IN THE GENERAL DIVISION OF
THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2025] SGHC 178

Originating Application No 576 of 2025 and Summons No 1599 of 2025

Between

Cheng Chang Hup

… *Applicant*

And

Attorney-General

… *Respondent*

JUDGMENT

[Administrative Law — Judicial review — Application for leave to apply for judicial review to quash the Coroner's findings]

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Cheng Chang Hup
v
Attorney-General

[2025] SGHC 178

General Division of the High Court — Originating Application No 576 of 2025 and Summons No 1599 of 2025
Kwek Mean Luck J
29 August 2025

5 September 2025 Judgment reserved.

Kwek Mean Luck J:

Introduction

1 It hurts deeply to lose a loved one. When that loss occurs from suicide, pain and grief is often compounded by a multitude of questions that revolve around – why?

2 Mr Cheng Chang Hup ("Mr Cheng") lost his sister, Ms Cheng Yun Xin, Alice ("Ms Cheng"), in such circumstances. He sought, in his words, closure and answers from a Coroner's Inquiry ("Inquiry") conducted in relation to his sister. Having unanswered questions after the conclusion of the Inquiry, he seeks leave to apply for judicial review to quash the Coroner's findings and for a new Coroner's Inquiry to be convened.

3 This touches on the statutory purpose of a Coroner's Inquiry, which is directed at ascertaining the identity of the deceased, as well as how, when and where the deceased came by her death. The Coroner fulfilled this statutory duty. He determined that the demise of Ms Cheng was due to suicide, which Mr Cheng did not dispute. The Coroner was unable to conclude why Ms Cheng committed suicide, which left Mr Cheng with unanswered questions. This, however, does not render the Coroner in breach of his statutory duty, as prescribed by s 27 of the Coroners Act 2010 (2020 Rev Ed) (the "Coroners Act"). I also do not find, after examining the evidence, a *prima facie* case of reasonable suspicion that the Coroner's findings are in breach of the established grounds for judicial review. I therefore dismiss this application. I set out my reasons below.

OA 576

4 In HC/OA 576/2025 ("OA 576"), Mr Cheng seeks leave to apply for judicial review of the Coroner's findings in the Coroner's Certificate dated 9 May 2025 (the "Coroner's Certificate"), made in relation to his sister, Ms Cheng. If and when leave is granted, Mr Cheng seeks the following reliefs:

(a) an order to quash the findings of the Coroner in the Inquiry;

(b) a declaration that the Coroner acted irrationally and/or failed to adhere to procedural fairness by:

(i) failing to compel the attendance of Ms Cheng's boyfriend at the time, Mr Chew;

(ii) failing to secure and closely examine deleted communications between Ms Cheng and Mr Chew;

(iii) failing to pursue investigations of Ms Cheng's missing handphones;

(iv) accepting medical conclusions without probing into inconsistencies in medication compliance and side effect reports; and

(c) an order for a fresh Coroner's Inquiry to be conducted.

SUM 1599

5 Mr Cheng also seeks through HC/SUM 1599/2025 ("SUM 1599"):

(a) An interim order that the mobile phone belonging to Mr Chew, currently held by the Police, be preserved and not released to any party pending the final determination of this judicial review application; and

(b) An injunction prohibiting the disposal, deletion, or alteration of any data in the phone until further order of the Court.

6 Mr Cheng is concerned that if the phone is returned by the police to Mr Chew, he will lose access to critical evidence including deleted messages relevant to Ms Cheng's mental state. He submits that it is central to his judicial review application, which challenges the procedural fairness of the Inquiry for failing to recover and examine the deleted messages.

Decision

7 The order which Mr Cheng seeks in SUM 1599 is contrary to s 27(1)(*a*) of the Government Proceedings Act 1956 (2020 Rev Ed), which provides that the court shall not grant an injunction in proceedings against the Government:

> **Nature of relief**
>
> **27.**—(1)(a) … **where in any proceedings against the Government** any such relief is sought as might in proceedings between private persons be granted by way of injunction or specific performance, **the court shall not grant an injunction** or make an order for specific performance, but may in lieu thereof make an order declaratory of the rights of the parties…
>
> [emphasis added]

8 SUM 1599 would be dismissed for this reason alone.

9 For completeness, I also considered if a declaration should be granted in lieu of an injunction. In *Bocotra Construction Pte Ltd and others v Attorney-General* [1995] 2 SLR(R) 262, the Court of Appeal held at [28] that "[t]he court is empowered only to grant a declaration if the circumstances are such that as between private parties, an injunction or an order for specific performance would be granted."

