立法會
Legislative Council

LC Paper No. CB(2)1330/02-03
(These minutes have been seen by the Administration)

Ref : CB2/PL/SE/1

Panel on Security

Minutes of special meeting held on Thursday, 23 January 2003 at 8:30 am in Conference Room A of the Legislative Council Building

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

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

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

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

Action

I. Follow-up on issues relating to the death of an inmate in Siu Lam Psychiatric Centre in November 2001
(LC Paper Nos. CB(2)947/02-03(01) and (02))

Commissioner of Correctional Services (C of CS) briefed members on the major findings and recommendations of the special task group appointed to conduct a detailed study into the circumstances surrounding the death of an inmate Mr CHEUNG Chi-kin (the deceased) in Siu Lam Psychiatric Centre (SLPC) in November 2001 with a view to enhancing the quality of service at the Centre, as set out in the Administration's paper and the report of the special task group (the report) at Annex A to the paper. He said that after the study, the special task group was satisfied that there had not been any inadequacy in supervisory and nursing procedures at SLPC which might be attributable to the death of the deceased.

2. C of CS added that the Correctional Services Department (CSD) was deeply concerned about the death of any inmate while in its custody, and felt regret over the death of the deceased in SLPC. He took the opportunity to convey an apology on behalf of CSD to the family of the deceased for the distress caused by the incident.

3. Mr Albert HO said that he did not understand the reason for the making of an apology to the deceased's family by CSD if it considered that there had not been any inadequacy in the management of SLPC over the incident. C of CS said that the apology was made on the basis that CSD felt sorry about the traumas caused to the family of the deceased over the incident.

4. In response to Mr Albert HO's question as to whether any areas of deficiency in SLPC which required improvement had been identified, C of CS said that no system was

Action

perfect and there was always room for improvement. After the review of the special task group, 34 recommendations had been made with a view to improving the overall system of SLPC to prevent the re-occurrence of similar incidents.

5. Mr CHEUNG Man-kwong pointed out that the report did not address a crucial issue as to how the incident had happened. According to paragraph 7.5 of the report, the reasons for the high level of chlorpromazine and the presence of ethyl alcohol found in the blood of the deceased as well as the fresh needle marks on his shoulder were still unknown. Based on the forensic pathologist's report, the two substances had, however, not been found in the urine sample of the deceased. This revealed that the substances should have gone into the body of the deceased only several minutes before his death.

6. In view of the above, Mr CHEUNG Man-kwong considered that the incident should either be a suicide or homicide case. If it was a case of suicide, he expressed doubt as to how the deceased had been able to have access to medicines, syringes and needles in view of the tight security control at SLPC. Otherwise, there might be someone who had performed injections on the deceased inside his cell.

7. With the various monitoring systems in place which included the ward patrolling system, the closed circuit television (CCTV) systems, the recording systems and the observation window in the cell concerned, Mr CHEUNG Man-kwong queried why CSD staff had not been able to detect any irregularities of the deceased prior to his death. Mr CHEUNG considered that had any of the above monitoring systems been able to perform its functions, the cause of the incident should have been known or the incident could have been prevented.

8. Mr CHEUNG Man-kwong pointed out that according to the findings of the special task group in paragraph 7.1(e) of the report, two control room staff of SLPC had been warned for their failure in paying attention on the CCTV monitors during recording to ensure that any defects/irregularities would be detected and recorded at once without delay. In the view of Mr CHEUNG, the failure of the two staff concerned in discharging their monitoring duties had already constituted maladministration on the part of CSD.

9. Mr CHEUNG Man-kwong further pointed out that the information concerning the failure of the two staff in performing their duties provided by the former Deputy Commissioner of Correctional Services (DC of CS), i.e. the present C of CS, at the special meeting on 5 November 2002 was in conflict with the findings of the special task group set out in paragraph 8 above. At that meeting, the former DC of CS informed members that the monitoring of the deceased by CSD staff through the CCTV systems had continued during the whole period. He also advised members that during the course of the internal investigation, two control room staff had been found to have deviated from the Superintendent's Order in performing part of their daily duties. However, the deviation was not directly relevant to the death of the deceased and internal disciplinary actions had been taken against the two staff.

10. Mr CHEUNG Man-kwong pointed out that so far, the Administration had not

Action

revealed any further details about the deviation in question. In this connection, he asked the Administration to explain why the deviation was considered to be not directly relevant to the incident. In addition, he asked the Administration to elaborate why it considered that the ward patrolling system was not ineffective given that the ward patrol staff on duty on the day of the incident had failed to detect any irregularities in the cell occupied by the deceased.

