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Panel on Security

Minutes of special meeting held on Tuesday, 5 November 2002
at 10:45 am in the Chamber of the Legislative Council Building

Members present	:	Hon LAU Kong-wah (Chairman) Hon James TO Kun-sun (Deputy Chairman) Hon Margaret NG Hon CHEUNG Man-kwong Hon Andrew WONG Wang-fat, JP Hon Howard YOUNG, JP Hon Ambrose LAU Hon-chuen, GBS, JP Hon Michael MAK Kwok-fung Hon IP Kwok-him, JP Hon Audrey EU Yuet-mee, SC, JP
Members attending	:	Hon Cyd HO Sau-lan Hon Emily LAU Wai-hing, JP Hon LEUNG Fu-wah, MH, JP Dr Hon LO Wing-lok
Members absent	:	Hon Albert HO Chun-yan Dr Hon LUI Ming-wah, JP Hon Mrs Selina CHOW LIANG Shuk-yee, GBS, JP Hon WONG Yung-kan
Public Officers attending	:	Mrs Jennie CHOK Deputy Secretary for Security Mr Benny C K NG Commissioner of Correctional Services

Mr Kelvin S Y PANG
Deputy Commissioner of Correctional Services

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

Dr Raymond TU Chie-tsing
Senior Medical Officer
Department of Health

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

Attendance by invitation : Mr LAM

Mr LEUNG

Mr YU

Mr LAW Yuk-kai
Director, Hong Kong Human Rights Monitor

Clerk in attendance : Mrs Sharon TONG
Chief Assistant Secretary (2) 1

Staff in attendance : Mr LEE Yu-sung
Senior Assistant Legal Adviser 1

Ms Dora WAI
Senior Assistant Secretary (2) 4

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I. Issues relating to the death of an inmate in Siu Lam Psychiatric Centre in November 2001
(LC Paper No. CB(2)231/02-03(01))

The Chairman said that three members of the public, Messrs LAM, LEUNG and YU, who had previously served prison sentence in penal institutions in Hong Kong (ex-inmates), would express their views relating to the administration of sedatives in such institutions to Members at the meeting. In addition, a representative from Hong Kong Human Rights Monitor (HKHRM) would present the views of HKHRM on issues relating to the death of an inmate in Siu Lam Psychiatric Centre (SLPC) in November

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2001.

2. The Chairman said that two of the three ex-inmates, Messrs LEUNG and YU, had expressed the view that they did not wish to appear in public nor did they wish to disclose their personal identity. Therefore, arrangements had been made for them to be seated in a simultaneous interpretation room to present their views to Members. Against this background, the Chairman appealed to the media to respect their wish and not to take/publish any photograph of these two individuals. Ms Emily LAU concurred with the Chairman and asked the media to respect Messrs LEUNG and YU's right to privacy.

3. The Chairman informed Members that he had, on behalf of the Panel, replied to Ms Emily LAU regarding the requests from two serving prisoners for attending this meeting to present their views relating to the administration of sedatives in penal institutions. He said that they were welcomed to attend the meeting if they had permission for their attendance granted by the Commissioner of Correctional Services (C of CS). A reply by the Correctional Services Department (CSD) to a public enquiry concerning the two prisoners' requests provided by Ms Emily LAU was tabled at the meeting for Members' reference.

(*Post-meeting note* : CSD's reply was circulated to Members vide LC Paper No. CB(2)290/02-03 on 6 November 2002.)

4. C of CS pointed out that section 12 of the Prisons Ordinance (Cap. 234) clearly stipulated the circumstances where the attendance of a prisoner at a certain place for a certain purpose might be granted. The section read as follows -

"(1) When the attendance of any prisoner at any place is required by a court, tribunal or other body performing judicial functions or for the purposes of any enactment, the Commissioner shall arrange for his transfer in custody to and from such place, and during any such transfer the prisoner shall be deemed to be in legal custody.

(2) Without prejudice to subsection (1), if the Chief Executive, after consultation with the Commissioner, is satisfied that the attendance of a prisoner at any place is desirable in the interests of justice or for the purposes of any public inquiry, the Chief Executive may by order direct that prisoner to be taken to that place in pursuance of such interests or for such purposes and while absent from a prison in pursuance of such order the prisoner shall be deemed to be in legal custody."

5. C of CS said that since the attendance of the two serving prisoners at this Panel meeting did not fall within the circumstances provided in section 12 of the Prisons Ordinance, arrangements could not be made for them to attend the meeting.

6. The Chairman said that the views of serving prisoners would unquestionably

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provide useful reference for Members to better understand the operation in penal institutions. However, if the two prisoners were, by law, unable to attend a meeting of the Panel to present their views, they might consider forwarding their views to Members through other means, such as written submission or audio tape.

7. In response to Ms Emily LAU's question, C of CS said that a request for attendance made under section 12(2) of the Prisons Ordinance would be duly considered provided that the pre-condition set out in section 12(1) was satisfied. He stressed that CSD welcomed any member of the public to give views or provide information/evidence relating to the case as CSD did hope to find out the cause of the incident.

8. Ms Emily LAU asked whether C of CS would make necessary arrangements for the two prisoners to appear before the Panel to give evidence if an inquiry into the incident was conducted by the Panel.