10 I do not find the circumstances to be such that an injunction would be granted. Investigative Officer ("IO") Joe Ng Ren Guang ("IO Ng"), of the Singapore Police Force, testified that the Police had, on 20 September 2023, sent Mr Chew's phone for forensic examination by the Cyber Crime Response Team ("CCRT").[1] The CCRT successfully extracted data from Mr Chew's mobile phone using forensic software via cable connection and retrieved 5,000 SMS messages and 161,904 WhatsApp messages. These were messages between Ms Cheng and Mr Chew from 1 October 2021 to 1 April 2022. This was the six-month period requested by Mr Cheng. The messages were made

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[1] Affidavit of Joe Ng Ren Guang dated 30 July 2025 ("IO Ng's 1st affidavit") at para 52.

available for Mr Cheng's viewing during the Inquiry.[2] The CCRT noted that there were "no deleted SMS messages and WhatsApp messages found in [Mr Chew's] phone".[3] There was no evidence surfaced during the Inquiry which suggested that the CCRT's forensic extraction process was flawed and that any further messages could be recovered. I therefore find that there is also no basis to grant a declaration in lieu of an injunction.

11 For these reasons, I dismiss SUM 1599.

The Coroner's Inquiry

12 The Inquiry was convened to inquire into the cause of and circumstances connected with Ms Cheng's demise on 1 April 2022.[4] The Inquiry was held over two days on 3 November 2022 and 19 August 2024.[5] Amongst other witnesses, the following testified: IO Dillion Lee ("IO Lee"), Dr Chew Ying Yin ("Dr Chew"), Resident Medical Officer at the Institute of Mental Health (the "IMH"), and Dr Lim Shanhui, Gillian ("Dr Lim"), Consultant Psychiatrist at IMH. During the hearings, Mr Cheng was given the opportunity to ask questions of each of the above witnesses, which he did.[6]

13 The matter was fixed for the Coroner to give his findings on 21 November 2024.[7] At the hearing, Mr Cheng requested the Coroner to order

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2 IO Ng's 1st affidavit at para 53.

3 IO Ng's 1st affidavit at para 52.

4 IO Ng's 1st affidavit at para 2.

5 IO Ng's 1st affidavit at para 12.

6 IO Ng's 1st affidavit at para 13.

7 IO Ng's 1st affidavit at para 17.

Mr Chew to be called to the stand to give oral evidence on several issues, including what he had said to Ms Cheng "four to five months" before she passed away and how much money he had given to Ms Cheng.[8] The hearing on 21 November 2024 was adjourned.[9] In Mr Chew's conditioned statement dated 14 September 2023, he stated that he was "currently under medication prescribed from Ang Mo Kio polyclinic and [had] been seeking regular consultation with psychologists and psychiatrist".[10] The Coroner stated that any testimony by Mr Chew would have to be on a voluntary basis in view of his mental health concerns.[11]

14 On 3 December 2024, Mr Chew gave a further conditioned statement, stating that he did not wish to attend the Inquiry due to his mental health conditions.[12] He later produced a medical report dated 20 January 2025. This stated that he had been on follow-up since 5 April 2022 for depression and anxiety. The Coroner decided not to call Mr Chew to the stand.[13] The Coroner found that Mr Cheng's queries were either already addressed by the evidence or were not required for the Coroner to satisfy the requirements set out in s 27(1) of the Coroners Act.

15 On 9 May 2025, the Coroner issued his findings in a 51-page Coroner's Certificate.[14]

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8 IO Ng's 1st affidavit at para 18.

9 IO Ng's 1st affidavit at para 22.

10 IO Ng's 1st affidavit at para 21.

11 IO Ng's 1st affidavit at para 22.

12 IO Ng's 1st affidavit at para 23.

13 IO Ng's 1st affidavit at para 24.

14 IO Ng's 1st affidavit at para 25.

16 The Coroner found that Mr Chew had been in a relationship with Ms Cheng since 2005 and was aware of Ms Cheng's schizophrenia diagnosis.[15] The Coroner considered Mr Chew's conditioned statements and the WhatsApp and SMS messages between Mr Chew and Ms Cheng, and observed that their messages revealed "a very tumultuous relationship, characterised by arguments and, at times, the use of vulgarities".[16] The Police concluded from their investigations that there was no foul play involved in Ms Cheng's demise and that there were no indications from the messages that Mr Chew had provoked Ms Cheng to commit suicide.[17] The Coroner noted that the Police had reached their conclusion after considering several factors. These include the content of the messages exchanged between Mr Chew and Ms Cheng, the fact that some of the messages were deleted and could not be retrieved, and the fact that Ms Cheng's mobile phones were not found.[18] The Coroner accepted the conclusion drawn by the Police that there was no foul play involved in Ms Cheng's demise.[19]

17 Further, the Coroner noted that two clinical decisions had been made.[20] First, at a consultation on 19 July 2021, Dr Lim examined Ms Cheng and assessed that she was "fairly stable". Dr Lim offered to reduce the dosage of Haloperidol from 5mg (which she took every three to four days) to 1.5mg nightly in the hope that Ms Cheng would consume the medication daily and this

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15 IO Ng's 1st affidavit at para 34.

