘話俾我聽肯定，咁我咪即刻過黎囉，咁你都係咁，你，即係你唔會嗰次懷疑黎幫佢做脊椎穿刺，做電腦掃瞄抽晒所有血，係真係會觀察個播，你呢度4點半話俾我聽，咁佢再抽7點半我7點鐘我已經出緊黎喇，咁咪7點，7點9度睇佢囉，咁8點鐘之後話俾爸爸聽囉，即係咁我又覺得 OK 喎，你話你呢個你就會...若果我黎到我都會老實講…"

(emphasis added)

53. From the said recording, the Defendant had unequivocally told the members/friends of the Patient's family twice that Nurse HO at 04:30 hours told him that she suspected the Patient had convulsion. The Defendant also told them that Nurse HO told him that the Patient was already placed inside the incubator.

54. After being played the said recording at the inquiry, the Defendant explained that *"the meeting happened 8 days after the incident of which the meningitis, the diagnosis of meningitis and neonatal seizures were completely established. By that time, I knew all the diagnosis and that's the reason why I addressed back all these episodes as suspected and suspected convulsion and convulsion. I think that's the reason."* However, according to the recording, the Defendant was clearly only recounting what Nurse HO had told him at 04:30 hours saying (i) "4 點半話俾我聽懷疑抽筋"; and (ii) "佢就懷疑" when being asked "你的護士、你的姑娘，不知道是抽筋嗎？" The Defendant's explanation that he only *"addressed back all these episodes as suspected"* was twisting what he said to the members/friends of the Patient's family as evidenced in the said recording.

55. By reasons above, we do not find the Defendant's evidence to be believable. On the other hand, Nurse HO's evidence was consistent all along. We accept in full Nurse HO's version of the telephone conversation she had with the Defendant at 04:20 to 04:30 hours on 22 December 2009. We do not accept the Defendant's version.

56. According to Dr SO King Woon Alan, the Secretary's expert ("Dr SO"), which we agree:

"...就係關於 neonatal seizures，即係新生兒抽筋呢樣嘢。新生兒抽筋呢樣嘢呢，其實係一個好難診斷嘅情況嚟嘅。吓。新生兒抽筋嘅時候呢，其實佢有好多嘅情況出現啦，即係可能見過話隻手腳可能有少少硬咗啦，眼仔可能郁吓或者定咗，甚至隻腳好似郁吓郁吓好似踩單車咁樣樣，好多好特別嘅 ques，嘅情況呢，甚至有時唔抖氣啊，個氧份會跌低咗，呢啲都可能係新生兒抽筋嘅。

咁所以呢，其實要診斷一個新生兒抽筋呢，其實係唔容易嘅。吓。咁所以呢，我哋通常絕對唔會 relied on 一個護士呢去診斷一個 neonatal seizures。吓。

咁護士個責任係咩呢？就係佢就係要觀察有啲佢懷疑嘅嘢，佢有懷疑嘅時候呢，佢就要話俾醫生聽。咁因為我哋要診斷 neonatal seizures 呢，其中一樣嘢就係要有一個 high index of suspicion，即係我哋有懷疑，就要跟進喇，咁啊再睇吓會唔會係，如果係嘅時候呢，就要即係嚴肅跟進啦。吓。

…

咁所以，我諗即係喺呢一個 point 嗰度呢，睇完晒之後呢，我都覺得 4 點半嗰陣時呢，得到呢啲資料呢，我應該係要返去睇一睇個 BB 仔，assess 吓個 BB 仔有無啲乜嘢 investigation 要做，有無啲乜嘢即刻嘅 treatment 需要做。吓，即係我諗即係我哋兒科醫生即係如果有姑娘話俾我聽有個新生兒作抽筋呢，我通常唔會 take it lightly，吓。

…

嗱，其實呢，如果睇返薛醫生嗰個 statement 啦，吓，咁有啲，limb 有啲 slight stiffening 啦，有 staring of eyes 啦，吓，咁即係有，"個人有啲緊、眼定定"，oxygen saturation 跌到 80%，吓。咁樣樣，即係呢幾樣嘢呢，其實都係幾令人懷疑嘅，即係見到手腳有啲硬，有啲眼定定咁呢，我哋應該好多時都會懷疑其實佢係咪抽筋㗎喇。當然我哋就憑呢兩句，我哋唔可以肯定佢係咪抽筋，但係我覺得係會需要跟進囉，即係話你會睇吓問多啲 history 啦，要做返一個 physic examination 啦，甚至可能有，即係如果我哋係擔心嘅話，我哋可能會做啲 investigation 添。吓。

…

咁另外仲有一樣嘢呢，就係話，即係呢個 statement 呢，就係 acute 嗰個 nurse 呢，俾唔夠足夠嘅 information，俾佢去 made 個 diagnosis。嗱，咁喺唔夠足夠 information 呢樣嘢呢，係一個，兒科醫生嚟講呢，好常見嘅，因為兒科病人佢唔識得講嘢㗎嘛，即係佢唔識得表達自己㗎嘛，咁所以好多時候我哋就要 depends on 個家長啦，或者醫院度就 depends on 個姑娘啦。咁我哋呢啲咁嘅 informants 呢，好多時啲資料呢，未必足夠嘅，個家長可能好多時啊講咗其他嘅嘢啊，咁但係你作為一個兒科醫生，