11. C of CS said that according to the observation of the ward patrol staff on duty on the day of the incident, the deceased had slept inside his cell without any irregularity. Until 5:25 am on that day, the deceased had been observed by the staff thereat to have no respiratory movement inside the cell. This demonstrated that the ward patrolling system and the CCTV systems had achieved the function of enabling CSD staff to detect irregularities in occupied cells. As regards the two control room staff, since the deviation of duties in question occurred after they were alerted of the incident, the deviation was therefore considered to be not directly relevant to the death of the deceased.

12. C of CS further said that as problem had only occurred on the recording system, monitoring of the deceased by CSD staff through the CCTV systems had indeed not been affected. He pointed out that based on expert advice, the seven hours of non-recording in the CCTV tape were not the seven hours immediately before the death of the deceased.

13. C of CS added that CSD had a responsibility to ensure the safety of inmates, and felt uneasy about the death of the deceased while in CSD's custody. He did not consider that there was maladministration on the part of CSD over the incident. However, improvement measures would be taken to prevent any inadequacy in procedures.

14. Given that the CCTV tape in question was a crucial evidence, the Deputy Chairman asked whether the Police had considered seeking assistance from overseas counterparts, such as the Federal Bureau of Investigation of the United States, to re-examine the CCTV tape with a view to finding out the reason why the tape had only 17 hours of recording and the causes for non-recording for seven hours, as these agencies might have more advanced technologies in retrieving superimposed or erased images on the tape. He said that Dr LUI Ming-wah also considered that the tape should be further examined with the application of advanced and sophisticated technologies, with a view to ascertaining whether more images could be retrieved.

15. The Deputy Chairman suggested that the Police should consider adopting other means to identify evidence for further investigation of the incident, e.g. the use of lie-detector test and hypnosis on staff who were on duty during the period in question. This would help rule out the possibility of certain staff having an involvement in the incident. Hence, the scope for further investigation could be narrowed down.

16. Deputy Regional Commander (New Territories North), Hong Kong Police Force (DRC(NTN), HKPF) said that the following follow-up actions had been taken by the

Action

Police -

(a) a comprehensive review of the investigation, which included the taking of statements from more witnesses, had been completed, reconfirming that all possible leads had been thoroughly looked into; and

(b) a thorough examination of the transcript of the proceedings of the death inquest had been conducted, reaffirming the consistency of the statements of witnesses during both the investigation and the court hearing.

Despite the above follow-up actions, no fresh evidence had been surfaced.

17. In respect of the CCTV tape, DRC(NTN), HKPF said that the Police had further liaised with its Technical Services Division (TSD) on whether assistance from overseas enforcement agencies should be sought to ascertain whether more images could be retrieved. According to the report submitted by TSD, the tape could record as long as 51 hours but it was a normal practice in SLPC that each tape would be used for recording a period of 24 hours only. The tape in question was a re-used tape with 17 hours of recording, which showed the activities inside the cell after being occupied by the deceased. Based on the images on the tape, TSD derived that the recording should start at around 2 pm on the day before the death of the deceased. However, it was unable to establish the exact time the tape had been inserted into the video cassette recorder (VCR) concerned. After the 17-hour recording, there were some 40 minutes of previous recording with images not related to the incident and the remainder of the tape was blank.

18. DRC(NTN), HKPF added that although TSD was unable to identify the reason why the tape had only 17 hours of recording, it considered that the tape was a true copy with no editing made and the recording was continuous throughout the entire recording period. Given that no superimposed image had been found on the tape, TSD was of the view that even overseas enforcement agencies might not be able to retrieve further images from the tape. On the request of the Deputy Chairman, DRC(NTN), HKPF undertook to provide the report prepared by TSD concerning the CCTV tape and as much information relating to the tape as possible.

Adm

19. Mr Michael MAK said that some of the recommendations in the report, such as the use of proper terminology and the more general use of mechanical restraints, would bring about a cultural change to the operation in SLPC. He expressed worry as to whether CSD staff would be able to cope with the series of new practices and procedures. He also expressed concern whether these practices and procedures would be enforceable in actual practice.