16 IO Ng's 1st affidavit at para 38.

17 IO Ng's 1st affidavit at para 39.

18 IO Ng's 1st affidavit at para 40.

19 IO Ng's 1st affidavit at para 41.

20 IO Ng's 1st affidavit at para 33.

would reduce the side effects of sedation that arose from a higher dosage.[21] This was a clinical decision made by Dr Lim. Second, at a consultation on 30 March 2022, Dr Chew assessed that Ms Cheng appeared to be functioning well, was coherent, forthcoming and engaged despite being off the medication for two weeks.[22] Dr Chew offered Ms Cheng various medication options. However, Ms Cheng decided to continue with the dosage of 1.5mg nightly until her next appointment.[23] Dr Chew did not see a need to prescribe a higher dose of Haloperidol as Ms Cheng had stated that she would take the medication daily, that she would update her boyfriend about taking the medication and that there was no evidence of an increase in her schizophrenia symptoms.[24] This was a clinical decision made by Dr Chew. The Coroner stated that he was "not in a position to second guess these clinical decisions" by Dr Lim and Dr Chew.[25]

18 The Coroner returned a finding of suicide in relation to Ms Cheng's demise and concluded that the exact reason why Ms Cheng took her life is unclear.[26]

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21 Coroner's Certificate as annexed at Tab 11 of IO Ng's 1st Affidavit (the "Coroner's Certificate" at para 246.

22 Coroner's Certificate at paras 249–250.

23 Coroner's Certificate at para 250.

24 Coroner's Certificate at para 251.

25 Coroner's Certificate at para 252.

26 Coroner's Certificate at paras 237, 254.

Mr Cheng's case

19 Mr Cheng does not dispute that Ms Cheng died by suicide on 1 April 2022.[27] He nevertheless contends that the Inquiry failed to comply with s 27(1) of the Coroners Act, which requires investigation into both cause and circumstances of the death.[28]

20 Mr Cheng set out four categories of concern: (a) Procedural Impropriety; (b) Irrationality; (c) Failure to Consider Relevant Evidence; and (d) Systemic Gaps. These four categories relate broadly to two concerns that were raised by Mr Cheng during the Inquiry:

(a) Whether Mr Chew provoked Ms Cheng's suicide and the adequacy of the Police's investigations into this (the "Relationship Issue"); and

(b) Whether Dr Lim and Dr Chew contributed to Ms Cheng's suicide by reducing her daily medication dosage for her schizophrenia (the "Treatment Issue").

21 Under Mr Cheng's category of Procedural Impropriety, he set out the following.

(a) With respect to the Relationship Issue:

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27 Reply Affidavit of Cheng Chang Hup dated 25 August 2025 (Mr Cheng's reply affidavit") at para 3.

28 Mr Cheng's reply affidavit at paras 3–4.

(i) *Failure to recover material evidence*: Ms Cheng's phone was traced as active in Woodlands yet never recovered.[29] Mr Chew also removed one of Ms Cheng's bags, but it was not searched.[30]

(ii) *Failure to retrieve deleted messages*: Deleted messages between October 2021 to February 2022 were not recovered or queried.[31] The Police also ignored Ms Cheng's second registered mobile number.[32]

(iii) *Failure to probe witnesses*: Mr Chew was not called to testify despite contradictions in his accounts.[33]

(b) With respect to the Treatment Issue:

(i) *Withholding of IMH records*: IMH admitted contemporaneous records existed but would not be disclosed. Only summaries were given.[34]

(ii) *Failure to probe witnesses*: The psychiatrists were not cross-examined on contradictions.[35]

22 Under Mr Cheng's category of Irrationality, he set out the following.

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29 Applicant's Written Submissions ("AWS") at para 4.

30 AWS at para 5.

31 AWS at para 6.

32 AWS at para 7.

33 AWS at para 10.

34 AWS at para 8.

35 AWS at para 9.

(a) With respect to the Relationship Issue:

(i) *Unsafe "no provocation" finding*: The IOs concluded there were no indications of provocation but ignored large volumes of deleted messages.[36]

(ii) *Contradictions in Mr Chew's evidence*: The landlord's text that Mr Chew referred to never appeared in records. Mr Chew's claim of "planning a family" with Ms Cheng was contradicted by his 30/3/22, 1:53 a.m. message: *"From now on I will not care anymore..."* These contradictions were unresolved yet accepted.[37]

(b) With respect to the Treatment Issue:

(i) *Illogical Haloperidol dosage reduction:* the Haloperidol dosage was reduced by IMH doctors from 5mg to 1.5mg. This was described as "optimal", despite there being no adherence by Ms Cheng at 5mg. There was no objective monitoring of Ms Cheng.[38]

(ii) *"Stable" vs contemporaneous evidence*: IMH labelled Ms Cheng as "stable" even though she was recorded with active schizophrenia.[39]

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[36] AWS at para 11.

