LC Paper No. CB(2)1774/16-17(02)

SOCIETY FOR COMMUNITY ORGANIZATION

POLICE CUSTODY: PHYSICAL CONDITIONS AND PREVENTION OF SUICIDE

JUNE 2017

Submission to Panel on Security meeting 4 July 2017 under item II: Custodial management and detention management of the Hong Kong Police Force

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1 Conditions in police detention facilities

1.1 INTRODUCTION

An investigation was conducted by SoCO into the conditions of the police detention facilities in Hong Kong between March and June 2015. The investigation was triggered by large amount of complaints received by Society for the Community Organization (SoCO) from persons held in police custody. All complainants had undergone in-depth interviews concerning current conditions at the police detention facilities.

There are 67 police report rooms all over Hong Kong.[1] Of these 33 have designated cell facilities.[2] In 2014, 33,679 people were arrested by uniformed police.[3]

1.2 DID THE DETENTION UPGRADE PROGRAMME BENEFIT DETAINEES?

A Detention Facility Upgrade programme took place between January 2010 and December 2011. Renovations were focused on improving the following areas: privacy of detained persons; physical features of detention cells; personal hygiene of detained persons; and health and welfare of detained persons. A total of 16 improvement measures were promised to be implemented by the Hong Kong government, and included: provision of mattresses integrated with pillow, installation of hot water shower and privacy door[4];

However, despite the upgrade, it seems there has been no change in the conditions faced by detainees since SoCO released a survey in 2009.

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[1] Hong Kong, Police Force, *Police Review: Annual Review 2014* <http://www.police.gov.hk/info/review/2014/tc/index.html> at 14 August 2015.

[2] Hong Kong Police Force, Letter from Commissioner of Police to SoCO, 'Capacity in police cells' from 19th of November 2009.

[3] Hong Kong Police Force, above n10.

[4] Government Secretariat, Letter to the Legislative Council, 'Conditions of Detention Facilities at Police Stations' from 23 June 2010.

1.3 CURRENT CONDITIONS AT THE POLICE CELLS

SoCO's 2015 project focuses on the current conditions of the police detention facilities after the 2010-2011 upgrade programme. The results from our research shows that there are no improvements since 2009.

1.3.1 Unsuitable Physical Conditions

Detained persons were generally required to sleep on the concrete bench. No pillows or mattresses were provided, only one blanket per person and more blankets if requested. This has led to body pain when sleeping and blankets have been reported to be dirty. Every complainant informed us that blankets provided were not enough to keep them warm (during winter period) or provide comfortable sleep.

Detainees reported of unhygienic conditions and that the cells were dirty and smelly.

There was no drinking water available inside the cell and detained persons were forced to ask police officers for water every time they felt thirsty. Some complained that it took over an hour to receive water, and then only a single small cup was brought. Some police officers would pretend not to hear or just reply: 'I can't hear you!' Many detainees, even though they were thirsty, did not ask for water at all due to the police attitudes.

1.3.2 Difficulties to Maintain Personal Hygiene

The majority reported that they were not allowed to brush their teeth or shower during the entire time in police station (some for as long as 6 days). All complainants were not allowed to have shower and received responses from police officers such as: 'This is not your home!' or 'You are a criminal.' One detained woman shares:

As there is no washbasin in the cells, detainees were not able to wash their hands after using the toilet and would also have to eat without the chance to wash their hands. Detainees reported that they were not provided with enough of toilet paper.

1.3.3 Medical attention

It is worth noting, that 7 out of 13 detainees requested medical attention because of the police beating. One 73 years old detainee was beaten during arrest, punched in the stomach and suffered a heart attack as a result.

Amongst the complainants systematic refusal of requests to see a doctor is observed.

Out of all complainants, 13 requested to see a doctor and only 2 were allowed.

Another 68-year-old detained woman asked for her prescribed medicine as she is suffering from hyper-tension, but was denied. When she was finally taken to the hospital the next day, her blood pressure was 198/115. She recalls: ‘I was in shock at the whole experience. I was admitted to hospital in order to contain lower blood pressure due to being denied of my medicine.’

1.3.4 Right to Information

Many were not informed of their rights upon being arrested. A few who were given notice to persons in custody, either could not understand what was written on it due to the language barrier or were given the notice after the police interrogation. Almost all foreign complainants were forced to sign documents in a language they didn’t understand and detriment themselves in the future court proceedings. One detainee recalls:

> ‘During arrest police officers lied to me. Made me sign documents, but did not explain to me. And now I know about the right to make a phone call. But they didn’t let me call my family or friends.’