9. Senior Assistant Legal Adviser 1 (SALA1) said that the Legislative Council (Powers and Privileges) Ordinance (Cap. 382) empowered the Legislative Council (LegCo) and its standing committees to order any person to attend before LegCo or any of such committees and to give evidence or produce any document in the possession or under the control of that person. Such powers conferred on a standing committee might be exercised by any other committee of LegCo, such as a Panel, provided that the committee was specially authorised by a resolution of LegCo to exercise such powers in respect of any matter specified in the resolution. Pursuant to this power, the Panel might go through the necessary procedure to bring required persons before the Panel.

Briefing by the Administration

10. Deputy Secretary for Security (DS for S) said that the Administration was very concerned and felt regret about the death of an inmate Mr CHEUNG Chi-kin (the deceased) in SLPC, and would like to take this opportunity to convey the Administration's regards to Mr CHEUNG's family. She further said that the Police had conducted an in-depth investigation into the incident since its occurrence in November 2001 but there was no evidence of any illegal act involved in the incident. The Police's investigation report had already been submitted to the Coroner's Court for the purpose of conducting a death inquest on the case. After the inquest, the Coroner's Court had returned an open verdict with the following two recommendations -

(a) to improve the medicine prescription forms, listing consumed and yet to be consumed medicine; and

(b) to improve the closed circuit television (CCTV) and recording systems.

11. DS for S said that although the Coroner's Court had not attributed the incident to any inadequacies in the management of SLPC, CSD had, apart from following up the two recommendations referred to in paragraph 10 above, set up a special task group to conduct a detailed study into the circumstances surrounding the case with a view to

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enhancing the quality of service at SLPC so as to prevent recurrence of similar incidents in future. Major areas to be reviewed included the procedures for handling medical drugs, administration of medication to inmates and the overall monitoring mechanism in these respects. The terms of reference of the special task group were detailed in paragraph 29 of the Administration's paper.

12. C of CS said that CSD was deeply concerned about the death of any inmate while in its custody. In Mr CHEUNG Chi-kin's case, a seven-day death inquest involving 57 witnesses had been conducted by the Coroner's Court in conjunction with investigation by the Police. The special task group, headed by the Deputy Commissioner of Correctional Services (DC of CS) with two non-official Justices of Peace (JPs) included as Members, would complete its work in six weeks' time, i.e. around mid-December 2002. It would report its findings and recommendations, if any, to the Security Bureau and the Panel in due course.

13. DC of CS supplemented that other Members of the special task group were two Assistant Commissioners of Correctional Services, a Consultant Psychiatrist from the Hospital Authority and a Superintendent (Nursing and Health Services) of CSD. He also briefed Members on the following aspects as detailed in the Administration's paper -

(a) the guidelines and procedures for the administration of sedatives to inmates;

(b) the patrolling system of cells;

(c) the guidelines and procedures for monitoring the CCTV systems installed in inmate cells, and the recording and keeping of the CCTV tapes; and

(d) the progress of the project for the improvement of the CCTV system of SLPC.

Meeting with individuals/deputation

14. The Chairman drew Members' attention that discussion should be focused on the policies, systems and procedures involved in the incident. The findings of the Coroner's Court and the imprisonment experiences of the three ex-inmates should be taken as reference to facilitate discussion on how the quality of service at SLPC could be improved. Detailed study into the incident in question or individual cases should be avoided. The Chairman also reminded the attending individuals/deputation that when addressing the Panel, they would not be protected by the immunity under the Legislative Council (Powers and Privileges) Ordinance (Cap. 382).

Views of Mr LAM

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15. Mr LAM commented that the membership of the special task group was not trustworthy. In his view, CSD should only appoint those who were trusted upon by the public in order to enhance public confidence in the work of the task group. He added that to his knowledge, sedative injections to inmates in penal institutions had not always been prescribed by medical officers. He considered that there should be a mechanism to better monitor the injection of sedatives to inmates in order to protect their safety.

16. Mr LAM further said that in 1990, he had lodged a complaint with the then Office of the Commissioner for Administrative Complaints Hong Kong (the then COMAC), currently known as The Ombudsman, against CSD staff for abuse of power. A letter dated 6 June 1990 from the then COMAC, setting out its findings of the investigation into the complaint, had been issued to him. He considered that the findings of the then COMAC would provide useful reference for Members to better understand issues relating to the incident. It was clearly stated in the letter that the then COMAC had found that the series of injections given to him in SLPC were without proper authorisation from medical officers before and after the injections.

17. Mr LAM said that he had intended to provide Members with the letter. However, he was informed that according to legal advice obtained by the LegCo Secretariat, prior written consent from The Ombudsman should be obtained before the letter could be circulated. He had enquired with The Ombudsman who had advised him that the legislation did not require him to keep the letter confidential. He then provided the Chairman with The Ombudsman's written reply in this regard.

18. SALA1 said that under the common law, any person in receipt of any information with the knowledge that the information was confidential had a responsibility to keep it confidential. Based on this principle, such information should not be released to a third party unless with the consent of the author. Similarly, any person in receipt of any information from a third party with the knowledge that the information was confidential should also not disclose it to other party/parties unless with the author's consent.

19. SALA1 further said that pursuant to The Ombudsman Ordinance (Cap. 397), the Ombudsman had to inform the complainant of the result of the investigation carried out by the Office of The Ombudsman. As there was a "Confidential" chop on the letter from the then COMAC to Mr LAM, it was a clear indication that the giver of the information intended it to be kept confidential, the receiver and a third party would have a duty under the common law to keep the letter in confidence unless consent to disclose was obtained. SALA1 observed that The Ombudsman's written reply did not explicitly give consent for the disclosure of the letter but merely stated the position in the Ordinance. The Chairman asked SALA1 to further examine the appropriateness of circulating the letter to Members.