[37] AWS at paras 12–14.

[38] AWS at para 15.

[39] AWS at para 16.

23 Under the category of Failure to Consider Relevant Evidence, Mr Cheng set out the following.

(a) With respect to the Treatment Issue:

(i) *Digital evidence:* Video logs from 12 February to 20 February 2022 on Ms Cheng's laptop recorded hallucinations, fear, suicidality, but were not engaged with.[40]

(ii) *IMH notes vs police report*: The medical notes dated 16 January 2020 recorded deterioration and non-compliance. However, the IMH report to the Police said that Ms Cheng was "compliant and doing well".[41]

(iii) *30 March 2022 consultation notes*: Ms Cheng stopped medication for two weeks and had new side effects on 1.5mg daily. Yet, she was still assessed as "functioning well".[42]

(iv) *Legal and clinical framework ignored*: The Mental Health (Care and Treatment) Act 2008 (2020 Rev Ed) ("Mental Health Act") was not considered despite repeated relapses and impaired insight. International guidelines and the absence of updated Ministry of Health ("MOH") guidelines were not addressed.[43]

24 Under the category of Systemic Gaps, Mr Cheng set out the following.

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40 AWS at para 18.

41 AWS at para 19–20.

42 AWS at para 21.

43 AWS at para 22–23.

(a) With respect to the Treatment Issue:

(i) Peer-reviewed studies confirm abrupt antipsychotic dose reductions raise relapse and suicide risk.[44]

(ii) MOH has not updated schizophrenia guidelines since 2011, leaving no domestic benchmark.[45]

AG's case

Leave to commence judicial review

25 To obtain permission for judicial review, an applicant must show that: (a) the subject matter of the complaint has to be susceptible to judicial review; (b) the applicant has to have a sufficient interest in the matter; and (c) the materials before the court have to disclose an arguable or *prima facie* case of reasonable suspicion in favour of granting the remedies sought by the applicant; *Gobi a/l Avedian and another v Attorney-General and another appeal* [2020] 2 SLR 883 ("*Gobi*") at [44].[46]

26 The Respondent, the Attorney-General ("AG"), does not take issue with limbs (a) and (b). However, the AG submits that Mr Cheng has failed on limb (c) as set out in *Gobi* at [44], by failing to raise an arguable or *prima facie* case of reasonable suspicion in favour of granting the remedies sought.[47]

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44 AWS at para 24.

45 AWS at para 25.

46 Respondent's Written Submissions ("RWS") at para 32.

47 RWS at paras 33–34.

27 The purpose of an inquiry, as prescribed under s 27(1) of the Coroners Act, is to inquire into the cause of and circumstances connected with the death. This involves ascertaining the identity of the deceased and how, when and where the deceased came by his or her death. As such, issues of illegality, procedural impropriety or irrationality must be examined in the context of s 27 of the Coroners Act. The phrase "circumstances connected with the death" in s 27(1) of the Coroners Act has been interpreted by the High Court in *Selvi d/o Narayanasamy v Attorney-General* [2014] 1 SLR 458 ("*Selvi*") to refer to circumstances that "must ultimately relate to the four matters in s 27(1)" (*ie*, identity, how, when and where) and the phrase "how, when and where" in s 27(1) indicates that the circumstances "must be relevant and proximate in time and place" to the death; at [45].[48]

28 In the present case, the Coroner's role was to ascertain the identity of the deceased, and how, when and where the deceased came by her death. These have been answered in the Coroner's Certificate: the deceased, Ms Cheng, passed away on 1 April 2022 at just after 1.03 pm, after a fall (by suicide) from the 10th floor of Block 350 Ang Mo Kio Street 32 to the ground. Above and beyond this, the Coroner considered the circumstances leading to Ms Cheng's suicide, including, but not limited to, the Relationship Issue and the Treatment Issue.[49]

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48 RWS at paras 35–36.

49 RWS at para 41.

29 The Coroner's role was not to establish whether Dr Chew and Dr Lim were negligent or whether Mr Chew should bear civil or criminal liability for Ms Cheng's demise.[50]

30 Mr Cheng's four categories of concerns appear to have arisen from a serious misunderstanding of the role of the Coroner. They are legally and/or factually unsustainable as they all relate to: (a) matters that the Coroner has already considered as part of the Inquiry; or (b) matters that are irrelevant to the Inquiry.[51]

31 "Procedural Impropriety" typically relates to questions of whether there has been a breach of the rules of natural justice or failure to adhere to prescribed rules in the decision-making process. Mr Cheng has not asserted any failure to adhere to prescribed rules. The twin pillars of natural justice are: (a) no one may act as a judge in his own cause; and (b) no person should be condemned without having been heard or having been given prior notice of the allegations. Mr Cheng's assertions do not engage either of these pillars. Moreover, Mr Cheng had been given the opportunity to ask questions of both doctors.[52]

32 There is no arguable or *prima facie* case of irrationality in relation to the Coroner's findings. In *Tan Seet Eng v Attorney-General and another matter* [2016] 1 SLR 779 ("*Tan Seet Eng*"), the Court of Appeal held that for irrationality, the Court must ask if the decision made is one which is so absurd that no reasonable decision-maker could have come to it; at [80]. This test sets

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50 RWS at para 42.