20. C of CS said that the special task group, in working out the recommendations, had consulted the views of the management of SLPC. Therefore, he was confident that the new practices and procedures would be enforceable. He further said that the use of inappropriate jargon "Doping Injection" was common among prisoners, but not staff members. However, staff members would be reminded not to use inappropriate jargons

Action

in order to avoid any misconception and misnomer. The importance of not using inappropriate jargons would be emphasised in staff training. Staff of all penal institutions would be encouraged to make more general use of mechanical restraints in dealing with inmates who displayed violent and agitated behaviour during the absence of the medical officer. The nursing staff concerned should be able to notify the medical officer of the situation by mobile telephone within 15 minutes so that the latter, upon his return to the institution, would be able to examine the inmate and prescribe an appropriate treatment for him.

21. Mr Michael MAK said that apart from the two non-official Justices of Peace and Dr YUEN Cheung-hang, all other members of the special task group were government officials. In fact, Dr YUEN had been providing psychiatric service to inmates in SLPC for a long time. Mr MAK opined that in order to uphold the neutrality of the special task group, more independent members of a non-official status should be appointed should there be similar task groups in future.

22. C of CS said that Dr YUEN Cheung-hang was working in the Castle Peak Hospital, and was a staff of the Hospital Authority. Apart from being a visiting consultant psychiatrist to SLPC, Dr YUEN had no relationship with CSD.

23. Referring to the information note on the procedure for applying sedatives to inmates prepared by the Legislative Council (LegCo) Secretariat, Mr Michael MAK asked whether the local reference materials listed in the last page of the information note had been reviewed since their issuance.

24. Superintendent (Nursing and Health Services), Correctional Services Department (S(N&HS), CSD) said that guidelines and procedure manuals adopted in penal institutions, which included the Hospital Manual and Complaints Handling Manual issued by CSD, were subject to review and updating on a regular basis. However, he was unable to provide information concerning the Department of Health's Standing Circular No. 716/9 as it was outside the purview of CSD.

25. With regard to the recommendation to strengthen the recording system in the use of injectable sedatives, Mr Howard YOUNG asked whether measures would be put in place to ensure that such records would be completed immediately after each injection.

26. C of CS said that for the purpose of enhancing the monitoring over the use of injectable sedatives, the recording system of these injections had been strengthened similar to the practices adopted in the case of dangerous drugs. Under the new recording system, two nursing staff were required to sign in the inmate's medical record to corroborate the dosage and condition of use whenever sedative injection was prescribed.

27. C of CS further said that different monitoring mechanisms were in place to ensure full compliance with the new recording system. For example, the ward-in-charge would conduct checking against records of sedative injections administered by nursing staff. Apart from this, the Superintendent responsible for nursing and health services of

Action

CSD institutions would pay visits to SLPC on a regular basis to inspect and review sedative injection records. It was, therefore, believed that any inadequacy in completing such records would be detected within a short period of time.

28. Mr Howard YOUNG noted that an information booklet on inmate's rights would be given to each inmate upon his admission to the institution. He expressed concern whether inmates with psychiatric problem would be able to comprehend the booklet.

29. C of CS said that apart from the booklet, each newly admitted inmate would be given an induction, which included a video presentation and a verbal introduction on the rights of an inmate. In the case of SLPC, there was a welfare officer who would provide assistance to inmates with a view to helping them overcome their problems.

30. Ms Emily LAU said that she had written to the Chairman relaying a number of serving prisoners' concern about incidents relating to the administration of sedatives in penal institutions. According to these prisoners, inmates in penal institutions were scared of being sent to SLPC because of the great power conferred on the staff thereat. She considered that there was a need to strengthen the existing system to prevent abuse of power by CSD staff.

31. Ms Emily LAU noted the following from the Coroner's summing-up -

(a) A "symptomatic treatment" was prescribed to the deceased two days before his death. However, the nursing staff concerned were unable to ascertain whether the deceased had consumed all the medication prescribed for him on ground of the poor design of the dispensary sheet;

(b) The CCTV tape recorded in the control room was so blurred that no image could be seen. As regards the CCTV tape recorded in the Observation Unit of the Admission Ward (the Observation Unit) where the deceased had stayed before his death, the following had been detected -

(i) The time display, namely the hour and minute, appeared on the images on the tape had a sign of having been moved. Hence, the exact time of recording could not be ascertained;

(ii) Based on the images, there had been another inmate and some CSD staff inside the cell occupied by the deceased. The CSD staff concerned were holding something in their hands. However, the kind of object(s) being held could not be identified due to unsatisfactory replay effect;

(iii) Some CSD staff had been aware that the VCR in the Observation Unit had been out of order while some other staff claimed that they had not been aware of its breakdown; and

(iv) The tape had not been handed over to the Police until 4 December

Action

2001 since the occurrence of the incident on 19 November 2001. The reason given by CSD staff for the delay in delivering the tape was that it had to be seen by the management.

