**Society for Community Organization**

**Press release**

 18 May 2017

**SoCO calls for independent review of suicides in police stations**

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)

**1. Independence of investigation**

**a. 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 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.

***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.

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| ***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. |

**1.2 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:

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| ***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. 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.

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 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 or, 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))

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.

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| ***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 |

**3. Levels of observation**

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))

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.

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| ***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.  |

**4. 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.

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| ***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.  |

**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**

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| **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:**

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| **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’ disposal2. 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. |