51 RWS at para 43.

52 RWS at paras 45–46.

a "high bar"; *Manjit Singh s/o Kirpal Singh and another v Attorney-General* [2013] 4 SLR 483 at [7]. [53]

33 For example, Mr Cheng asserted that the Coroner "accepted, without scrutiny, the psychiatrists' explanation for reducing [Ms Cheng's] Haloperidol dosage from 5mg to 1.5mg daily", despite "her history of noncompliance and repeated relapses". Dr Lim and Dr Chew testified at the Inquiry that they made these clinical decisions after assessing Ms Cheng and reviewing her condition. The further question of whether Dr Lim and Dr Chew made these clinical decisions wrongly or negligently is a matter of civil liability, which is beyond the scope of the Coroner's Inquiry pursuant to s 27(2) of the Coroners Act.[54]

34 There is no *prima facie* case that the Coroner's findings are tainted by illegality. In *Tan Seet Eng*, the Court of Appeal held at [80] that the ground of illegality in judicial review entails inquiring into, *inter alia*, whether the decision-maker has taken into account irrelevant considerations or failed to take into account relevant considerations.[55]

35 The Coroner did take into account all relevant considerations, *ie*, the evidence placed before the Court, in returning a finding of suicide in relation to Ms Cheng's demise. For example, Mr Cheng asserted that the Coroner did not address "the pattern of emotional abuse in [Ms Cheng's] relationship with Mr Chew, including psychological manipulation, frequent references to 'jumping' together, and dismissive responses to her distress". However, the Coroner considered Ms Cheng's video logs as well as her WhatsApp messages

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53 RWS at paras 48–49.

54 RWS at paras 49–51.

55 RWS at para 54.

and SMS messages with Mr Chew. Even if Mr Cheng disagrees with the Coroner's findings, this does not render the Coroner's findings illegal or irrational.[56]

36 Under the heading of "Systemic Gaps and International Standards", Mr Cheng asserted that the Coroner failed to inquire into how Ms Cheng's medication dosage did not follow international guidelines and whether IMH's clinical decisions amounted to a departure from those standards. Mr Cheng raised this during the Inquiry and the Coroner considered it. Nonetheless, it is not the role of the Coroner to determine if the clinical decisions were made in breach of medical guidelines. The question of whether Dr Lim and/or Dr Chew may have breached the medical guidelines is a matter of civil liability, which the Coroner cannot rule on. The medical guidelines are also not relevant or proximate in time and place to Ms Cheng's passing.[57]

Decision

37 The primary issue before the court is whether the third requirement of *Gobi* as set out at [44] is satisfied, namely, whether the materials before the court disclose an arguable or *prima facie* case of reasonable suspicion in favour of granting the remedies sought by Mr Cheng. He seeks an order to quash the findings of the Coroner in the Inquiry and for an order that a fresh Coroner's Inquiry into Ms Cheng's demise be conducted. The established grounds for quashing an order pursuant to judicial review include illegality, irrationality and procedural impropriety.

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56 RWS at paras 55–57.

57 RWS at paras 58–59.

38 The question is thus whether there is an arguable or *prima facie* case that the Coroner's conduct of the Inquiry or his decisions in the Inquiry demonstrate illegality, irrationality or procedural impropriety.

39 In assessing this, the statutory purpose and ambit of a Coroner's Inquiry has to be borne in mind. This is set out in s 27 of the Coroners Act, which provides:

> **Purpose of inquiry**
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> 27.—(1) The purpose of an inquiry into the death of any person is to **inquire into the cause of and circumstances connected with the death** and, for that purpose, the proceedings and evidence at the **inquiry must be directed to ascertaining the following matters** insofar as they may be ascertained:
>
> (*a*) the **identity** of the deceased;
>
> (*b*) **how**, **when** and **where** the deceased came by his or her death.
>
> (2) A Coroner at an inquiry is not to frame a finding in such a way as to determine any question of criminal, civil or disciplinary liability but is not inhibited in the discharge of his or her functions by any likelihood of liability being inferred from facts that the Coroner determines or recommendations that the Coroner makes.
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> [emphasis added]