Ms LAU said that she was surprised to learn that the nursing staff were unable to ascertain whether the deceased had taken all the medication prescribed for him. She considered that apart from improving the overall system to prevent the recurrence of similar incidents, unresolved issues surrounding the case should also be looked into.

32. S(N&HS), CSD explained that "symptomatic treatment" was a "P.R.N." treatment, which meant that the medication should be taken as and when needed. In other words, the patient might choose to take the medication or not. He believed that the problem relating to the failure of the nursing staff in providing a detailed record of the medicines consumed by the deceased was attributed to the design of the former dispensary sheet. Under the former design, the different types of medicines of varying dosage and frequency prescribed for an inmate were all included in the same dispensary sheet without clear indication. However, he considered that qualified nursing staff should be able to comprehend such records.

33. S(N&HS), CSD said that as far as the case was concerned, nine times of "Largactil" in oral form had been prescribed for the deceased, however, only five times had been consumed by him. According to the medical records concerned, the deceased had not received any sedative injections in either SLPC or Lai Chi Kok Reception Centre and no prescription for such injections had been made during his stay in these two centres. Therefore, CSD did not understand why the deceased had several fresh needle marks on his shoulder.

34. S(N&HS), CSD added that given the inadequacy in the design of the dispensary sheet, the special task group had recommended the introduction of a new "Prescription and Medicine Issue Record" to replace the former dispensary sheet. The new design would enable nursing staff to compile a precise and detailed record of the medication prescribed by a medical officer and the dosage consumed by an inmate.

35. Ms Emily LAU pointed out that according to a psychiatrist who had provided psychiatric service to SLPC in the past, there was a standard procedure for nursing staff to examine the blood pressure and pulse of an inmate after the administration of sedatives. She expressed doubt as to whether such procedure had been strictly followed in SLPC. To ensure the provision of better and proper health care services to inmates, she considered that the administration of sedatives should be performed in the presence of nursing staff in a hospital ward rather than in a cell.

36. Ms Emily LAU further pointed out that according to the experience of that psychiatrist when he provided psychiatric service to SLPC, an inmate treated by him had been given the maximum dosage of sedatives under a P.R.N. prescription during his absence. The nursing staff concerned had subsequently presented a neatly typed dispensary sheet to him for endorsement. This had given the psychiatrist an impression that the sedatives had not been administered based on the need of the inmate, and the

Action

dispensary sheet had not been completed immediately after each application of sedatives.

37. Regarding the CCTV tape, C of CS said that the VCR in the Observation Unit had been out of order before the deceased was transferred to SLPC on 17 November 2001. The staff responsible for the respective recording work had been on leave on 16 and 17 November 2001. Upon his return to work on 18 November 2001 at around 9 am, he was not aware that the VCR was out of order. However, soon after 9 am when he proceeded with the recording work, he learned that the VCR was not working properly. After his attempt in fixing it, he managed to insert a tape into the VRC for recording.

38. C of CS added that as the staff concerned was not a professionally trained repairman, the VCR might therefore not be able to fully perform its functions even after the "repair". This might be the reason why the Coroner's Court had found that the time display on the images on the CCTV tape had a sign of having been moved. He assured members that measures would be put in place to enhance the communications between staff members with a view to ensuring effective discharge of their duties.

39. Ms Emily LAU considered that SLPC, being a psychiatric hospital, should have its own resident psychiatrist. S(N&HS), CSD said that there was a total of five teams of visiting psychiatrists from the Castle Peak Hospital providing psychiatric service to SLPC during office hours, namely from 9 am to 5 pm from Mondays to Fridays. To overcome the deficiency of not having a resident psychiatrist, CSD had accepted the special task group's recommendation that transfer of inmates to SLPC would only be carried out during office hours when there was a visiting psychiatrist on duty.

40. Ms Emily LAU understood that the Royal College of Psychiatry (the College) had, during its visit to Hong Kong in 1996, made some recommendations on the facilities in SLPC. She enquired whether such recommendations had been implemented in the Centre. S(N&HS), CSD said that he did not have the information on hand and undertook to provide it after the meeting.