1.4 LACK OF TRANSPARENCY

1.4.1 Visit to police cells denied

A request to visit police station detention facilities, following renovations, was sent to the Hong Kong Police Force on 27 March 2015. The request has been denied due to operational reasons and protection of privacy of detainees. A request to review decision was submitted to the Commissioner of Police on 23 April 2015, but was unsuccessful and the visit was denied.

1.4.2 Inadequate information supplied by the police

On 9 April 2015, Hong Kong Police Force proposed that instead written replies to any enquires relating to the detention facilities will be provided to SoCO. Accordingly, on 28 April 2015, SoCO wrote to the Commissioner of Police with 27 enquiries relating to specific procedure in relation to vulnerable detained persons inside police cells, physical conditions of the police cells, and access to medical care.

With great disappointment, SoCO did not receive a satisfactory reply to any of the enquiries. Only a brief **4-sentence summary of current Hong Kong laws and procedures** was received on 16 June 2015. SoCO complained to the Commissioner of Police of the lack of a response.

A letter was then received on 10th September 2015, where **19 out of 27 questions remain unanswered**. The lack of transparency is disappointing.

An example of the questions, that the police has not answered are:

"Please indicate what measures have been put in place to ensure that detainees have access to washing basin facilities and drinking water inside the cells."

"In 2014-2015, how many detained persons requested medical treatment? How many of them received medical treatment?"

"Please clarify whether request for medical treatment is recorded by police officers."

The conclusion would be that either the Police Force does not record this type of information, which highlights a lack of monitoring of custody cells, or the police may have withheld the information, pointing to a lack of transparency of information for the public.

1.5 ARE HK POLICE CELLS ADEQUATELY REGULATED AND MONITORED?

1.5.1 Laws in HK

In Hong Kong the main documents that regulate the conditions in police station cells are The Force Procedures Manual (FPM) and the Police General Orders (PGO). These concern mostly the duties of the custody officers, such as the duty to provide medical treatment[5], and the duty to ensure the welfare of each prisoner, so that he is given reasonable opportunity to wash, eat and relieve himself[6]. It is important to note, that unlike PGO, FPM are not available to the general public.

1.5.2 Stricter Laws and Precise Guidelines

UK guidelines[7] contain much more detailed protection of police detainee rights. This includes:

A. Maintain personal hygiene

Access to replacement clothing[8], shower facilities[9] and hand-washes[10].

B. Physical conditions

Temperature: There are precise guidelines regarding the internal temperature to be maintained 5 degree Celcius below external temperature[11], and cells must be adequately heated, cleaned and ventilated[12].

Bedding: Blankets, mattresses, pillow and other bedding shall be of reasonable standard and in a clean and sanitary condition[13]

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[5] FPM 49-01, para. 9 (g)

[6] FPM 49-01, para 11

[7] *The Code of practice for the detention, treatment and questioning of persons by police officers (Code C) under the Police and Criminal Evidence Act 1984 (PACE)*[7] (PACE Code C), which came into force on 1 February 2008 in UK, serves as a useful reference. Other useful references are the *"Police Buildings Design Guide – Custody – Policy Document"* (PD) published in July 2009 by the Home Office[7] and the *"Guidance on the safer detention & handling of persons in police custody"* (PCG) published 2006.

[8] PCG section 6.6.3

[9] PD1.04.04.02

[10] PD1.04.04.01

[11] PD3.02.05

[12] PACE Code C Section 8.2

Day light: All cells must have natural daylight[14]

C. Health

Clinical attention: Even it if the detainee does not make any request for clinical attention the custody officer must make sure a detainee receives appropriate clinical attention as soon as reasonable practicable[15].

Drinking water: Hand wash units can be fitted with a drinking water supply[16]

D. Information about rights

In general rights of detainees can be protected when they know themselves what their rights are. Notices of entitlements, including visits, reasonable standards of physical comfort, adequate food and drink, access to toilet and washing facilities, clothing, medical attention and exercise where practicable should be available in translated versions[17].

1.6 MONITORING OF POLICE DETENTION FACILITIES

In Hong Kong the Justices of Peace, which do have access to prisons and detention centres, do not have any investigative powers when it comes to police stations[18]. Nor does the Ombudsman have authority to investigate the police[19].

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[13] PACE Code C Section 8.3

[14] PD1.04.04.01

[15] PACE Code C Section 9.5

[16] PD1.04.04.01

[17] PACE Code C, Section 3, Notes for guidance 3A-3B

[18] The only exceptions are: The only people that JP's can visit at a police station are

1) A Vietnamese refugee or;

2) A person detained under the Independent Commission Against Corruption (Treatment of Detained Persons) Order.

[19] According to the Ombudsman Ordinance (Chap 397, Schedule 1, Part II and Section 7 (1)) the Ombudsman cannot investigate the Police or the Secretariat of the Independent Police Complaints Council, unless it relates to exercise of its administrative functions in relation to the **Code on Access to Information** published by the Government.

In addition Hong Kong is not party to the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Being a party enables an international body[20] to conduct visits, provide advice and recommendations. It also offers training and technical assistance to governments. Lastly it also requires the government to scrutinize all places of detention.

Thus in UK, which is a party to the OPCAT, there's a National Preventive Mechanism (NPM) which is made up of 20 statutory bodies that independently monitor places of detention. The visits are also preventive in nature is the visits are systematic and ongoing.

Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Prisons (HMIP) have established a programme of inspections of custody conditions in all police forces, at an average of 12 inspections per year. [21] Each year will be a mix of announced and unannounced inspections – with individual reports for each inspection and periodic thematic reports (those covering a particular subject or theme across more than one force) on emerging trends or findings of particular importance. The inspections look not only at the implementation of statutory requirements, but also at the conditions of detention and the treatment of detainees.[22]

In UK the Independent Custody Visiting Association (ICVA) is composed of unpaid members of the public who are appointed as lay visitors to police stations in their communities.[23]

1.7 SUMMARY OF RECOMMENDATIONS

- Review the condition of all cell complexes

[20] The Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of the Committee against Torture

[21] Ibid.

[22] Ibid.

[23] SoCO, above n 7.

- Upgrade cells where necessary. Make reports for all improvement measures available to general public.
- Establish an independent monitoring body to increase accountability of the Police. The monitoring body should have access to all parts of the police stations including cells, detention rooms, charging areas, washing facilities, kitchens and medical rooms. Also they should have access to detainees and be able to interview them.
- Delegate the power of independent monitoring of police station cells to the Independent Police Complaints Council, the Ombudsman and Justices of Peace.
- Sign the OPCAT, a treaty that is based on preventing torture through the monitoring and transparency of places of detention.
- All police officers dealing with the detention and custody of people should receive regular training on their role as protectors of human rights. NGOs should be allowed to actively participate in such training sessions.
- Provide regular statistics on police cell conditions.
- Ensure availability of doctors or nurses on call at each police station.
- Provide legal representation in police stations.
- Install CCTV surveillance systems that record everything taking place in the reception area, cells, corridors and other locations, in all police stations.

1.8 CASE ILLUSTRATIONS

1.8.1 Sunny and Angel

Sunny, who was working with the Employees Retraining Board and Angel, who is a native English teacher and currently taking a degree in psychology, were having a family dinner in December 2013 in Hung Hom Ferry Pier. They later chatted with 3 people, who they later found out were police officers from Scotland and also a CID officer from Hong Kong, who was

off duty. At some point one of the Scottish officers lost his phone and they put the blame on Sunny and Angel. Police arrived but found no phone on their persons or in their belongings. In fact the Scottish officer soon found his phone, and found that he had just misplaced it. However, the police said that they suspected Angel for having taken it, and they said they wanted to bring her to the police station. Sunny, knowing that she didn't speak Cantonese, said that he wanted to come along.

When they arrived at Hung Hom Police Station they were locked up in police cells and searched. They were not informed whehter they were under arrest and no explanation was given about what was going on.

Sunny asked to call a lawyer, as he had a lawyer's number on his mobile, which had been removed from him. However, the police said he was not allowed to call any lawyer, nor his family. Angel was not allowed to call her mother either, although it was in the middle of the night.

When Sunny wanted to use the washroom, he was taken to some other cells, where three officers were standing just next to him. He expressed concern about his privacy, and that he felt it difficult to relieve himself in front of 3 officers, but they said that they had to stand there. Thus he didn't use the toilet until later, after searching him, they let him use it out of sight. Angel, hearing about the toilet without walls or doors, didn't use the toilet, although she wanted to.

When they asked for water or food, they were denied it. Angel, who sometimes suffer from panic attacks when locked in small rooms, needed water to calm herself down, but it was denied. She was unable to tell the officers that she suffers from panic attacks, as the officers didn't speak English well, nor did they ever offer her an interpreter who could do English/ Cantonese translation or Hindi/Cantonese translation.

Sunny offered to pay for the food himself, but they were denied it. They just looked on the police officers ordering their own food and eating it.

As it was December it was cold, but they were not offered any jackets, blankets or mattresses. They just slept on the floor.

Sunny and Angel plan to complain to the Complaints Against Police Office and also explore legal redress.

1.8.2 Case A

A is a refugee in Hong Kong, trying to escape mistreatment in his own country. When **A** was arrested last year, he was faced with cruelty again - this time in Hong Kong.

A spent 4 days at the police station and was subjected to the police brutality and abuse. He has been pushed, verbally attacked, intimidated and severely beaten by police officers during the arrest, interrogations and at the police station. **A** had attained visible injuries such as broken leg, twisted thumbs, bruises and now permanent scar on his forehead. During 4 days at the police station, **A** was not given any medical attention or simple medications. Despite asking to see a doctor numerous times, **A** was not taken to the hospital, but instead was told not to tell anyone about what happened. It was not until he was transferred to Correctional Centre, he was first arranged to go to the hospital, where he spent 3 days recovering from the cruelty he has received at the police station.

From **A**'s recounts of his time at the police station, terrible conditions of such facilities are also evident. During 4 days, **A** was not provided with any of the items (which HK Government insists are given to all arrested persons who are detained in police stations), such as clean towel, liquid soap, shaving kit, face mask, box tissue. **A** was not even provided with enough toilet paper when he needed to use the toilet. He was not able to brush his teeth or have shower during the entire time. When he asked police officer why he was not allowed to have shower, he received reply: "This is not your home!"

To sleep, **A** was not given matrass or pillow, but only a dirty blanket, which he had to use to sleep on a concrete slab. It was not enough to keep him warm or provide a comfortable sleep. The cell was described by A as dirty, with no natural light, windows, fan or any fresh air.

A is a Muslim. The food provided at the police station did not satisfy his religious dietary requirements. Furthermore, when he asked for Koran, his request was refused. There was no access to drinking water inside the cell and every time A was thirsty, he had to ask a police officer for some water, which took a very long time to receive and only small amounts of water were provided.

In search for fairness, **A** made complaints to the Ombudsman and CAPO. It has been almost a year since the frightening experience **A** had received at the police station, and it seems that justice is far from being served. Ombudsman had replied to **A** that it is outside of their powers to pursue such claims. CAPO had encouraged **A** to pursue his claim after he is discharged from prison, which in his case could take another year.

1.8.3 投訴人個案撮要

投訴人為香港居民，2015 年 9 月 21 日晚上 11 時，因涉嫌在公物上寫字，被旺角警署人員當場拘捕並帶返警署。案年已於 2016 年 2 月 22 日審結，在控方不提供證據下承認案情，並獲法庭判簽簿守行為 18 個月。

投訴人在案件調查期間，於旺角警署內共被拘留長達 30 多個小時。被拘捕後，警方並未有向她錄取口供，警方於 2015 年 9 月 22 日上午聯繫社署社工及志願機構社工，查詢是否合適獨自錄取口供，直至 9 月 22 日晚上近 11 時(即拘留近 23 小時後)，始以視像及筆錄方式向錄取口供，最後於 9 月 23 日凌晨時份保釋候查，並需於 10 月 22 日再次返回警署報到。在旺角警署拘留期間，遇到以下問題並欲投訴，分述如下：

1. 投訴警方不適時安排如廁: 如常人一般，每 3 至 4 小時需要如廁，在被拘留的 30 多小時期間，共需如廁近 5 至 6 次。由於首間拘留室缺乏廁所，需通知警員出外如廁；然而，當值警員只安排如廁 2 至 3 次，其餘數次均不得要領。值日警員對的要求置之不理，或者著令等等；奈何人有三急，只好在拘留室地上蹲下小便合共 4 次，尿液亦從拘留室流到拘留室鐵欄外的走廊。表示小便期間走男警和女警出入，由於沒有遮擋，只好趁沒有人看到時才急急小解。當然，如廁後亦沒有獲發清水洗手。

2. 投訴警方拖延時間提供食飲: 被拘留近 2 日期間，前後只獲准飲用 3 次清水，當值警員只准早上及中午喝水，晚上不准喝水。

3. 投訴拘留室中被鋪不衛生: 在拘留室睡覺時不獲發枕頭，提供的被鋪均附有痰印，要求更換不果，直至翌日才有人更換。

4. 投訴拘留室沒有風扇且悶熱翳焗: 拘留室內空氣不流通、氣溫高且非常焗促，沒有風扇或開啟的窗戶，拘留室外的走廊雖有安裝風扇，但亦不能吹入拘留室內。

5. 投訴有廁所的拘留室沒有沖廁設備: 投訴人被拘留一晚後，曾被轉至有裝設廁所的拘留室，然而，如廁後並不能沖水(據了解是壞了，只能由外面的人沖水)，拘留室亦沒有洗手設施。

6. 投訴警方沒有向被拘留人士提供梳洗物品，包括:牙刷、牙膏清潔牙齒，以及毛巾梳洗。

7. 投訴警方沒有向被拘留人士提供洗手及洗澡的設施。

8. 投訴警方沒有主動提供枕頭予被拘留人士

2 Suicides in police custody

The Police force is currently investigating whether any form of misconduct, negligence or security laps was involved in the suicide of the rape suspect, Mr. Lam, at Sau Mau Ping Police Station on 11 May 2017.

However, besides from identifying negligence or security issues, it is also important to identify any deficiency in policy or procedure, systemic problems, poor practice or lack of adequate guidance so that suicides in police custody can be prevented.

Some important questions are:

1. Is the investigation independent and thorough?

2. Does any wider review of policy and practice take place?

3. Is the current system of assessment of risk and vulnerability adequate?

4. Is observation and monitoring of detained people appropriate to the level of risk?

5. Are other professionals, such as health and especially mental health professionals involved in assessment and observation of people at risk?

According to the World Health Organization pre-trial detainees have a suicide attempt rate of about 7.5 times the rate of males out of prison in the general population. The crucial question is how we can prevent death of this vulnerable high risk group? (World Health Organization "Preventing Suicide in jails and prisons" 2007)

SUICIDES IN POLICE CUSTODY

2.1 INDEPENDENCE OF INVESTIGATION

2.1.1 Level of independence of investigation

Current HK procedure

Under the current system an investigation into a suicide which occurs in police custody will be carried out by the Police Force with a Coroner's Court inquest.

According to the Police General Orders, when a person dies in police custody, the investigation will be carried out by a regional or other district unit of the Police not directly connected with the arrest or detention, or an independent Regional or Headquarter formation (PGO 49-33(2)).

Furthermore, according to the Coroners Ordinance (cap 504), if a person dies in official custody the case must be referred to the Coroner to hold an inquest into the death (Cap 504, para 15). The purpose of an inquest into the death of a person shall be to inquire into the cause of and the circumstances connected with the death Cap 504, para 27)

Improve level of independence

Society for Community Organization is of the view that where it is clear from the outset that the individual has not died from natural causes, there should be an independent statutory body in place to conduct the investigation instead of solely relying on the Police Force.

Such an approach would be in line with that taken in the United Kingdom where the Independent Police Complaints Commission has such powers to conduct an investigation. In fact all incidences of death or serious injury in custody settings must be referred by the UK Police Force to the IPCC. (https://www.ipcc.gov.uk/page/referral)

However, in Hong Kong, the IPCC does not have such investigative powers and we therefore have to rely on the Police Force. In the UK, the IPCC will determine the mode of investigation, with different modes indicating levels of involvement of the IPCC and the Police.

2.1.2 Different Modes of Investigation in UK's IPCC.

Independent: **IPCC investigators conduct the investigation,** with an IPCC commissioner having ultimate responsibility for it.

Managed: Investigation is conducted by the police under **IPCC direction and control** under the ultimate responsibility of an IPCC commissioner.

Supervised: Investigation is conducted by the police with **oversight by the IPCC**, who must approve the investigator and agree the terms of reference and investigation plan.

Local: Investigation is conducted by the police with **no IPCC involvement**.

(Independent Police Complaints Commission (UK) 2014: *Review of the IPCC's work in investigating deaths,* p. 31).

An investigation that initially is independent can change to a lower level of independence depending on the circumstances, for instance if it becomes apparent that the person died of natural causes.

Recommendation 1:

It is recommended that the Independent Police Complaints Council of Hong Kong is given statutory powers to investigate deaths in police custody and the power to determine which mode of investigation is to be adopted.

2.2 SCOPE OF INVESTIGATION AND WHO TO REVIEW PROCEDURES

Current Hong Kong practice

The Hong Kong Police Force is now looking into whether any misconduct has taken place and whether the procedures have been followed. It could hopefully also result in some recommendations as to what should/should not be done in the future.

As for the Coroner's Court it will conduct an inquest, resulting in determination of cause and circumstances into the death. It also often leads to some recommendations to the Police regarding preventive measures.

Problems of current practice

However, the current practice is to look at an isolated case and make case specific recommendations. For instance if the investigation into the case reveals that no CCTV was available, it might be recommended to improve CCTV surveillance. However, the investigation by the Police and the inquest Coroners' Court would most likely not make a broader review in terms of how procedures, guidelines and legislation could be improved.

In fact when taking a look at the recommendations made by the Coroners' Court (Appendix 1) regarding suicides in police or prison custody published in the yearly Coroners' Report, it is apparent that the recommendations are very case specific and do not take a broad look to review policies or guidelines.

During the period 2003-2015, the Coroner has made recommendations regarding one incident of suicide in police custody, and 4 incidences in prisons. The recommendations in the 2015 report regarding a suicide in police custody solely focuses on the arrangement and operation of CCTV. It does not review policies or other practices, such as risk assessment of people arrested, the lack of involvement of the IPCC to investigate etc.

However, the IPCC has statutory powers to review practice or procedure adopted by the police force that has led to or might lead to a reportable complaints (paragraph 8 (1) (c) of the Independent Police Complaints Council Ordinance (Cap 604)). SoCO therefore recommends the following:

Recommendation 2:

a. The IPCC should review **the Police General Orders** Chapter 49 regarding the handling of person detained in police custody and the **Force Procedure Manual** referring to experience and legislation overseas, such as those in the UK, in order to prevent deaths in custody.

b. The IPCC should also analyse **recommendations and statistics published by the Coroners' Court** not only in relation to suicide attempts and deaths in police custody, but

also those relating to suicides in prisons and other places where people are detained such as mental health institutions, as such recommendations might be relevant when considering police custody settings.

c. The Security Bureau should initiate an **independent review** into suicides and incidences of self-harm in all places where people are detained by the disciplinary forces, including the Police, the Correctional Services Department, the Immigration Department, the Customs and Excise Department. This could enhance cross-departmental learning, as experience and issues investigated in one department may be useful for other departments.

d. The Security Bureau should also set up an independent **advisory panel** to shape government policy and provide independent advice and expertise in order to share learning and information to prevent deaths in custody.

2.3 ASSESSMENT OF VULNERABILITY AND RISK

Not all arrested persons are equally vulnerable and some may be more prone to suicidal attempts or self-harm. The question is whether the current guidelines or training properly identifies high risk detainees and therefore should be more closely monitored.

2.3.1 Current Hong Kong system

The Police General Orders do to a certain extent include an assessment of vulnerability or risk:

1. **Custody search**: Firstly, the scope of a custody search is determined by the Custody Officer which includes considering suicidal tendency exhibited and previous record of self-harm (PGO 49-4(c))

2. **Records and communication:** Whenever a person in police custody attempts to inflict self-harm or is known to have suicidal tendencies, the Duty Officer shall make an entry in CIS. Where applicable, the Duty Officer shall also inform the I/C

Detained Person Escort Team or the officer taking over custody of the detained person (PGO 49-6(14)).

3. On handing over a person in police custody, the handing over officer shall inform the receiving officer of any relevant matters, which are necessary to know in order to ensure the well-being of such person, including anything said or done by such person that indicates a suicidal tendency or escape (PGO 49-9)

4. **Special Watch Detained Persons** include people with previous records of serious or violent offences; being suspected for, or charged with, serious and violent offences; having an expressed or known suicidal tendency. Officers are to be informed of the presence of Special Watch Detained Persons and the special orders in force for each of them.

5. Special Watch detained persons shall be allocated separate cells form other detained persons and their safe custody shall be subject to the provisions of specific orders (PGO 49(7))

2.3.2 Discussion of risk assessment in the PGO

As SoCO does not have access to internal documents we do not know whether more detailed information as to risk assessment exists. If such exist, they should be published, in order for the public to scrutinize. However, the following could be referenced:

Check list

The college of Policing of the UK has developed a detailed **checklist** on what to ask the detained person in order to assess risk and vulnerability. It includes questions such as:

- Are you experiencing any mental ill health or depression?
- Have you ever tried to harm yourself? If yes, how often, how long ago, how did you harm yourself, have you sought help?
- Is there anything I can do to help?