40 This provision was examined by Tay Yong Kwang J (as he then was) in *Selvi*, who held at [45]:

> **The applicant was in effect demanding that every circumstance be looked into.** However, I reiterate here the purpose of a Coroner's Inquiry as stipulated in s 27(1) of the Act (set out at [35] above). The four matters – identity, how, when and where – have been answered by the criminal proceedings. **The applicant is not entitled to take out judicial review proceedings to compel an inquiry to be conducted for the purpose of wanting to know everything that happened in the prison (or perhaps even in the ambulance, the hospital and the mortuary). The "circumstances connected with the death" must ultimately relate to the four matters in s 27(1) and "how, when and**

> **where" indicate that the circumstances must be relevant and proximate in time and place**.
>
> [emphasis in original omitted, emphasis added in bold]

41 In relation to Ms Cheng, the Coroner had determined the four matters set out under s 27(1) of the Coroners Act, by finding that: (a) Ms Cheng; (b) fell to her death by suicide from the 10th floor of a block; (c) on 1 April 2022 at 1.03pm; (d) at the foot of Block 350 of Ang Mo Kio St 32 in front of unit #01-109.

Procedural Impropriety

42 I first consider whether there is an arguable or *prima facie* case that there was procedural impropriety. In *Muhammad Ridzuan bin Mohd Ali v Attorney-General* [2015] 5 SLR 1222, the Court of Appeal held at [75] that:

> a challenge based on procedural impropriety would be made out when it can be shown that a decision-maker reached a decision in breach of basic rules of natural justice and/or that he failed to adhere to legislatively prescribed procedural rules in reaching that decision.

43 In *Management Corporation Strata Title Plan No 301 v Lee Tat Development Pte Ltd* [2011] 1 SLR 998, the Court of Appeal explained at [56] that "a breach of natural justice, whether involving a breach of the bias rule or a breach of the hearing rule, is basically a procedural wrong because it denies the aggrieved party a full, fair and impartial hearing".

44 There is no evidence that the Coroner was in breach of any prescribed rules or the rules of natural justice. Mr Cheng was present at the Inquiry. He

was also allowed to ask questions of both doctors.[58] I find that there is no arguable or *prima facie* case that there was procedural impropriety.

Illegality

45 I next consider whether there is an arguable or *prima facie* case of illegality in relation to the Coroner's findings. In *Tan Seet Eng*, the Court of Appeal explained the concept of illegality at [80]:

> … illegality serves the purpose of examining whether the decision-maker has exercised his discretion within the scope of his authority and the inquiry is into **whether he has exercised his discretion in good faith according to the statutory purpose** for which the power was granted, and **whether he has taken into account irrelevant considerations or failed to take account of relevant considerations** … illegality examines the source and extent of the Minister's power and whether the power has been informed by relevant and only relevant considerations …
>
> [emphasis in original omitted, emphasis added in bold]

46 I will assess this first with respect to the Relationship Issue, followed by the Treatment Issue.

47 With regards to the Relationship Issue, Mr Cheng's main submission is that the Coroner failed to consider the contradictions between Mr Cheng's evidence and the messages in evidence, as well as the possibility of deleted messages that may have showed that Mr Cheng provoked Ms Cheng. The failure of the Police to retrieve Ms Cheng's phones contributed to this gap. The Police's conclusion that there was no foul play was thus unsafe, and the Coroner should not have relied on it. Hence, it is contended that the Coroner failed to take into account relevant considerations.

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[58] Coroner's Certificate at paras 207–212; paras 216–221.

48 After examining the Coroner's Certificate, I find that the Coroner did take into account the concerns raised by Mr Cheng. The Coroner took into consideration the following:

(a) Two black bags were left outside Mr Chew's home on 1 April 2022. The police searched the two bags. They found a laptop in one of the bags. This was seized by the police for investigations.[59] I also note that there is no evidence that Mr Chew took Ms Cheng's phones or anything from the bags.

(b) The Police had searched for Ms Cheng's phones to where they were last traced but were unable to pinpoint the exact locations. The phone signals were later lost and the phones could not be recovered.[60]

(c) The Police seized Mr Chew's mobile phone and sent it for forensic examination.[61] The forensic team noted that there were "no deleted SMS messages and WhatsApp messages found in [Mr Chew's] phone".[62]

(d) The CCRT extracted 5,000 SMS messages and 161,904 WhatsApp messages,[63] which were made available to Mr Cheng. The

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59 Coroner's Certificate at para 63.