Adm

41. Dr LO Wing-lok said that the College performed an accreditation function for psychiatric professionals in Hong Kong. In acquiring psychiatric qualifications recognised by the College, a medical officer had to receive psychiatric training in a centre accredited by the College. To be an accredited centre, such as SLPC, the centre had to meet certain standards set by the College. He, however, pointed out that as the various standards required by the College mainly focused on training, the meeting of such standards might not be considered as a benchmark in assessing the overall effectiveness of a centre.

42. Ms Emily LAU pointed out that according to the comparison of procedures for applying sedatives to inmates in Florida of the United States, Canada and Hong Kong prepared by LegCo Secretariat, the circumstances under which sedatives could be applied, the requirement of an inmate's consent, and the roles of a medical officer, a nurse and a correctional operations staff in the sedative application process were more relaxed in Hong Kong as compared with those in Florida and Canada. She considered that the Administration should review the relevant practices and procedures in Hong

Action

Kong with reference to those adopted in Florida and Canada. She also suggested that the Administration should examine the practicality of discontinuing the use of sedatives and, if it was inevitable, more stringent procedures governing its use should be adopted.

43. C of CS said that in Hong Kong, as in many other places, the application of sedatives to an inmate in an emergency situation would not require the consent of the inmate in accordance with the Mental Health Ordinance. In non-urgent cases, the consent of an inmate might be given by his gesture. He cited as an example that the removing of pants by an inmate on his own to have an injection on his buttocks would be considered as giving his consent. C of CS pointed out that as correctional services staff in Hong Kong were required to also perform nursing duties, there was no question of whether a correctional operations staff would be present in the sedative application process in view of the dual responsibilities of these staff.

Adm 44. At the request of the Chairman, C of CS undertook to provide a written response on the comparison of procedures for applying sedatives to inmates in Florida, Canada and Hong Kong, especially the procedures and practices which were different from those in Hong Kong.

45. Referring to the recommendation in paragraph 10.31 of the report, Ms Emily LAU suggested that psychiatrists, medical officers and nursing staff should meet on a weekly basis to discuss the psychiatric, medical and nursing services provided to inmates in SLPC. She also suggested that CSD should consider adopting the practice of daily ward-rounds by psychiatrists, medical officers and nursing staff in SLPC as in hospitals administered by the Hospital Authority.

46. C of CS said that considering that SLPC worked jointly with other institutions in providing psychiatric, medical and nursing services to inmates of the Centre, the special task group considered it appropriate to include psychiatrists as members of the Medical Services Committee. Under such arrangement, the psychiatrists would be able to hold regular discussions with general medical officers and nursing staff of other institutions to share knowledge and practical experience in the psychiatric, medical and nursing spheres.

47. With the more general use of mechanical restraints on agitated inmates, Mr IP Kwok-him asked whether CSD would consider discontinuing the use of strong sedatives or, where situation warranted, using milder drugs as a replacement.

48. C of CS said that the use of mechanical restraints was only a temporary means to control an inmate who displayed violent behaviour or serious emotional problems during the absence of the medical officer. The medical officer, upon his return to the institution, would examine the inmate and determine whether any medical treatment, e.g. sedative injection, was necessary to stabilise the mental state of the inmate. The need to use sedatives and the class of sedatives to be used should be a matter of professional judgment of a medical officer.

49. Dr LO Wing-lok agreed that the need for using sedatives on an inmate and the

Action

class of sedatives to be used should be determined by a medical officer. He pointed out that a sedative injection was necessary on some occasions, for example, if an inmate with serious emotional or mental problems who needed to be sedated was too unstable to consume oral sedatives.

50. S(N&HS), CSD said that the so-called "Doping Injection" was a kind of strong sedative named "Paradehyde". In view of its strong nature and the serious side effects, its use had been discontinued after a review in 1996. Since then, a sedative commonly used in penal institutions was "Haloperidol". It was a mild drug used on inmates with psychiatric problems or who displayed acute emotional fluctuation. Another sedative in use in penal institution was "Largactil". This could be applied by injection or in the form of oral medication. Injection would be prescribed for inmates with severe drug withdrawal symptoms whereas the oral form would be used on those with less serious drug withdrawal symptoms.

51. Referring to the recommendation in paragraph 10.13 of the report, Mr IP Kwok-him expressed doubt as to whether effective compliance with procedures and documentation in SLPC could be achieved merely by pursuing certification from the International Organisation for Standardisation (ISO). He suggested that more effective measures to improve work procedures and practices should be explored.