(https://www.app.college.police.uk/app-content/detention-and-custody-2/risk-assessment/)

Factors which may indicate an increased risk include:

- People arrested in relation to violent or sexual offences, especially where they involve children, a close friend or family
- Being unemployed
- Breakdown of social support and isolation
- Mental ill health including depression, personality disorder, anorexia and schizophrenia
- Drug, alcohol or substance abuse or withdrawal
- Previous episodes of deliberate self-harm, especially if occurring within a custodial environment
- Young males (ages 15-49)
- Elderly people

(World Health Organization "Preventing Suicide in jails and prisons" 2007, and (https://www.app.college.police.uk/app-content/detention-and-custody-2/risk-assessment/)

Whether such factors are part of a risk assessment in the Police Force needs further clarification, as the Police guidelines mainly focuses on people with a history of violence or suicidal behaviour.

Recommendation 3:

a. The Police should develop guidelines and amend the Police General Orders to include a more detailed risk assessment of arrested persons. A check list of questions that should be asked the arrested person. The Police should also indicate factors that should be considered when identifying high risk groups.

b. The assessment of risk and vulnerability should be ongoing as it may change over time.

c. Officers should be properly trained to assess risk and vulnerability.

2.4 LEVELS OF OBSERVATION

2.4.1 Current practice

The Police General Orders do to a certain extent include different levels of observation depending on risk.

1. The Duty Officer shall personally supervise the searching of all cells not less than once per shift (PGO 49-6 (4))

2. A visit to the cells has to be conducted at a minimum of once per hour (49-6 (9))

3. In a station where the individual cells do not open directly into the report room, the Duty Officer will order a police constable to check the detained persons at regular intervals not exceeding 25 minutes (e.g. one check every 25 minutes throughout the shift). (PGO 49-6 (11))

4. The Duty Officer shall arrange a continuous watch over a detained person who is known or is reported to be dangerous, violent or have suicidal tendencies (PGO 49-6(15a))

2.4.2 Discussion:

The Police General Orders only refer to frequency of supervision, visits and checks. However, the UK guidelines are much more detailed and systematized as it based on a thorough risk assessment and also details requirements regarding checking, visiting and rousing the detainee, level of observation, removal of ligatures, communication with the detainee and the involvement of health care professionals where necessary.

Level 1 general observation:

Risk assessment:

Following full risk assessment, this is the minimum acceptable level of observation required for any detainee

Observation:

The detainee is checked at least every hour

Level 2 intermittent observation:

Risk assessment:

Subject to medical direction, this is the minimum acceptable level for detainees who are under the influence of alcohol or drugs, or whose level of consciousness causes concern.

Observation:

- the detainee is visited and roused at least every 30 minutes
- physical visits and checks must be carried out – CCTV and other technologies can be used in support of this

Level 3 constant observation

Risk assessment:

Indicates a heightened level of risk to the detainee (eg, self-harm, suicide risk or other significant mental or physical vulnerability)

Observation:

- the detainee is under constant observation and accessible at all times
- physical checks and visits must be carried out at least every 30 minutes
- CCTV is constantly monitored (other technologies can also be used)
- any possible ligatures are removed
- the detainee is positively communicated with at frequent and irregular intervals
- review by the health care professional in accordance with the relevant service level agreement.

Level 4 close proximity

Risk assessment:

Detainees at the highest risk of self-harm should be observed at this level.

Observation:

- the detainee is physically supervised in close proximity to enable immediate physical intervention to take place if necessary
- CCTV and other technologies do not meet the criteria of close proximity observation but may complement it
- issues of privacy, dignity and gender are taken into consideration
- any possible ligatures are removed
- the detainee is positively communicated with at frequent and irregular intervals
- review by the HCP in accordance the relevant with service level agreement.

Recommendation 4:

Develop a more structured response to risk by detailing levels of observation referring to requirements regarding checking, visiting and rousing the detainee, level of observation, removal of ligatures, communication with the detainee, and the involvement of health care professionals where necessary.

2.5 INVOLVEMENT OF HEALTH CARE PROFESSIONAL

The PGO does not mention involvement of a health care professional if a person is deemed to be vulnerable or at risk.

The College of Policing in the UK stipulates that detainees who are deemed to be a high risk of suicide or self-harm must be seen by an HCP and kept under close proximity supervision. The HCP should provide a care plan that will specifically identify their assessment of the risk and any mitigating measures in all cases of suicidal ideation and self-harm.