60 Coroner's Certificate at paras 198, 203 and 243.

61 Coroner's Certificate at paras 152 and 158.

62 CCRT Report at Tab 13 of IO Ng's 1st affidavit ("CCRT Report") at para 11; Coroner's Certificate at para 204.

63 IO Ng's 1st affidavit at para 52.

Coroner also highlighted that he had searched the SMS messages for terms relating to suicide.[64]

(e) Ms Cheng had a tumultuous relationship with Mr Chew, and exchanged messages, including some with references to suicide.[65]

(f) The Police investigated and concluded that there were no indications from the messages found in Mr Chew's handphone that Mr Chew had provoked Ms Cheng to cause her own demise.[66]

49 With regards to the Treatment Issue, Mr Cheng's main submission is that the Coroner failed to consider that there was evidence that contradicted the IMH doctors' clinical assessment to reduce Ms Cheng's Haloperidol dosage from 5mg to 1.5mg.

50 I find that the Coroner did take into account the concerns raised by Mr Cheng. The Coroner took into consideration the following:

(a) the family's concerns about Ms Cheng's suicidal ideations;[67]

(b) the WhatsApp and SMS messages between Mr Chew and Ms Cheng relating to suicide;[68]

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64 Coroner's Certificate at para 158.

65 Coroner's Certificate at paras 28–37; 152-160 and 233.

66 Coroner's Certificate at para 152-153.

67 Coroner's Certificate at para 107.

68 Coroner's Certificate at paras 158–160.

(c) Dr Lim and Dr Chew's reasons for their clinical assessment as to why 5mg of Haloperidol was less optimal for Ms Cheng than 1.5mg;[69]

(d) Dr Chew's notes showing that Ms Cheng reported worsening side effects on 1.5mg of Haloperidol compared to 5mg, and Dr Chew's opinion that this was probably because Ms Cheng was less compliant on the past dosage of 5mg compared to the new dosage of 1.5mg. As Ms Cheng was more compliant on 1.5mg, she developed the side effects.[70] While Mr Cheng was concerned about the possibility that only summarised notes from IMH were made available due to a call he had with an IMH staff,[71] the Police had requested IMH to produce all medical notes pertaining to Ms Cheng's treatments[72] and there is no evidence to consider that what was released was incomplete;

(e) Mr Cheng's concern that Ms Cheng's medication dosage did not follow the manufacturer's and medical guidelines;[73]

(f) the video logs, WhatsApp messages, and SMS exchanges, where Ms Cheng expressed fear, hallucinations, and repeated suicidal thoughts;[74]

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69 Coroner's Certificate at paras 212 and 221.

70 Coroner's Certificate at para 221.

71 2nd Supplementary Affidavit of Joe Ng Ren Guang dated 20 August 2025 ("IO Ng's 3rd affidavit") at p 9.

72 IO Ng's 2nd affidavit at Exhibit C100.

73 Coroner's Certificate at para 113.

74 Coroner's Certificate at paras 151, 154 and 235.

(g) the doctors' assessment that Ms Cheng did not display behaviour that would justify admission under the Mental Health Act, during Dr Lim's consultations with Ms Cheng in 2021 and Dr Chew's consultation with Ms Cheng on 31 March 2022;[75]

(h) evidence that Dr Lim and Dr Chew discussed the treatment options with Ms Cheng during the consultations.[76] They observed Ms Cheng's condition and recorded their observations.[77]

51 I therefore do not find there to be an arguable or *prima facie* case of illegality in relation to the Coroner's findings on the Relationship Issue or the Treatment Issue.

52 To the extent that Mr Cheng submits that the Coroner failed to take into account relevant considerations because he did not order for further investigation into these matters, it is important to go back to the statutory purpose of a Coroner's Inquiry as set out in s 27 of the Coroners Act. As Tay J emphasised in *Selvi* at [45], an applicant is not entitled to take out judicial review proceedings to compel an inquiry for every circumstance to be looked into. The "circumstances connected with the death" must ultimately relate to the four matters set out in s 27(1), namely, the identity of the deceased, and "how, when and where" the death occurred.

53 The Coroner has examined the considerations that are relevant to the determination of these four matters. While Mr Cheng submits that there may be

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75 Coroner's Certificate at paras 211 and 219.

76 Coroner's Certificate at paras 183 and 215.

77 IO Ng's 1st affidavit at paras 27–32.

potential liability on the part of Mr Chew, or the two IMH doctors, it bears reiterating that s 27(2) of the Coroners Act states that a Coroner at an inquiry "is not to frame a finding in such a way as to determine any question of criminal, civil or disciplinary liability". It was hence not part of the Coroner's remit here to assess if there was such liability on the part of these other parties. I also note that the Coroner was cognisant of Mr Cheng's concerns, and provided him an opportunity to question Dr Lim and Dr Chew.

Irrationality

54 In so far as Mr Cheng disagrees with the Coroner's assessments based on the considerations which the Coroner took into account, that relates to whether it could be said that there is an arguable or *prima facie* case of irrationality in relation to the Coroner's findings. It is to that which I now turn. In *Tan Seet Eng*, the Court of Appeal held at [80] that:

> … irrationality is a more substantive enquiry which seeks to ascertain the range of legally possible answers and asks if the decision made is one which, though falling within that range, is **so absurd that no reasonable decision-maker could have come to it** … irrationality looks at the decision that was made and asks if it was so unreasonable that after considering the correct factors, no reasonable decision-maker could have come to it.
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> [emphasis in original omitted; emphasis added in bold]

55 While Mr Cheng only dealt with the Treatment Issue under his category "Irrationality and Clinical Considerations", I have also assessed if there is an arguable or *prima facie* case of irrationality in relation to the Coroner's findings on the Relationship Issue. I do not find that there is.

(a) The Police had reported to the Coroner that despite their searches, they could not locate Ms Cheng's phones.[78]

(b) The CCRT had also conducted a forensic examination and found "no deleted SMS messages and WhatsApp messages" in Mr Chew's phone.[79]

(c) There is no evidence of any bad faith or lack of scrupulousness on the part of the Police.

(d) The Coroner had assessed the messages relating to suicide, which the Police had also investigated. Extracts of the messages were also set out in the Coroner's Certificate.[80]

(e) The Coroner considered whether to call Mr Chew to testify. Besides Mr Chew's messages with Ms Cheng, the Coroner also had before him the conditioned statements from Mr Chew. There was evidence that Mr Chew was being medically treated for anxiety and depression. The Coroner considered that Mr Cheng's queries for Mr Chew were either already addressed by the evidence or were not required for satisfying s 27(1) of the Coroners Act.[81]

56 Arising from the above, the Coroner decided not to direct the Police to make further inquiries into the missing phones and not to call Mr Chew to

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78 Coroner's Certificate at paras 198, 203 and 243

79 CCRT Report at para 11; Coroner's Certificate at para 204.

80 Coroner's Certificate at paras 158–160.

81 Coroner's Certificate at paras 225–227.

testify.[82] He also accepted the Police's conclusion that there was no foul play involved in Ms Cheng's demise.[83] It could not be said that these are decisions or findings which are so absurd that "no reasonable decision-maker" could arrive at.

57 I next consider if there is an arguable or *prima facie* case of irrationality in relation to the Coroner's findings on the Treatment Issue. Mr Cheng submits that the Coroner should not have accepted Dr Lim and Dr Chew's clinical assessment to reduce Ms Cheng's dosage of Haloperidol to 1.5mg, given Ms Cheng's history of non-compliance with 5mg of Haloperidol, Ms Cheng's reported worsening side effects from taking 1.5mg of Haloperidol, and international guidelines. However:

(a) Dr Lim and Dr Chew testified that they had discussed with Ms Cheng about her treatment.[84]

(b) Both doctors also explained their reasoning for reducing the daily dosage, which is that Ms Cheng was non-compliant on 5mg daily. Dr Lim also took into account that Ms Cheng had informed her that she would be collecting medication with two weeks of medications left when she was on the 1.5mg daily regime, compared to the past when Ms Cheng would go four months without collecting medication.[85] The

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82 Coroner's Certificate at para 228.

83 Coroner's Certificate at para 229.

84 Coroner's Certificate at paras 206 and 215.

85 Coroner's Certificate at para 212.

reported side effects from Ms Cheng was assessed to be due to Ms Cheng being more compliant on 1.5mg daily.[86]

(c) The Coroner noted a toxicology report which reported the presence of Haloperidol in Ms Cheng's urine, and also Dr Lee's opinion that its presence did not cause or contribute to Ms Cheng's death.[87]

58 On the whole, taking into account the evidence before the Coroner, it could not be said that there is an arguable or *prima facie* case of irrationality in relation to the Coroner's findings on the Treatment Issue. While Mr Cheng may not agree with the Coroner's findings, that in itself is not a basis for the findings of the Coroner to be quashed. Mr Cheng would have to satisfy the established legal thresholds for judicial review, which I find he has not.

Conclusion

59 In summary, I find that Mr Cheng has failed to raise an arguable or *prima facie* case of reasonable suspicion in favour of granting the remedies sought. OA 576 is therefore dismissed. I fully appreciate that Mr Cheng is still grieving over the loss of his sister, and in his words, is looking for closure. However, for the reasons above, I do not think that this is to be found through the judicial review of the Coroner's findings.

60 It is deeply painful to lose a loved one. Our journey through such pain is not an easy one to make. When that loss occurs through suicide, it is natural

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86 Coroner's Certificate at para 221.

87 Coroner's Certificate at paras 69–70.

that questions will linger and repeat themselves in our minds. I hope that Mr Cheng will find healing from his grief.

Kwek Mean Luck
Judge of the High Court

The applicant in person;
Dierdre Grace Morgan and Emily Zhao (Attorney-General's Chambers) for the Attorney-General.