(*Post-meeting note* : On the confirmation from The Ombudsman that she had no objection to circulation and with the concurrence of the Chairman, the letter was

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circulated to Members vide LC Paper No. CB(2)293/02-03 on 6 November 2002.)

Views of Mr LEUNG

20. The Chairman drew Members' attention to Mr LEUNG's request that his submission, tabled at the meeting, should be restricted to Members of the Panel and non-Panel Members who attended the meeting. All other parties, including the Administration, should not be provided with the submission.

21. Mr LEUNG presented his views as set out in his submission. He said that injection of sedatives to inmates in penal institutions had, on many occasions, been made on punitive grounds rather than for medical reasons. He had seen inmates being given sedative injections without medical officer's prescription.

22. Mr LEUNG expressed concern about the complaints mechanism in penal institutions. He considered that the powers conferred on CSD staff under the Prisons Ordinance to open and search complaint letters written by inmates had prejudiced their rights to make complaints. To his knowledge, some complaints with substantial grounds had been screened out by CSD staff. Besides, there had been occasions where CSD staff had prevented some "uncooperative" or "problematic" inmates from seeing visiting JPs in order to curb them from lodging complaints with these JPs. He hoped that the human rights of inmates in penal institutions could be better protected.

(*Post-meeting note* : Mr LEUNG's submission was circulated to absent Members under "Restricted Cover" vide LC Paper No. CB(2)295/02-03 on 6 November 2002.)

Views of Mr YU

23. Mr YU said that his views were similar to those of Mr LEUNG. He understood that it had been a common practice in penal institutions that "problematic" inmates would be sent to SLPC for sedative injection as a punishment. He noted the requirement that the ward patrol officer should patrol the ward at 15-minute intervals for detection of any abnormality. According to his observation during imprisonment in Stanley Prison, there had only been two ward patrol officers responsible for the wards located on three levels. He expressed doubt as to how the two officers could manage to patrol all these wards at 15-minute intervals and to ensure the safety of inmates in the wards.

Views of HKHRM

24. Mr LAW Yuk-kai, HKHRM presented the views of HKHRM as set out in its submission tabled at the meeting. In brief, he considered that CSD should be held responsible for the safety and health of inmates while they were in its custody. CSD should also ensure that the basic human rights of inmates were duly protected. In addition, he expressed concern about the conflict of role of CSD officers who also

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performed nursing duties. To ensure fairness to inmates, he suggested that officers responsible for correctional duties should not be assigned to also discharge nursing duties.

25. Mr LAW Yuk-kai added that HKHRM had conducted a study on the management of penal institutions in Hong Kong and had released a report on the topic in 1997. One of the major recommendations in the report was the establishment of a dedicated body to perform a monitoring role over the management of penal institutions. The proposal was that such body should be independent from CSD and should engage its own personnel with expertise in prison management for carrying out visiting duties in penal institutions and taking follow-up actions on issues identified during visits. However, the recommendation had not been accepted by the Government.

(*Post-meeting note* : The submission from HKHRM tabled at the meeting was circulated to Members vide LC Paper No. CB(2)290/02-03 on 6 November 2002.)

Issues raised by Members

Composition and work of special task group

26. Ms Emily LAU declared interest as a member of HKHRM. She opined that the special task group, if chaired by a Government official, would lack independence and its impartiality might also be called into question. Having regard to the fact that similar task groups formed in the past had usually been led by non-officials, she questioned why the Government had appointed DC of CS to head the special task group over this incident. Given the lack of confidence expressed by Mr LAM on its membership, she asked whether the Administration would consider reviewing the membership and appointing people who were trusted upon by the general public so as to enhance the credibility of the special task group.

27. DS for S said that she understood Members' concerns over the incident. She assured Members that the Administration would take a serious view on the matter and ensure that proper and thorough follow-up actions would be taken to prevent a recurrence. While investigation into the case was carried out by the Police, a special task group was entrusted to conduct a detailed review of the existing system in SLPC with a view to identifying necessary improvement measures to enhance the overall management of the Centre. The Administration believed that the appointment of two non-official JPs to serve on the special task group could help enhance the transparency of its work. The Security Bureau would closely monitor the progress of the review carried out by the special task group. The outcome of the review would be reported to the Panel once it was available.

28. In response to Ms Emily LAU's enquiry, DC of CS said that the two non-official JPs were Mr Raymond YUNG Hin-kwong and Mr Sammy POONE. Both of them had sound knowledge in penal institution management and were currently serving on the Post-Release Supervision Board.

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29. Mr Michael MAK considered that the scope of the review conducted by the special task group should not be strictly confined to SLPC since certain operations performed in SLPC were also performed in other penal institutions. He said that any change to the existing procedures for these operations should be introduced across the board.

30. DC of CS responded that improvement measures deemed suitable for SLPC would also be introduced to other penal institutions where applicable. For example, if there were changes to the existing guidelines on the use of medical drugs in SLPC, the revised guidelines would be introduced to all penal institutions which had a need to handle medical drugs.

Follow-up actions by the Police in respect of the incident

31. Mr Michael MAK enquired whether the Police had continued its investigation into the case after the return of an open verdict by the Coroner's Court and, if so, whether the investigation was along the line of murder.