你要識得問返一啲你需要知嘅嘢，一個 proper 嘅 history 出嚟，咁先得，甚至其實唔係淨係 nurse 㗎，甚至係有一個，一個醫生同你講，一個 junior 啲嘅醫生同你講，你覺得個 information 唔足夠呢，你都要 further question 佢。吓。咁但係，當然，如果你問完之後都係問唔到嘅話呢，咁無辦法喇，你點都要自己去再睇一睇個病人，咁係，先至可以肯定到個病人係無事嘅。吓。"

57. We accept Dr SO's opinion that a seizure may present a number of features and is very difficult to diagnose. In our view, nurses cannot make a diagnosis on her own. They can only suspect. A doctor should not rely on a nurse to make diagnosis on seizure. Assessment from doctor is mandatory. Newborns cannot speak and cannot express themselves. A doctor must probe further or go and see the patient himself before he can be certain of the patient's clinical condition.

58. According to Dr SO, the clinical features documented in the Nursing Kardex in relation to the episodes at 02:30 and 03:30 hours suggested that the Patient was suffering from suspected seizure with cardio-pulmonary instability. Common and important causes of neonatal seizure at day 2 after birth included central nervous system infections like meningitis, intracranial haemorrhage, hypoglycaemia, electrolytes disturbances like hypocalcaemia, inborn error of metabolism and cerebral ischaemic event. A proper physical examination to look for features suggestive of infection, increased intracranial pressure, and abnormal neurological signs, was necessary to determine the underlying cause and treatment. Investigations like blood glucose, electrolytes and lumbar puncture should have been done after the first episode of seizure. Any unnecessary delay in diagnosis and treatment of seizures especially those due to infective causes may have worsen the prognosis. We agree with the opinion of Dr SO. The Defendant should have in this case attended to the Patient immediately and provided the necessary and immediate investigations and treatment accordingly and as soon as possible after the first episode of seizure at 03:30 hours, and after he was informed at 04:20 to 04:30 hours. The Defendant should have gone back to the Nursery immediately, instead of waiting till the next morning. The Defendant's action plan based on his working diagnosis of "choking" was plainly inadequate. Neonatal seizure is a very serious and life-threatening condition and can have lifelong complication. In our view, the Defendant's failure to carry out necessary and immediate investigations on the Patient after the Patient developed the 1st episode of neonatal seizure at around 03:30 hours was very serious and would amount to misconduct in a professional respect.

59. The Defendant told us that he had thought of the differential diagnosis of neonatal seizure at 04:30 hours on 22 December 2009, and that neonatal seizure was a possibility. He agreed that neonatal seizure is *"very serious"*, *"life threatening"* and *"can have a lifelong complication ... to the victim"*.

60. The Defendant alleged that he thought the chance of neonatal seizure for the Patient was small. Dr SO took the view that though the chance of neonatal seizure is small, the consequence is serious and has lifelong impact. Even Dr YAU Kin Cheong, the Defendant's expert, agreed. Hence, the Defendant must exclude it as soon as possible rather than leaving the situation to observe.

61. On the alternative basis of the Defendant having formed a differential diagnosis of neonatal seizure at 04:30 hours on 22 December 2009, we find that the Defendant's failure to carry out all necessary and immediate investigations on the Patient regarding the differential diagnosis of neonatal seizure would also amount to misconduct in a professional respect.

62. We are satisfied on the evidence before us that the Defendant has by his conduct in the present case fallen below the standards expected amongst registered medical practitioners in Hong Kong and we find him guilty of professional misconduct as charged.

Sentencing

63. The Defendant has a clear disciplinary record.

64. The offence committed by the Defendant was very serious. Although there is no evidence that the outcome for the Patient would have been better but for the Defendant's misconduct, the Patient was nonetheless diagnosed to have cerebral palsy with global delayed development. This is lifelong to the Patient.

65. We bear in mind that the primary purpose of a disciplinary order is not to punish the Defendant. Rather, our task is to protect the public from persons who are unfit to practise medicine and to maintain public confidence in the medical profession by upholding its high standards and good reputation.

66. A cardinal principle of medical practice is that registered medical practitioner should first of all do no harm on his patient. Neonatal seizure is a very serious

and life-threatening condition and can have lifelong complications. The Defendant's failure to diagnose and manage neonatal seizure as soon as possible in this case is inexcusable.

67. Throughout the Inquiry, the Defendant still maintained that Nurse HO had not told him during their telephone conversation that she suspected convulsion. This reflected badly on his honesty and integrity.

68. We have grave concerns about the Defendant's insights into his wrongdoing. Throughout the Inquiry, the Defendant still maintained that he was entitled to rely on the professional judgment of the nursing staff when it was his primary responsibility, as case doctor, to probe further or go and see the Patient himself to ensure that the Patient was safe. In our view, the Defendant also failed to reflect on his wrongdoings and this indicated the lack of remorse on his part.

69. We have considered all the mitigating factors presented. Nevertheless, in the course of the Inquiry, the Defendant was adamant that what he had done was proper and correct. This only showed that his lack of insight into his wrongdoings remained unchanged.

70. Taking into consideration the nature and gravity of the disciplinary charge for which the Defendant is convicted and what we have heard and read in mitigation, we shall order that the name of the Defendant be removed from the General Register for a period of 9 months.

71. We have also considered whether our removal order should be suspended. For the reasons above, we do not find suspension appropriate.

Prof. TANG Wai-king, Grace, SBS, JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong