立法會
Legislative Council

LC Paper No. CB(2)2092/02-03
(These minutes have been seen by the Administration)

Ref : CB2/PL/SE+HS

Panel on Security
and
Panel on Health Services

Minutes of joint meeting
held on Wednesday, 5 March 2003 at 10:45 am
in the Chamber of the Legislative Council Building

Members present : Panel on Security

Hon LAU Kong-wah (Chairman)
Hon Margaret NG
Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP
Hon CHEUNG Man-kwong
Hon Andrew WONG Wang-fat, JP
Hon WONG Yung-kan
Hon Howard YOUNG, JP
Hon Ambrose LAU Hon-chuen, GBS, JP
Hon Audrey EU Yuet-mee, SC, JP

Panel on Health Services

Dr Hon LO Wing-lok (Chairman)
♦ Hon Michael MAK Kwok-fung (Deputy Chairman)
Hon CHAN Kwok-keung
Hon Andrew CHENG Kar-foo
Hon LI Fung-ying, JP

Member attending : Hon Emily LAU Wai-hing, JP

Members absent : Panel on Security

Hon James TO Kun-sun (Deputy Chairman)
Hon Albert HO Chun-yan
Dr Hon LUI Ming-wah, JP
Hon IP Kwok-him, JP

Action

Panel on Health Services

Hon Cyd HO Sau-lan
Hon CHAN Yuen-han, JP
Hon Mrs Sophie LEUNG LAU Yau-fun, SBS, JP
Dr Hon YEUNG Sum
Dr Hon LAW Chi-kwong, JP
Dr Hon TANG Siu-tong, JP

♦ Also a member of Panel on Security
\# Also a member of Panel on Health Services

Public Officers attending :

Mrs Jennie CHOK
Deputy Secretary for Security

Mr David WONG
Principal Assistant Secretary for Security

Mr Kelvin S Y PANG, CSDSM, JP
Commissioner of Correctional Services

Mr CHAN Chun-yan, CSDSM
Assistant Commissioner of Correctional Services (Operations)

Mr Vanny M C WONG
Superintendent (Nursing and Health Services)
Correctional Services Department

Mr LEUNG Kam-shing
Superintendent (Siu Lam Psychiatric Centre)
Correctional Services Department

Mr NG Chee-kin
Deputy Regional Commander (New Territories North)
Hong Kong Police Force

Clerk in attendance :

Mrs Sharon TONG
Chief Assistant Secretary (2) 1

Action

Staff in attendance	:	Mr LEE Yu-sung Senior Assistant Legal Adviser 1 Ms Dora WAI Senior Assistant Secretary (2) 4

Action

I. Election of Chairman

Mr LAU Kong-wah was elected Chairman of the joint meeting.

II. Follow-up on issues relating to the death of an inmate in Siu Lam Psychiatric Centre in November 2001 - security-related issues

(LC Paper Nos. CB(2)1323/02-03(01), CB(2)947/02-03(01) and (02))

2. Commissioner of Correctional Services (C of CS) briefly took Members through the Administration's response to security-related issues raised by Members at the meeting on 23 January 2003 as set out in its paper. He informed Members that 28 of the 34 recommendations made in Chapter 10 of the report of the special task group had already been implemented. For the remainder, two recommendations relating to improvement to the closed circuit television (CCTV) monitoring systems in other penal institutions were being actively pursued, while the remaining four were being followed up by the Correctional Services Department (CSD) and the Security Bureau (SB).

3. C of CS said that Members who had visited Siu Lam Psychiatric Centre (SLPC) on 4 March 2003 should have a better understanding of the management and operation of the Centre. He pointed out that the arguments relating to the cause of death of CHEUNG Chi-kin (the deceased) put forward by Mr LEUNG Kam-shing, Superintendent (SLPC), CSD (S(SLPC)/CSD), during the visit was made from his personal observations. C of CS added that Mr LEUNG was an experienced psychiatric nursing officer and was currently the deputy head of SLPC.