32. The Chairman said that he had written to the Commissioner of Police (CP) on the case. CP had advised him that no further follow-up action on the case was necessary at this stage. He questioned whether the Police's investigation work on the case had stopped.

33. Deputy Regional Commander (New Territories North), Hong Kong Police Force (DRC(NTN), HKPF) said that the Police had conducted a detailed and thorough investigation into the incident since its occurrence. The investigation had been completed and the report of which had been submitted to the Coroner's Court for conducting the death inquest. He pointed out that under normal circumstances, the Police would take follow-up actions on cases having an open verdict based on the direction given by the Coroner's Court or the Department of Justice. However, neither of these two parties had given any such direction over the case in question.

34. DRC(NTN), HKPF further said that despite the completion of the investigation mentioned in paragraph 33 above, the Police's follow-up actions were as follows -

(a) reviewing the concluded investigation mentioned in paragraph 33 above to identify whether there was any oversight in the investigation;

(b) obtaining a copy of the record of proceedings of the death inquest conducted by the Coroner's Court to identify whether there would be any new direction/evidence which was conducive to resolving the case; and

(c) conducting further investigation based on any new direction, new evidence identified or any new development in the case.

Existing system in SLPC

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35. Mr CHEUNG Man-kwong queried whether the death of the deceased had reflected a breakdown in the existing system of SLPC, which seemed to be a perfect one based on the information provided by the Administration. He questioned whether the relevant guidelines and procedures had been strictly enforced in daily operation. He considered that the incident might not have occurred should the relevant guidelines and procedures have been fully adhered to.

36. The Deputy Chairman said that based on his past experience in handling complaints from prisoners, he believed that incidents of similar nature of the case in question did exist. In fact, the causes leading to most of these incidents were still unknown after investigations by various parties. He considered that it was most important to set a common goal towards an improvement to the existing system with a view to bring the possibility of recurrence of similar incidents to the minimum. In this connection, he asked whether the Administration had any immediate measures or specific proposals to improve the current system.

37. Superintendent (Nursing and Health Services), Correctional Services Department (S(N&HS), CSD) responded that the existing system in SLPC had all along been working well. CSD had no difficulties in enforcing the relevant rules and guidelines on the management and operation of penal institutions.

38. DC of CS said that the special task group had already held a meeting to discuss the ways to enhance the overall management of SLPC. As recommended by the special task group, the following new arrangements in respect of the transfer of an inmate to SLPC had already been put in place -

(a) transfer would only be carried out during office hours when the psychiatrist in SLPC was on duty so as to ensure that each inmate would be examined by the psychiatrist upon admission to SLPC; and

(b) the medicines previously prescribed for an inmate before his transfer to SLPC should not be taken to SLPC so as to ensure that a fresh prescription would be given by the medical officer or psychiatrist in SLPC.

39. Mr Michael MAK enquired whether any negligence on the part of CSD nursing staff over the incident had been identified in the internal investigation conducted by CSD.

40. DC of CS said that given that there were already a criminal investigation carried out by the Police and a death inquest conducted by the Coroner's Court over the incident, the internal investigation conducted by CSD had mainly focused on whether the duties discharged by CSD staff had deviated from the established guidelines and procedures. The outcome of the internal investigation revealed that the CSD staff concerned had not been negligent in their duties over the incident. Indeed, the observations and recommendations derived from the internal investigation coincided

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with those suggested by the Coroner's Court. He added that during the course of the internal investigation, two of the control room staff had been found to have deviated from the Superintendent's Order in performing part of their daily duties. However, such deviation was not directly relevant to the incident. Internal disciplinary actions had been taken against these two staff members.

Control on the use of medical drugs in penal institutions

41. Mr CHEUNG Man-kwong pointed out the remarks made by the Coroner's Court that the system of issuing medical drugs by the dispensary in SLPC was not stringent enough. On many occasions, drugs had been issued without medical officer's prescription. In addition, the records for the handling and administration of drugs had not been properly maintained.

42. Mr CHEUNG Man-kwong also pointed out that the Hong Kong Medical Council had issued a set of guidelines for medical practitioners to follow in respect of proper prescription and dispensing of dangerous drugs. Under the guidelines, a medical practitioner who gave a prescription for any dangerous drug was required to keep a detailed record of the prescription. The information required to be recorded included the delivery date of the drugs, name of supplier and details of the patient such as his name, age, address, medical history as well as the date and dosage of prescription for such drugs. Non-compliance with this requirement would be subject to disciplinary action by the Hong Kong Medical Council. He questioned whether these guidelines had been strictly followed in SLPC.

43. S(N&HS), CSD said that SLPC had an independent dispensary and its own dispensers. All medicines used in SLPC were supplied by the Department of Health and subject to central administration to ensure their compliance with the relevant statutory requirements. He stressed that the relevant guidelines and procedures for handling dangerous drugs had been strictly enforced in SLPC.

44. Regarding the existing practices and procedures for the issue of medical drugs in SLPC, S(N&HS), CSD explained that after a medical officer had examined a patient, he would write down the prescription on the Medical History of the patient. The prescription would be copied on a Dispensary Sheet to be initialled by the medical officer. After the medical officer had visited all patients in the ward, the nursing staff would enter the details of all prescriptions into a Dispensary Book for requisition of the medicines from the dispensary, which would keep records of the medicines issued and returned.