Recommendation 5: The Police Force should provide a care plan for people deemed vulnerable or at risk, and set up a working relationship with community mental health institutions.

2.6 SUMMARY OF RECOMMENDATIONS:

Recommendation 1:

It is recommended that the Independent Police Complaints Council of Hong Kong is given statutory powers to investigate deaths in police custody and the power to determine which mode of investigation is to be adopted.

Recommendation 2:

a. The IPCC should review **the Police General Orders** Chapter 49 regarding the handling of person detained in police custody and the **Force Procedure Manual** referring to experience and legislation overseas, such as those in the UK, in order to prevent deaths in custody.

b. The IPCC should also analyse **recommendations and statistics published by the Coroners' Court** not only in relation to suicide attempts and deaths in police custody, but also those relating to suicides in prisons and other places where people are detained such as mental health institutions, as such recommendations might be relevant when considering police custody settings.

c. The Security Bureau should initiate an **independent review** into suicides and incidences of self-harm in all places where people are detained by the disciplinary forces, including the Police, the Correctional Services Department, the Immigration Department, the Customs and Excise Department. This could enhance cross-departmental learning, as experience and issues investigated in one department may be useful for other departments.

d. The Security Bureau should also set up an independent **advisory panel** to shape government policy and provide independent advice and expertise in order to share learning and information to prevent deaths in custody.

Recommendation 3:

1. The Police should develop guidelines and amend the Police General Orders to include a more detailed risk assessment of arrested persons. A check list of questions that should be asked the arrested person. The Police should also indicate factors that should be considered when identifying high risk groups.

2. The assessment of risk and vulnerability should be ongoing as it may change over time.

3. Officers should be properly trained to assess risk and vulnerability

Recommendation 4:

1. Develop a more structured response to risk by detailing levels of observation referring to requirements regarding checking, visiting and rousing the detainee, level of observation, removal of ligatures, communication with the detainee, and the involvement of health care professionals where necessary.

Recommendation 5:

The Police Force should provide a care plan for people deemed vulnerable or at risk, and set up a working relationship with community mental health institutions.

Appendix 1

Recommendations in the Coroners' Report regarding suicides in police and prison custody 2003-2015

Year of report	Incidence	Recommendation
2015	A male committed suicide by hanging himself in a police cell	1. To increase the number of CCTV or to adjust the angle of the CCTV cameras so as to enable the surveillance of the situation in various cells. 2. To arrange contractors to conduct regular check on the video system and recording functions of the CCTV. 3. To add more monitor to display through respective CCTV to situation in the cells throughout to facilitate the surveillance of various cells and to ensure the normal operation of the CCTV

Prison custody:

Year of report	Incidence	Recommendation
2015	Inmate hung himself in cell	1. All consumables upon depletion must be returned to the duty officer for replacements or to be written off, and cannot be at others' disposal 2. The windows of the prison cells are recommended to be moved to a position too high to reach. 3. Install additional barriers; for example cover surrounding key holes to prevent prisoners from touching the key holes from inside. (recommendation iii)
2015	Inmate committed suicide by hanging himself in cell	1. It is recommended that the department (CSD and police) may set out guidelines on the patrol duration so at to let CSD officers make good use of the opportunity during patrol to observe the prisoners' situation.

2011	Five prisoners committed suicide by hanging within a period of nice months; four of them being prisoners in Stanley prison	1. When situation arises which requires emergency rescue vehicles to be called, staff has to be deployed to stand by at the main entrance to open the gate, so at to reduce the time for rescue personnel to arrive at the scene. 2. The duty officers on patrol, when making entries in the "Remark" or "Finding" column in the escapee list and medical observation list, should record the prisoners' condition more specifically. 3. Strengthen the training of frontline staff so as to improve their alertness on the suicidal tendency of prisoners. 4. Study the feasibility of bedsheet substitutes. 5. Ensure adequate supervision of prisoners during shift handovers. 6. When the number of inmates in a block has increased, the number of patrolling officers should also increase accordingly so as to maintain the quality of patrolling.
2010	Prisoner hanged himself in cell not being noticed by Correctional Services Department's staff several hours after his death, despite the staff claiming regular patrol of 20 minutes intervals	1. Senior officers to carry out surprise inspections on the work of patrolling officers. 2. Senior officers to conduct random patrols on cells. 3. The number of suicidal risk assessments on prisoners to be increased. 4. The number of psychological counselling on prisoners to be increased. 5. CCTVs to be installed in the corridors of prison cells.