4. Mr Michael MAK enquired about the feasibility of providing/improving the following facilities in SLPC from the security perspective as follows -

(a) provision of an intercom system, preferably with recording feature, inside the 20 rooms in the Observation Unit of the Admission Ward (the Observation Unit) to enable two-way communication between inmates and CSD staff; and

(b) modifications to existing observation windows or installation of transparent doors for the 20 rooms in the Observation Unit to enhance the monitoring of the activities inside these rooms by CSD staff.

Action

5. C of CS said that each of the 20 rooms in the Observation Unit had already been equipped with a bell to enable the inmate thereat to call out CSD staff when required. He pointed out that for the sake of security and personal safety of inmates, it was not advisable to provide any devices with power connection, such as an intercom system, inside a cell. Nevertheless, he agreed to further examine the practicality of installing an enhanced communication system inside the 20 rooms.

6. S(SLPC)/CSD said that staff of SLPC had been liaising with the Architectural Services Department on improvement works to the design of observation windows of the 20 rooms in the Observation Unit. The new design would enable CSD staff to have a complete view of the condition inside each room. The improvement works had been scheduled to commence in April 2003. Apart from improving the observation windows, CCTV cameras, which could capture the full view of a room, were being installed in the 20 rooms with a view to strengthening the monitoring of inmates thereat.

7. Mr Michael MAK asked about the reason why inmates, upon admission to SLPC, had to be put in solitary confinement. S(SLPC)/CSD responded that the purpose of locating a newly admitted inmate singly in a cell was to enable CSD staff to closely observe his behaviour and assess his mental state with a view to ascertaining his suitability to integrate with other inmates. If the mental state of a newly admitted inmate was stable, he would be relocated to a dormitory-type ward one or two days after his admission.

8. S(SLPC)/CSD added that an inmate who was sent to SLPC direct from court would also be located singly in a cell until there was no sign of remains of drugs in his urine samples. C of CS said that inmates in remand centres were also required to undergo similar procedure for security purpose.

9. Superintendent (Nursing and Health Services), CSD (S(N&HS)/CSD) highlighted that the prime objective of locating a newly admitted inmate in a single room was to facilitate the provision of appropriate treatment to him rather than isolating him from other inmates. He added that extremely refractory inmates who needed to be separated from other inmates for safety reason would be located in protected rooms.

10. Mr CHEUNG Man-kwong said that he remained dubious about the following -

(a) the reason for the high level (9.7 *ug*/mL) of chlorpromazine found in the blood of the deceased, having regard to the medical records which revealed that the deceased had not received any sedative injections in either SLPC or Lai Chi Kok Reception Centre (LCKRC) and no prescription for such injections had been made during his stay in these two centres; and

(b) the reason why there were four fresh needle marks on the shoulders of the deceased (three on the right and one on the left). The three needle marks on the right shoulder were particularly questionable as, according to his mother, the deceased was right-handed.

Action

11. C of CS said that he was unable to provide the reason why there was a high level of chlorpromazine in the blood of the deceased because, according to the relevant medical records, sedative injections had neither been administered on or prescribed for the deceased during his stay at SLPC or LCKRC. He added that S(SLPC)/CSD would provide his own views in this regard later at the meeting.

12. Mr CHEUNG Man-kwong noted that the CCTV tape recorded in the Observation Unit had only 17 hours of recording and that the special task group had made a comment in paragraph 7.6 of its report that another CCTV tape which had been recorded in the control room, though operated in a time-lapse mode, could have supplemented what had happened during the missing seven hours had it not been blurred. In view of this, he asked whether there were any clear recorded images which could show the activities leading up to the death of the deceased inside his cell, in particular the period between 4:00 am and 5:25 am on the day when the deceased was found unconscious because he gathered that the deceased still had respiratory movement inside the cell at approximately 4:00 am.

13. C of CS pointed out that the video cassette recorder (VCR) in the Observation Unit had been out of order since 16 November 2001, i.e. one day before the transfer of the deceased to SLPC. The staff responsible for the respective recording work had been on leave on 16 and 17 November 2001. When proceeding with the recording duties upon his return to work on 18 November 2001 at around 9:00 am, the staff concerned discovered that a tape was jammed in the VCR. He had, therefore, pressed the "eject" button and switched off the machine with a view to fixing it up. As he was not a professionally trained repairman, he did not perform the necessary re-setting procedures after re-starting the VCR. Despite this, he managed to insert a tape into the machine for recording. This might be the reason why the recording time had not been properly displayed on the images on the tape.

14. C of CS further pointed out that according to the expert advice from the Police, the local CCTV system, i.e. the one in the Observation Unit, had maintained about 17 hours of continuous and untampered videotape showing clear images of 10-odd hours' activities leading up to the incident, including the proceedings of discovery and rescue, and shortly going beyond the incident. This meant that the activities inside the cell during the period from 4:00 am to 5:25 am on the day of the incident had indeed been fully and clearly recorded by the local CCTV system. Based on expert advice, the reason for the non-recording of seven hours might be caused by a late start of the usual recording process.

15. C of CS added that the images on the tape recorded by the local CCTV system had been reproduced into photographs for detailed examination by the Coroner's Court. However, due to technical reasons, photographs could not be developed from the tape recorded by the central system inside the control room. Given that the central system displayed and recorded images captured by 120 surveillance cameras installed in different locations of SLPC in a sequential and cyclical manner, it might not be easy to swiftly identify the images of the activities in a particular cell. Nevertheless, he believed that a search on the tape on a frame-by-frame basis would help locate certain images of the activities in a particular cell.

Action

16. Mr CHEUNG Man-kwong queried whether there had been any negligence on the part of the management of SLPC over its failure to adopt adequate procedure in the past to ensure the replay quality of their videotapes.

17. C of CS said that videotapes used to be utilised for 30 times before disposal. Their replay effects had been tested from time to time and the results were found to be acceptable. Thus, he did not consider that the management of SLPC had any negligence in this regard. He informed Members that after review, a 14-time re-usable limit for videotapes had been adopted with a view to achieving better replay effects.

18. Deputy Regional Commander (New Territories North), Hong Kong Police Force (DRC(NTN)/HKPF) said that the expert of the Technical Services Division of the Police, who had examined the CCTV tape recorded in the Observation Unit, had made two witness statements regarding his examination on the tape. The expert derived that the first segment of the tape contained only 16.97 hours of recording with clear images of activities relevant to the incident. The recording should start at around 2:00 pm on 16 November 2001 and finish at around 6:00 am on 17 November 2001. In other words, clear images of activities between the period from around 9:00 am to 2:00 pm was missing in the tape. He considered that this might be the reason for the remark made by the special task group that the tape recorded in the control room could have supplemented what had happened during the missing hours had it not been blurred.

19. DRC(NTN)/HKPF further said that the second segment of the tape comprised some 40 minutes of previous recording with images not related to the incident and approximately 33 hours of fresh tape without any recording. In his second statement, the expert opined that there was at present no technology that could recover previous images from videotapes which had been rewritten upon due to rearrangement of the magnetic pattern after the overwriting operation.

20. DRC(NTN)/HKPF added that based on the images on the tape recorded in the Observation Unit, the deceased had no movement inside the cell most of the time. In view of the limited angle of the surveillance camera in the cell occupied by the deceased, the Police was unable to view clearly certain activities in several critical moments, e.g. the moment when there were three persons in the cell applying first-aid treatment to the deceased.

21. Mr Howard YOUNG enquired whether the CCTV monitoring systems were reliable in detecting irregularities of inmates inside their cells. In his view, it was difficult to ascertain from a display screen whether an inmate had made any movement while he was sleeping.

22. C of CS said that surveillance by CCTVs only served as a supplement to the patrolling system. All occupied cells in the Observation Unit would be patrolled at 15-minute intervals at night for close monitoring of the condition of the inmates thereat. In view of the vulnerability and unpredictability of the inmates in the Observation Unit, ward patrol staff would pay particular attention to these inmates to ensure their safety. In the incident, the ward patrol staff on duty activated the necessary emergency procedure after

Action

observing that the deceased had remained in his sleeping position since the last patrol and did not show any sign of respiration.

23. Ms Emily LAU said that during the visit to SLPC on 4 March 2003, CSD staff had provided Members with two information notes on some new points relating to the cause of death of the deceased. She suggested that the Administration should examine the points raised by the staff and assess the need to reopen an inquiry to further investigate into the case with a view to finding out the truth. While appreciating that the Legislative Council (LegCo) might not be an appropriate party for making an application to reopen the case, she enquired about the way forward of the Panel on Security and Panel on Health Services in following up issues relating to the incident as well as the Administration's view on reopening the case.

24. Senior Assistant Legal Adviser 1 (SALA1) said that section 20 of the Coroners Ordinance (Cap. 504) provided that where an inquest had been held, the Court of First Instance might, upon the application of a properly interested person or the Secretary for Justice, order another inquest if it was satisfied that, by reason of the discovery of new facts or evidence, or other grounds such as rejection of evidence or insufficiency of inquiry as stipulated in section 20(1)(b), it was necessary or desirable to hold such inquest.

25. SALA1 added that properly interested persons were specified in schedule 2 to the Ordinance, which included the following -

(a) parents and siblings of the deceased;

(b) an authorised representative of a Government department which was concerned with the death of the deceased; and

(c) any other person who, in the opinion of a coroner, should be regarded as a properly interested person by reason of any particular interest in the circumstances surrounding the death of the deceased.

SALA1 pointed out that Members of LegCo were not properly interested persons in schedule 2.

(*Post-meeting note* : A copy of section 20 of the Coroners Ordinance tabled at the meeting was circulated to Members vide LC Paper No. CB(2)1399/02-03 on 6 March 2003.)

26. C of CS said that being a properly interested party over the incident and in the interests of the public, CSD was willing to further pursue the case as appropriate, with a view to finding out the truth about the death of the deceased.

27. The Chairman enquired about the details of the points raised in the two information notes referred to in paragraph 23 above, and the reason why the information had been brought to the attention of Members at such a late stage.

Action

28. S(SLPC)/CSD said that the problem identified in the CCTV tape and the high level (9.7 *ug*/mL) of chlorpromazine found in the blood of the deceased had not come to the attention of CSD staff until nearly one year after the occurrence of the incident when the death inquest was held. Given the open verdict returned by the Coroner's Court, he considered it worthwhile to carry out a research in the light of the findings in the autopsy report with a view to identifying the cause leading to such a high level of chlorpromazine in the blood of the deceased. The points raised in the information notes had been extracted from a variety of reference materials on the day before Members' visit to SLPC.

29. S(SLPC)/CSD pointed out that chlorpromazine was a common anti-psychotic drug, which had been in use for several decades. According to the chemist's testification in the death inquest, the level of chlorpromazine in the blood of a person who had consumed 1 600 mg of chlorpromazine should stand at around 0.5 *ug*/mL. Following this formula, a person had to consume more than 30 000 mg of chlorpromazine if the level of this substance in his blood had to reach the level of 9.7 *ug*/mL. In the case of injections, a person must have received tens of ampoules of chlorpromazine injections if the level of such substance in his blood had reached a level of 9.7 *ug*/mL. Against this background, he did not consider it possible that the deceased had received such a high dosage of chlorpromazine during his some 30 hours' stay in SLPC. In fact, due to strict control of psychotropic drugs, the wards in SLPC would not be provided with such a large quantity of chlorpromazine.

30. S(SLPC)/CSD further said that due to its relatively high lipid solubility, chlorpromazine was prone to accumulate in the adipose tissues of a person who had a long history in consuming this drug. Chlorpromazine might also accumulate in the drug user's brain and liver over time. He briefed Members on his following observations concerning the circumstances where the release of a large amount of chlorpromazine accumulated in a human body could occur -

Effects of diabetes mellitus

(a) When blood glucose of a fat person with diabetes mellitus was not available for generating energy to meet the needs of the body, adipose tissues would be decomposed to help generate the required energy. After the decomposition, the agents accumulated in adipose tissues, such as chlorpromazine, would be released to blood vessels;

(b) There was a complication of diabetes mellitus called "ketoacidosis", which resulted from the by-products of fat metabolism when glucose was not available to be used as a fuel source of the body. Diabetic ketoacidosis would develop when the blood was more acidic than body tissues. The presence of acetone in blood and urine might be an indication of ketoacidosis. According to the pathologist's report, the acetone level of the deceased was high;

(c) The deceased was a fat gentleman with history of diabetes mellitus since childhood who, according to the knowledge of CSD staff, had not taken any medication for diabetes mellitus during the five days under CSD's custody. It was believed that the ingestion of shampoo by the deceased under the influence

Action

of drug withdrawal syndrome while remanded in LCKRC had used a lot of his energy to supplement the needs of his body. The energy might have been generated by his adipose tissues rather than blood glucose because of his diabetes mellitus and thus the agents accumulated in his adipose tissues might have been released;

(d) The consumption of adipose tissues for the generation of energy for the deceased before his death might be evidenced by the loss of 19 kg in weight during his five-day stay in CSD. His body weight upon admission to LCKRC was 84 kg but it had dropped to 65 kg after his death; and

Post-mortem decomposition

(e) Due to change in body tissues and the general condition of a person after death, adipose tissues might be decomposed. Decomposition of adipose tissues would cause the release of the agents accumulated in these tissues to blood vessels.

31. S(SLPC)/CSD added that sedative injections on inmates required the prescription from a medical officer. Even with such prescription, injections would not be performed unless the inmate concerned had displayed violent or agitated behaviour. Sedative injections would be administered by registered nursing staff. Before performing the injection, the staff concerned had to check the medical condition of the inmate. Information on the general medical condition and the mental state of the inmate would be entered into the nursing report for record. Besides, the reasons why the injection was required would also be recorded in the clinical note for the reference of medical officers.

32. S(SLPC)/CSD further said that details of the use of each syringe, needle and medicine, including the names of the inmate and the nursing staff concerned, would also be properly recorded in a ledger. According to the records in the ledger, which was subject to regular inspections by senior officers, no sedative injection had been administered on the deceased. Given that there had not been any sedative injections prescribed for the deceased during his stay in SLPC, S(SLPC)/CSD could not see any reason for CSD staff to administer sedative injection on the deceased.

33. Considering that some of the information contained in the two information notes provided by CSD staff was confidential, the Chairman asked about the view of the Administration on circulating the information to other Members who had not participated in the visit to SLPC.

34. C of CS said that the two information notes had only been provided to interested Members for reference during the visit. In view of the confidential nature of some data in the information notes, they should not be distributed to other Members and should be kept confidential in the meantime.

35. SALA1 said that according to the transcript of the proceedings of the death inquest, apparently the pathologist and the Government chemist of the case had explained to the

Action

Coroner and the jury the likely effects of post-mortem redistribution on the blood concentration level of the deceased.

36. SALA1 pointed out that in case there were new facts or evidence, or there was insufficiency of the inquiry already held, another inquest might be conducted under any of the circumstances stipulated in section 20(1)(b) and (c) of the Coroners Ordinance. He believed that the question whether the points raised in the two information notes were valid, whether they had been sufficiently covered at the inquest already held, or whether they were new facts or evidence would need to be considered with the assistance of experts.

37. Ms Emily LAU noted from the Coroner's summing-up that the cause of death of the deceased as suggested in the autopsy report was the adverse effect of chlorpromazine, methadone and ethyl alcohol. The pathologist considered that diabetes mellitus was not the significant cause leading to the death of the deceased.

38. Ms Emily LAU enquired when the Administration had started to consider carrying out further investigation into the case. She hoped that the Administration would explore a viable and appropriate option to follow up matters relating to the incident, after thoroughly examining the points raised in the two information notes as well as the arguments and issues already discussed at the inquest conducted by the Coroner's Court. She considered that such further investigation would not only help relieve the stress caused by the incident on CSD staff but would also prevent the recurrence of similar incidents.

39. Assistant Commissioner of Correctional Services (Operations) said that discussion on ways to follow up the case in the light of the points raised in the two information notes had only started at the return journey after the visit to SLPC on 4 March 2003. As the points raised were personal observations of CSD staff, he suggested that expert advice be sought on the validity of these points before a decision on the way forward in respect of the case was made.

40. C of CS said that as the information in question had only been brought to his attention during the visit on 4 March 2003, the points raised in the two information notes would be examined in detail by CSD and SB in consultation with medical experts. Legal advice would also be sought on viable options to pursue the case.