45. S(N&HS), CSD said that the medicines received from the dispensary would be stored in a drug cabinet in the ward. The handling of these medicines was subject to established guidelines. The consumption of each pill would be properly recorded and initialled by the ward's nursing staff. However, there might be occasions where a patient had not consumed the medication for one or two times for certain reasons. Under the circumstances, there might be a small surplus of such medicines kept in the ward. These medicines would be returned to the dispensary upon the patient's

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discharge from the hospital according to the procedures set out in the established guidelines. Apart from these excessive medicines, there might also be a small quantity of mild drugs, such as medicines for fever and influenza, stored in the ward's drug cabinet. Nursing officers were allowed to issue these drugs to inmates as and when necessary in view of its moderate efficacy. The issue and consumption of these drugs would also be properly recorded.

46. S(N&HS), CSD believed that the problem relating to the issue of medical drugs brought up by the Coroner's Court might be attributed to the reasons cited in paragraph 45 above. In fact, the findings of the investigation into the incident had revealed that the record of medicines, syringes and needles had been properly maintained with no deficiency found.

47. The Chairman asked whether the requisition of medicines from the dispensary and the injection of medical drugs to inmates must require prior authorisation from a medical officer. He said that according to the three ex-inmates, injections to inmates might be administered without medical officer's prescription. If this was the case, he asked about the circumstances where injections without medical officer's prescription would be allowed.

48. S(N&HS), CSD responded that in practice, injection of sedatives to inmates would only be administered on medical grounds according to medical officer's prescription. There was no question of the so-called "懵仔針" being used as a punitive measure against inmates in penal institutions.

49. S(N&HS), CSD pointed out the nursing officers in SLPC were all civil servants with recognised nursing qualifications. They were either Registered Nurse or Enrolled Nurse and were conversant with the standards required of health personnel in providing health care services to patients as stipulated in various guidelines and international conventions. Coupled with the fact that these officers were mainly working within the hospital precincts and had no direct day-to-day contacts with inmates not under medical or psychiatric care, he could not see why there would be personal conflicts between nursing officers and inmates. As such, he considered that the allegations of sedative injection being used as a punishment against inmates could unlikely be substantiated.

50. S(N&HS), CSD further said that each of the prison hospitals had a resident medical officer on duty during office hours, i.e. from 9 am to 5 pm from Monday to Friday. There would also be a medical officer on call beyond these hours. Inmates admitted to these hospitals during office hours would be examined by the resident medical officer, with prescription given where considered necessary. In cases where an inmate was admitted after office hours, the nursing staff would conduct a brief medical check on the inmate and give him the necessary preliminary treatment. Should there be any symptoms of a more serious nature, the nursing staff would contact the medical officer on call by telephone and report the conditions of the inmate to the medical officer over the phone. The medical officer would decide whether he should return to the hospital immediately to examine the inmate or whether the inmate should

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be sent to an outside hospital for treatment.

51. Regarding injection of sedatives, S(N&HS), CSD said that if an inmate was found to be very unstable and displayed emotional fluctuation during office hours, the resident medical officer would be called upon to examine the inmate and decide whether sedative injection was required. However, there might be occasions where an inmate was extremely unstable and unpredictable, e.g. who displayed suicidal ideation or self-harm tendency, at night when the resident medical officer was not in the hospital. Under the circumstances, the nursing staff would immediately telephone the medical officer on call to report the situation. Sedative injection might be prescribed over the phone if the medical officer, after being consulted over the phone, considered that an immediate injection was necessary to ensure the safety of the inmate as well as the others under such critical situation. He stressed that under no circumstance would nursing staff give sedative injections to inmates without a medical officer's authorisation.

52. S(N&HS), CSD further said that the medical officer who had ordered sedative injection over the phone must return to the prison hospital within approximately 15 minutes to examine the inmate in person, by which time the inmate should have already been sedated or might have fallen asleep. After examining the inmate, the medical officer had to prepare an injury report on the incident. This was a standard requirement in CSD that an injury report should be prepared for every sedative injection with the use of the minimum necessary force.

53. Mr LEUNG said that most of the nursing officers in penal institutions had also received correctional services training. In other words, these officers would be allowed to perform correctional-related duties in addition to nursing duties. Therefore, the possibility that an inmate having personal conflicts with any of these officers might receive sedative injections as a punishment did exist.

54. The Deputy Chairman enquired about the circumstances where an injection of sedatives to an inmate would be considered necessary. He also enquired whether a medical officer would prescribe sedative injection based on his own judgement after examining the inmate or based on the advice of CSD nursing officers. In addition, he asked about the number of sedative injections administered to inmates in penal institutions.

55. Ms Audrey EU asked whether an injection of sedatives to an unstable inmate prescribed by a medical officer over the phone must subsequently be endorsed by the medical officer, and whether there were any explicit guidelines permitting prescription for sedative injection over the phone. She also enquired about the overseas practices in respect of giving prescription for sedative injection over the phone.

56. Senior Medical Officer, Department of Health (SMO, DH) responded that the Department of Health considered that the practice of medical officers giving prescription for injection of sedatives over the phone, which was commonly known as "verbal order", was acceptable. However, he said that he had no information on

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overseas practices in respect of verbal order for sedative injection.

57. SMO, DH said that according to Prison Rules, each penal institution was supported by a medical officer round-the-clock. The resident medical officer in a penal institution would provide medical services to inmates in that institution during office hours. Beyond these hours, medical services would be provided by medical officers on call as and when necessary. Each medical officer on call after office hours would normally be responsible for providing medical services for several institutions.