52. C of CS said that the purpose of pursuing ISO certification was to obtain an accreditation to ensure compliance with procedures and documentation in SLPC, thereby enhancing the discharge of medical duties by nursing staff. It should not be taken to mean that ISO certification was the only channel to improve the work procedures and practices in the Centre.

53. Referring to the recommendation in paragraph 10.34 of the report, Mr IP Kwok-him considered it more desirable to have the air-conditioning inside the single rooms of the Observation Unit controlled by a central ventilation system rather than by individual staff members on a manual basis. This would help prevent an alleged situation where an inmate might be sent to a room of low temperature as a means of punishment.

54. C of CS said that there was no question of penalising an inmate by means of sending him to a room of low temperature. The recommendation was made having regard to the fact that the temperature of the cell occupied by the deceased on the day of the incident was only 20^{o}C, which was several degrees lower than the moderate room temperature. Although the low temperature had not attributed to the cause of the death of the deceased, the special task group considered it appropriate to standardise the room temperature of the single rooms of the Observation Unit at around 25^{o}C to 26^{o}C.

55. Noting that 19 of the 34 recommendations had been implemented, Dr LO Wing-lok enquired about the timetable for the implementation of the remaining 15 recommendations.

56. C of CS responded that full implementation of the recommendations would be completed by April 2004. He added that the first-phase of the CCTV improvement

Action

project in SLPC, i.e. the improvement work for the eight rooms equipped with CCTV cameras in the Observation Unit, would be completed by end January 2003 while the second-phase would be completed by end March 2004.

57. Given that the provision of sufficient evidence for investigation in cases of untoward or special incident was of paramount importance, Miss Margaret NG considered it undesirable if the preservation of data for evidential purposes had to rely heavily on mechanical or electrical systems. In her view, the Administration should explore measures to strengthen the work procedures in SLPC, e.g. introducing more stringent guidelines for monitoring the CCTV systems and handling CCTV tapes, with a view to ensuring the preservation of evidence.

58. C of CS said that in view of the importance of preservation of evidence, the special task group had recommended that the existing analogue CCTV system be replaced by a digital CCTV system. He briefed members on the following features and operational procedures of the digital CCTV system -

(a) The images captured by all CCTV cameras could be recorded continuously round-the-clock although the captured images would continue to appear on monitors on a cyclical basis as in the existing analogue CCTV system;

(b) If no untoward or special incident had taken place, CCTV discs would be retained for 14 days before re-use or disposal. The period of storage of data had also been predetermined for 14 days;

(c) If untoward or special incident had occurred, at least 48 hours' recording of any events prior to the incident would be preserved;

(d) There would be back-up hard disks to forestall accidental loss of recorded data caused by failure of any hard disk in the digital CCTV system;

(e) Comprehensive procedural guidelines relating to the operation, monitoring and recording of the digital CCTV system would be promulgated for observance by staff before the system was operational; and

(f) Comprehensive training for concerned staff would be provided before the full implementation of the digital CCTV system. Similar training would be included in future in-service staff training programmes.

59. C of CS added that before the implementation of the digital system, "Action Cards" consolidating the operational guidelines on the existing CCTV system would be issued to responsible staff for their easy reference. He was confident that the operation of the CCTV system would be greatly enhanced with the provision of more staff training and the future implementation of the digital system. Notwithstanding, CSD would spare no efforts in exploring ways to further enhance the preservation of evidence.

Adm 60. Members agreed that the Administration should report to the Panel, in one year's

Action

time, the progress and details of the implementation of the 34 recommendations made in Chapter 10 of the report, in particular the monitoring over the enforcement of the new practices and procedures.

61. As agreed by members and Dr LO Wing-lok, Chairman of the Panel on Heath Services, two joint meetings of the Panel on Security and Panel on Health Services would be held to follow up issues relating to the incident. Discussions at the two meetings would be focused on security-related issues and medical-related issues respectively. Members also agreed that the Panel should pay a visit to SLPC to facilitate members' understanding of the operation of the Centre.

(*Post-meeting note* : The two joint meetings have been scheduled for 5 March 2003 at 10:45 am and 7 March 2003 at 10:45 am, and the visit has been scheduled for the whole morning of 4 March 2003.)

II. Any other business

62. There being no other business, the meeting ended at 10:45 am.

Council Business Division 2
Legislative Council Secretariat
3 March 2003