41. Referring to the observation of S(SLPC)/CSD referred to in paragraph 30(c) above, Ms Emily LAU queried why the deceased had not been provided with medication for diabetes mellitus while in CSD's custody. She was surprised that CSD had not been aware that the deceased had suffered from diabetes mellitus, and asked about the procedure for conducting medical check on inmates upon their admission to penal institutions.

42. Dr LO Wing-lok shared similar concern of Ms Emily LAU. He was concerned whether penal institutions had adequate facilities to detect whether an inmate had any internal disease and to provide appropriate treatment accordingly. He enquired whether the deceased had consumed any food and/or drink during the some 30 hours in SLPC and whether any urine test had been conducted to ascertain his internal medical condition. He also enquired whether there was established procedure for handling inmates who refused to

Action

eat, drink and/or provide urine samples.

43. S(SLPC)/CSD said that the deceased had been sent to SLPC direct from the Queen Elizabeth Hospital. Upon arrival at the Centre, the deceased looked very tired and was barely responsive. In view of his weak condition, CSD staff had paid particular attention to him throughout his stay in SLPC. Medical examinations, including a check on the blood pressure, pulse and body temperature, had been conducted on the deceased no less than four times a day. Details of his medical condition after each examination had been recorded. In fact, CSD nursing staff had informed the medical officer of the deceased's general medical condition soon after his admission to the Centre. The medical officer had prescribed some medicines for the deceased based on the reported medical condition. The medical officer had personally examined the deceased in the morning following the day of his admission.

44. S(SLPC)/CSD further said that food and water had been provided to the deceased regularly. According to the CSD staff on duty, the deceased had sat inside the cell occasionally and had drunk some water but had not returned any urine samples despite the requests from CSD staff. As a result, no urine test had been conducted during his stay. Coupled with the uncooperativeness of the deceased in answering enquiries on his medical history, the fact that he had diabetes mellitus was therefore not known by CSD staff.

45. S(N&HS)/CSD said that as no intake and output chart in respect of the deceased had been prepared, CSD was unable to provide information on the exact quantity of food and water consumed by the deceased as well as the volume of urine he excreted. S(N&HS)/CSD, however, pointed out that according to the statements of the CSD staff given at the court hearing, the deceased had consumed some food and water during his stay in SLPC. In fact, a record book on return of food had been presented to the Coroner's Court during its hearing on the case, which also revealed that the deceased had consumed food and water during his stay in the Centre.

46. S(N&HS)/CSD also pointed out that the non-return of urine samples by the deceased, although he had been provided with a urine sample container, might not necessarily mean that he had no urinary excretion during the 30-odd hours in SLPC.

47. Ms Audrey EU held the view that a select committee of LegCo might not be an appropriate way to follow up the case as the parties involved in the incident could not be represented by counsel or solicitor if the inquiry was conducted by LegCo. She considered that a new inquest held by the Coroner's Court might also not be a desirable way to follow up the case in view of the limitations in what a coroner or jury might include in the finding. Moreover, not all the parties involved in the incident were entitled to be represented by lawyers at inquests conducted by the Coroner's Court.

48. Ms Audrey EU considered that the appointment of a Commission of Inquiry under the Commissions of Inquiry Ordinance (Cap. 86) might best serve the purpose in the context of this case, since the powers of a Commission of Inquiry could be much wider than that of the Coroner's Court and LegCo. She recalled that in 1980, a Commission of Inquiry had been appointed to look into the cause and surrounding circumstances leading to the death of Police Inspector MacLennan. One of the terms of reference of the Commission was to

Action

inquire whether there were good grounds for believing that the death of the inspector was other than suicide. She added that there were a lot of inquiries conducted in the past for the purpose of inquiring into matters of great public concern. She cited the appointment of an independent inquiry to look into the Lan Kwai Fong disaster as an example.

49. Ms Audrey EU enquired whether the family of the deceased had initiated any legal proceedings and whether they had applied for legal assistance from the Legal Aid Department (LAD). She also enquired whether the holding of a new inquest, a Commission of Inquiry or an inquiry by LegCo would affect the continuation of the case or the commencement of legal proceedings, as the case might be.