58. SMO, DH further said that a medical officer with professional ethics would certainly not use sedative injection as a punishment. In practice, injection of sedatives would not be prescribed unless a medical officer considered it absolutely necessary, e.g. in cases where an inmate with serious emotional problems had performed violent acts which were likely to cause harm to himself as well as the others. In these cases, counselling would first be provided with an intent to calm down the inmate. Sedative injection would not be administered unless the counselling was of no avail. He pointed out that as the administration of sedatives without medical officer's prescription would be subject to criminal liability upon conviction, he could not see the reason why nursing staff in penal institutions would administer sedatives to inmates without proper authorization.

59. SMO, DH explained that the so-called "懵仔針" was indeed a kind of sedative named "Paradehyde". This was a strong and dangerous sedative drug with serious side effects. As such, its use had been discontinued for approximately ten years. At present, a sedative commonly used in penal institutions was "Largactil". It was an oral medication effective in helping drug addicts overcome unpleasant withdrawal symptoms. He said that inmates with such symptoms would usually be sent to a penal institution hospital for observation. In cases where an inmate displayed severe withdrawal symptoms, an injection of "Largactil" would be necessary for greater efficacy. Oral medication would resume should the condition of the inmate get better. He said that the number of prescriptions for injection of "Largactil" in SLPC in the first nine months in 2002 was seven, while there had not been any such prescription in both 2000 and 2001.

60. SMO, DH further said that another sedative named "Haloperidol" was commonly used on non-drug dependent inmates who displayed acute emotional fluctuations, suicidal ideation, self-harm tendency or violence which might cause harm to themselves and/or the others. "Haloperidol" was a mild drug with no significant side effects but highly effective and safe in sedating an unstable inmate. An inmate who had received an injection of this sedative would not even feel sleepy. He said that the numbers of prescriptions for injection of "Haloperidol" in SLPC in 2000, 2001 and the first nine months in 2002 were 860, 1 599 and 1 169 respectively. He pointed out that in actual practice, it was not common for medical officers in penal institutions to give prescriptions for sedative injections over the phone. However, if situation did warrant, only the minimum dosage at the safest level would be given.

61. SMO, DH added that at present, each penal institution had its own resident

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clinical psychologist as well as a resident medical officer. Whether an inmate should be transferred to SLPC for observation or psychiatric treatment would depend on the result of the examination by the medical officer as well as the assessment by the clinical psychologist. There was no question of sending an inmate to SLPC on grounds of bad or uncooperative behaviour.

62. Noting that inmates in the eight special rooms in the Observation Unit of Admission Ward in SLPC were relatively unstable and unpredictable, Dr LO Wing-lok asked whether advance prescription for sedatives to these inmates would normally be given by medical officer such that the nursing staff could follow the prescription and give appropriate injections to inmates where circumstances warranted. He also asked, if such arrangement was already in place, when the medical officer would be notified after these inmates had been given a sedative injection.

63. S(N&HS), CSD said that each inmate, upon admission to SLPC, would first be examined by a medical officer and subsequently a visiting psychiatrist, who normally visited the Centre at least three times a week. If an inmate was considered to be in need of psychiatric treatment, advance prescription for psychiatric drugs, such as sedatives, for two to three days would normally be given by the visiting psychiatrist for administration to the inmate by CSD nursing staff where necessary. The prescription given in advance would not normally last beyond the next visit of the psychiatrist. Details of such prescription would be entered in an Injection Sheet and duly signed by the visiting psychiatrist. Every injection made by CSD nursing staff would also be recorded in an Injection Chart for the reference of the visiting psychiatrist as well as the medical officer.

Patrolling system of cells

64. Mr CHEUNG Man-kwong noted that it was the primary duty of the ward patrol officer to patrol the ward and the inmates therein at 15-minute intervals, and every ward patrol officer would be visited by a night orderly officer at hourly intervals to ensure the former's alertness and correctness throughout the shift of duties. He expressed doubt as to whether the ward patrol officer on duty on the day of the incident had strictly followed the established guidelines and patrolled the cell occupied by the deceased at 15-minute intervals to ensure his safety.

65. DC of CS said that the deceased had stayed in one of the 20 rooms located in the Observation Unit of Admission Ward immediately before his death. Each of these rooms had a small window to facilitate the ward patrol staff to observe the conditions of the inmates inside the rooms once every 15 minutes. As the size of the Observation Unit was relatively small and the number of inmates located there was not large, the ward patrol staff should have no difficulty in meeting the 15-minute requirement. He believed that the duties performed by the ward patrol staff on that day had not departed from the established guidelines.

66. DC of CS further said that eight out of the 20 rooms were connected to a CCTV system which screened these eight rooms, when occupied, cyclically every six seconds

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to facilitate close surveillance of the inmates inside these rooms by CSD staff. In view of the unstable condition of the deceased, he had been arranged to stay in one of these eight rooms for closer surveillance. The ward patrol staff, when not performing patrolling duties, had observed the inmates inside these eight rooms through the CCTV system. At about 5:25 am on 19 November 2001, the inmate was observed by the ward patrol staff to have no respiratory movement inside the room. First aid treatment had been applied to him by staff responding to the scene.

Monitoring of CCTV systems and recording of CCTV tapes

67. Mr CHEUNG Man-kwong noted that the CCTV cameras installed in eight out of the 20 rooms in the Observation Unit were linked to two different systems. The images captured by these cameras would appear on a monitor in the ward as well as the monitors in the control room to facilitate close surveillance of the inmates occupying these rooms by the ward patrol staff and the staff manning the control room. Video recording for captured sequential images was provided and the recorded tapes were normally kept for 14 days.

