Society for Community Organization

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Government should review of suicide prevention measures in prisons

Introduction

On 10 July 2017 a rape suspect remanded in Lai Chi Kok Reception Centre was found to have attempted suicide by hanging himself from a window frame of a toilet. The case has been reported to the police. According to media reports the man has a previous criminal record of indecent assault and robbery.

SoCO has previously commented and made recommendations in relation to prevention of suicide in police custody. The background was the suicide of another rape suspect in Sau Mau Ping police station on 11 May 2017.

According to the World Health Organization pre-trial detainees are 7.5 times more likely to commit suicide than the general population. Therefore a particular focus on suicide prevention is necessary in order to protect and take care of people who are detained in different facilities, including police stations, detention centres and prisons.

When looking at the self-harm statistics of prisoners in Hong Kong, in fact every 4-5 days, a person in custody attempts to harm himself.

It is therefore recommended that the government sets up a comprehensive suicide prevention programme to protect persons in custody.

Statistics:

Yearly statistics published by the Correctional Services Department

Year	Number of suicide attempt	Number of people who died from suicide
2011	95	0
2012	88	2
2013	81	1
2014	68	1
2015	72	1
2016	79	1

(Source: CSD annual reviews and press releases)

Government policy

According to the CSD the most recent review was conducted in 2011. The CSD states that it has implemented improvement measures including enhanced training to increase staff sensitivity to and awareness of suicidal signs and symptoms, enhanced mechanism for monitoring and reporting of at-risk cases, refinement of the screening protocol for early screening of inmates for suicidal tendencies, and modifications to the fittings in prison accommodation to make suicide attempts more difficult. (HKSAR report under the Convention Against Torture 2013).

Recommendations by the Coroner's Court

The CSD will refer cases of suicide to the Coroner's Court. The following table lists out the recommendations that the Coroner's Court has made in relation to specific incidences of suicide of persons in custody (Appendix 1`)

Some of the recommendations are:

Physical barriers:

a. move windows higher up

Monitoring:

Guidelines for patrol duration

Install CCTV in corridors

Training:

Training of CSD staff alertness of suicidal tendency

Risk assessment:

Increase number of risk assessment

Counselling:

Increase psychological counselling

It is recommended that the Correctional Services Department reports to the public which measures have been taken up and the follow up actions.

Problems with the current mechanism

SoCO welcomes the fact that CSD has stated in the government report to the United Nations Committee against Torture that it regularly reviews how to prevent suicide.

However, the review is internal and not made public, which makes it difficult for the public to monitor the scope of the review and its implementation.

Furthermore the recommendations by the Coroner's Court are case specific and one cannot expect the Coroner's Court to conduct a comprehensive review of the suicide prevention mechanism or policy.

World Health Organization (WHO) best practice model

The WHO has published a booklet called "Preventing Suicide in Jails and Prions" in association with the International Association for Suicide Prevention in 2007.

According to the WHO there are certain factors where people may be at higher risk of suicide in prisons:

Factors:

1. Suicide profile: target high-risk groups and situations: pre-trial detainees who attempt suicide are generally young, unmarried and first time offenders. However, profiles change over time.

2. Situational factors: tend to occur by hanging, when staffing is low, such as nights or when prisoners are alone. People who are in solitary are also at higher risk.

3. Psychosocial factors: poor social and family support or prior suicidal behaviour. They often experience bullying or inmate-inmate conflict.

The following may also indicate higher risk of suicide:

a. Substance abuse

b. Inmate expresses high level of shame and guilt
c. Mental health problems
d. Previous suicide attempts, thoughts or planning.

Key components of a suicide prevention programme:

1. **Training:** Correctional staff should have training in suicide prevention, and have a refresher training course each year. It should include health care and mental health personnel. The training includes warning signs and symptoms, high risk groups, suicide prevention policy. Standard first aid, use of emergency equipment.
2. **Intake screening:** Medical and psychological assessment by facility based professionals should be conducted. If there is a lack of resources, correctional staff can screen persons through a questionnaire.

3. **Ongoing observation is important**
   a. Routine security checks: look for indicators such as crying, insomnia, change of mood, change of eating habits, loss of interest in activities, refusal to take medication.
   b. Officers need to cultivate the type of relationship with the prisoner that will facilitate the prisoner disclosing his distress and despair.

4. Monitoring of suicidal inmates:

a. Monitoring should be increased during night shift where staffing levels may be lower.
b. Supervision according to risk level.
c. Provide social support to high risk inmates.
d. Monitoring of those who have been placed in isolation.
e. Minimize bullying, reduction of stress levels in prisons.

Mental health treatment:

a. Those with mental disorders and suicide risk should receive treatment.

b. If identified as at risk of suicide further evalution and treatment by mental health staff should be provided.

c. The prison should forge strong links with community-based health and mental health facilities.

Recommendations:

1. 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.

2. 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.

3. The CSD should develop **guidelines** and **amend the Prison rules** to set up a comprehensive suicide prevention mechanism. A check list of questions for screening of persons to identify people at high risk should be developed. The CSD should also indicate factors that should be considered when identifying high risk groups.

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

5. Officers should be properly trained to assess risk and vulnerability and to monitor people at risk.

6. 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.

Appendix 1

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

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	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

	staff several hours after his death, despite the staff claiming regular patrol of 20 minutes intervals	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.