50. Deputy Secretary for Security (DS for S) responded that the family of the deceased had applied for legal assistance from the Government. Their application had already been approved by LAD. However, the Administration had not yet received any related documents in respect of the case.

51. Miss Margaret NG pointed out that the terms of reference of an inquest conducted by the Coroner's Court was indeed very limited. The main duties of a coroner or jury was to identify the cause of death of a deceased and to make general recommendations to the system in question. It should be noted that the making of recommendations was at the discretion of the Coroner's Court. In her view, if the Administration intended to further pursue the case by another inquest in accordance with section 20 of the Coroner's Ordinance, she would suggest that the application for holding the new inquest be put forward by the Secretary for Justice on grounds of public interests. She believed that this course of action would help reinstate the integrity of CSD and enhance the public's confidence in the Department and the Government as a whole.

52. Miss Margaret NG shared the view of Ms Audrey EU that the scope of a Commission of Inquiry could be much broader as compared with other inquests or inquiries. In accordance with the Commissions of Inquiry Ordinance, the Chief Executive in Council might appoint Commissioner(s) to inquire into any matter of public importance. She considered that the appointment of a Commission of Inquiry would be the most desirable and appropriate approach to inquire into the cause and surrounding circumstances leading to the death of the deceased. Upon the completion of the work of the Commission, any deficiencies in the existing system the Commission had identified should be properly followed up by the relevant authorities.

53. Members were in general supportive of conducting further investigation into the case by means of a reasonable and legally viable approach, with a view to finding out the truth of the incident and doing justice to CSD, its staff and the family of the deceased. Members believed that the improvements to be made to the existing system in the light of the deficiencies, if any, identified in the course of further investigation would effectively help prevent the recurrence of similar incidents and bring about benefits to all the parties concerned.

54. In considering the appropriate way forward in following up the case in the light of the purported new points raised by CSD staff, SALA1 was requested to provide a paper on the

SALA1

Action

following for Members' reference -

(a) the various options available with examples of previous cases and an analysis of the most appropriate option in the context of this case; and

(b) whether further inquiries would affect the progress of legal proceedings taken by the family of the deceased.

(*Post-meeting note* : An information paper on the above prepared by SALA1 (LC Paper No. LS80/02-03) was circulated to Members vide LC Paper No. CB(2)1628/02-03 on 28 March 2003.)

55. In response to the Chairman, DS for S said that medical experts' advice on the new points raised in relation to the cause and surrounding circumstances of the death of the deceased would be sought as soon as possible. Legal advice would also be sought on viable options to follow up the case in light of the advice to be obtained from medical experts. She hoped that the relevant information could be available in April 2003.

56. A majority of Members were of the view that the work of the Panel on Security and Panel on Health Services in following up issues relating to the incident would hinge on the Administration's way forward in respect of the case. In view of this, Members considered that discussion on the Administration's way forward in respect of the case should be held first before deciding on the timing for holding follow-up discussion on how to improve the overall system, including the quality and standards of medical, psychiatric and nursing services provided at SLPC.

57. Members agreed that the joint meeting of the two Panels originally scheduled for 7 March 2003 to discuss medical-related issues be cancelled and that a joint meeting of the two Panels be held in April 2003 for a follow-up discussion on the Administration's way forward in respect of case.

(*Post-meeting note* : With the concurrence of the Chairmen of the two Panels, the meeting has been scheduled for 29 April 2003 at 8:30 am. At the request of the Administration and with the concurrence of the two Panel Chairmen, the meeting has subsequently been cancelled as the Administration expects that it may be some weeks before the experts will be ready to give their opinion on the medical hypothesis put forward by CSD staff.)

58. Mr Michael MAK took the opportunity to appeal to the Administration and the general public not to put too much pressure on CSD staff over the incident. He said that in fact, the series of recommendations put forward by the special task group for implementation in SLPC and some other penal institutions had brought about a cultural change to the long-established work practice in these institutions. He hoped that the public would appreciate the difficulties and work pressure faced by CSD staff.

Action

III. Any other business

59. There being no other business, the meeting ended at 12:45 pm.

Council Business Division 2
Legislative Council Secretariat
15 May 2003