68. Mr CHEUNG Man-kwong expressed doubt as to why the video tape containing the images captured on the day of the incident had only 17 hours of recording, while the remaining seven hours without recording was incidentally the most critical period over the incident. He questioned whether the guidelines and procedures for monitoring the CCTV systems and the recording of CCTV tapes had been followed by the staff concerned on that day. Given that the eight rooms with CCTV cameras and video recording were designated to accommodate the comparatively unstable and unpredictable inmates with a view to protecting their own safety, he questioned how inmates could be protected if they had been arranged to stay in a room in which the CCTV system was out of order.

69. DC of CS said that in SLPC, only the above-mentioned eight rooms were provided with CCTV cameras. The main reason for arranging the deceased to stay in one of these rooms was to facilitate closer surveillance of him through the CCTV systems. He pointed out that the system of recording the sequential images captured on monitors through the CCTV cameras inside the eight rooms had already been out of order before the deceased was transferred to SLPC on 17 November 2001. As problem had only occurred on the recording system, the images appeared on monitors to facilitate surveillance of the conditions inside the eight rooms had not been affected. Therefore, the monitoring of the deceased by CSD staff through the CCTV systems had continued during the whole period.

70. DC of CS added that the recording and keeping of CCTV tapes had all along been handled by security staff of SLPC. In fact, a repair service order had been placed with the Electrical and Mechanical Services Department (EMSD) by the security staff concerned once the breakdown of the recording system had been brought to his attention on 17 November 2001, which was a Saturday. As general repair services would not normally be provided by EMSD on Saturdays and Sundays, therefore the recording system had not yet been fixed on the early morning of 19

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November 2001 when the deceased was found unconscious in his room. He understood that the Police had carried out a detailed investigation into the reason why the CCTV tape had only 17 hours of recording.

71. DRC(NTN), HKPF said that the areas with suspicions identified by the Police during its investigation into the incident had been reported to the Coroner's Court for detailed examination. As regards the CCTV tape in question, an expert from the Police's Technical Services Division had worked out the starting and finishing time of the 17 hours of recording contained in the tape by using a "second-by-second backward-counting" approach. The time of death of the deceased and the facts gathered from the investigation had also been used in working out the recording time. The expert considered that the tape was intact with no editing made and there had neither been any interruption throughout the entire recording period. However, the expert could not identify the reason why the tape had only 17 hours of recording.

72. Considering that the CCTV tape was a crucial evidence, the Deputy Chairman asked whether the Administration could provide more details about the tape, such as the exact time the recording system had broken down, the problem/fault detected in the system and any possibilities which could lead to the non-recording for seven hours.

73. DC of CS said that given that even the Police and the Coroner's Court had not been able to identify the cause of the non-recording, he did not think he could provide the reason. Nevertheless, he pointed out that there could be a great number of factors leading to the non-recording, which included -

(a) a fault in the video recorder which had disabled the normal recording function if proper re-setting had not been done after changing a tape;

(b) the tape had not been fully rewound to its beginning;

(c) the speed of recording had been affected by the fault in the video recorder; and

(d) unsatisfactory quality of the tape due to repeated use.

74. DRC(NTN), HKPF supplemented that the Police had indeed tried to obtain the tapes with the recording for the two days prior to the day of the incident, i.e. 16 and 17 November 2001, for making a comparison with the tape in question. However, the Police was unable to make such comparison as no recording had been made since the breakdown of the video recorder on 16 November 2001.

75. The Deputy Chairman suggested that the Police should consider liaising with overseas enforcement agencies to see whether there were more advanced technologies which could help find out the reason why the tape had only 17 hours of recording, and the causes for non-recording for seven hours.

Complaints mechanism in penal institutions

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76. Mr Michael MAK asked whether the three ex-inmates had aired their grievances to CSD staff when they were serving their sentences and whether the grievances, if reflected to CSD, had been properly dealt with. He also asked about the views of the ex-inmates on the complaints mechanism in penal institutions.

77. Mr LAM said that as CSD was empowered to open and search letters to and from inmates, letters of complaints which had substantial grounds or significant implications on CSD would normally be screened out by CSD staff.

78. Mr LEUNG shared the view of Mr LAM. He said that inmates who wished to lodge a complaint with visiting JPs against CSD staff would not normally be able to see visiting JPs because CSD staff would make arrangements to prevent the inmates from seeking an interview with visiting JPs. In the event of a complaint successfully lodged by an inmate against CSD staff with a visiting JP, subsequent retaliatory acts by CSD staff against the inmate would follow.

79. DC of CS said that CSD officers were not empowered to open and search correspondence between inmates and those regarded as "specified persons" under the relevant ordinance. These persons included LegCo Members and The Ombudsman, etc. In view of this, there was no question of CSD staff intercepting inmates' complaint letters to these persons. He added that SLPC had received 50 complaints of varying nature from different channels in the past three years, which included assault by CSD staff and unsatisfactory arrangement for medical services, etc. He assured Members that CSD would not handle complaints on a selective basis.

80. DC of CS also provided the following figures for Members' reference -

Channel of receiving inmates' complaints	2001	January to October 2002
(a) Complaints Investigation Unit of CSD	284	over 200
(b) Complaints Division of LegCo or individual LegCo Members	60	51
(c) The Ombudsman	91	49
(d) JP visits to penal institutions	253	226

81. DC of CS said that as there were in average more than 200 complaints lodged with JPs during their visits to penal institutions, the allegation that CSD had made

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special arrangements to prevent certain inmates from seeing visiting JPs should not be substantiated. In fact, the existing mechanism enabled inmates to register their wish to see visiting JPs. Those who had expressed their wish would be arranged to see the visiting JPs accordingly. He pointed out that under the existing mechanism, the two JPs appointed to visit a penal institution for a period of two weeks might pay their visit at any time of their own choice within the period without giving prior notice to the institution. Such mechanism provided a safeguard against the alleged possibility of not allowing inmates to see visiting JPs.

82. Mr Michael MAK enquired whether guidelines were available for JPs to facilitate their discharge of duties during visits to penal institutions. C of CS responded that all newly appointed JPs would be given a briefing on the duties of a JP and the arrangements for carrying out visits at different types of institutions before they were appointed to conduct JP visits. Prior to each visit, guidelines or background information on the institution to be visited would also be provided to facilitate the discharge of visiting duties by JPs. He added that the provision of such guidelines and background information to JPs was within the purview of the Director of Administration.

Clerk

83. The Chairman asked the Clerk to obtain a copy of the relevant guidelines referred to in paragraph 82 above for Members' reference.

(*Post-meeting note* : The relevant guidelines provided by the Director of Administration were circulated to Members vide LC Paper No. CB(2)482/02-03 on 2 December 2002.)

84. Ms Emily LAU considered that irregularities existed in penal institutions in normal days might have been rectified before JP visits with prior notice given to CSD. In view of this, she hoped that the Administration would encourage JPs to pay surprise visits to penal institutions. CSD staff should also render every possible assistance to JPs in their surprise visits.

85. C of CS explained that usually two JPs would be appointed to carry out inspection at a penal institution for a period of two weeks. During this period of appointment, the two JPs were required to visit the institution at least once, but more frequent visits might be made if they considered it necessary. The existing mechanism imposed no requirement on visiting JPs to give prior notice to CSD for their visits to an institution within the appointed two-week period. They were welcomed to pay surprise visits to the institution.

86. Ms Emily LAU suggested that visiting JPs, upon arrival at the penal institution to be visited, should be informed of the total number of inmates in that institution and the number of inmates that the visiting JPs would not be able to see during the visit as well as the reasons for their absence.

87. C of CS said that information which could facilitate JPs in discharging their visiting duties in a penal institution would be provided to visiting JPs upon their arrival

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at the institution. Such information included the number of inmates housed in the institution, the number of inmates who were absent from the institution during the visit as well as a breakdown on the number of inmates at different spots within the institution, etc. Indeed, all inmates inside an institution could be seen by visiting JPs and that they were welcomed to inspect every facility in the institution.

Other issues

88. Dr LO Wing-lok enquired about the number of cases of death of inmates in SLPC since its opening as well as the cause of death. DC of CS said that he did not have the information on hand and undertook to provide it after the meeting. Dr LO further enquired whether there must be an inquest on each case of death of inmate while in the custody of CSD. DC of CS answered in the affirmative.

Adm

89. Mr Michael MAK asked how an inmate, upon his admission to a penal institution, could know about his rights in the institution. DC of CS responded that each newly admitted inmate would be given an induction of three to five days' duration, which included an introduction on the rights of an inmate. In addition, each of them would be given an information booklet with the rights of an inmate clearly set out. Notices about their rights were also prominently displayed in inmates' assembly points inside institutions. At the request of Mr MAK, DC of CS undertook to provide Members with the information booklet.

Adm

90. Mr Michael MAK further asked how the rights of inmates in local penal institutions compared with those in overseas countries. Mr LAW Yuk-kai, HKHRM said that the findings of the study on local penal institutions conducted by HKHRM jointly with experts from the United States and United Kingdom in 1997 had revealed that the rights of inmates and the management of penal institutions in Hong Kong broadly met the international standards. Based on the findings of the study, certain areas which displayed inadequacy included the following -

(a) interviews with inmates could not be conducted in an uninhibited manner without the supervision of CSD staff; and

(b) the rights of an inmate could not be adequately protected by the complaints mechanism due to its lack of independent investigatory power.

HKHRM

He undertook to provide a copy of the report of the study for Members' reference.

II. Any other business

(LC Paper No. CB(2)231/02-03(02))

91. Members noted the letter dated 26 October 2002 from the Association of Hong Kong Nursing Staff to the Panel, which proposed that a joint meeting of the Panel on Security and Panel on Health Services be held to discuss issues relating to the provision of medical and nursing services in SLPC.

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92. As agreed by members and Dr LO Wing-lok, Chairman of the Panel on Health Services, a further meeting of the Panel on Security, instead of a joint meeting of the two Panels, would be held in January 2003, when the special task group should have completed its work, to follow up the issues discussed. Members suggested that the following be provided by the Administration prior to the meeting in January 2003 -

Adm

(a) the report of the special task group as well as the follow-up actions taken or to be taken by CSD in response to the findings and recommendations in the report of the special task group; and

(b) the progress of the follow-up actions in respect of the case taken by the Police.

93. The Chairman said that the way forward in following up the issues relating to the incident would be dealt with at the meeting in January 2003.

94. The meeting ended at 1:50 pm.

Council Business Division 2
Legislative Council Secretariat
14 January 2003