**Society for Community Organization**

**Press release**

9 January 2018

**The government should respect the rights of people in custody**

**The government’s public consultation on civil and political rights**

The government is preparing its fourth report to the United Nations Human Rights Committee (HRC) in light of the International Covenant on Civil and Political Rights (ICCPR), which has been in force in Hong Kong since 1976. The government is supposed to submit its report to the United Nations by 30 March 2018 covering civil and political rights in Hong Kong from 2011 to 2018. The previous hearings by the HRC took place in 1999, 2006 and 2013.

The Constitutional and Mainland Affairs Bureau (CMAB) has prepared an outline of topics to be included in the report[[1]](#footnote-1), and is therefore conducting a public consultation, inviting the public to comment on the outline on the civil and political rights in the HKSAR. The consultation started 1st December 2017 and ends 12th January 2018.

Society for Community Organization is submitting its views to the Constitutional and Mainland Affairs Bureau and urges the government to highlight in its UN report issues relating to the human rights of people arrested, are remanded in detention or imprisoned (people in custody).

SoCO calls on the CMAB to thoroughly review whether the current system in place provides adequate human rights protection to people in custody, and is of the strong view that it is necessary to set up independent monitoring mechanisms to protect people in custody.

**United Nations’ major concerns on Hong Kong in 2013**

According to the 2013 concluding observations[[2]](#footnote-2) of the UN Human Rights Committee, some of the major concerns are:

1. The Human Rights Committee called for an **independent statutory body to investigate and monitor violations of human rights.** It called on Hong Kong to strengthen the mandate and independence of the existing bodies and reiterated its concern about the lack of an independent human rights institution with competence to consider and act on individual complaints on hum rights violations (para. 8 of the concluding observations)

2. **Investigations of police misconduct** are carried out by the Complaints Against Police Office (CAPO) while the Independent Police Complaints Council (IPCC) only has advisory and oversight functions.

The Human Rights Committee recommended the establishment of a fully independent mechanism to conduct independent, proper and effective investigations into complaints about abuse of power or inappropriate use of force by the police.

**The government’s outline of its submission to the Human Rights Committee**

Besides from commenting on the above, the government has further noted in its outline that it will report on:

Article 6: Right to life:

The number of deaths in custody of the disciplinary forces.

Article 7: No torture or inhuman treatment:

Instances of alleged use of torture or other forms of ill-treatment.

Article 10: Rights of persons deprived of their liberty:

* The rights of persons in custody
* Regulation and management of penal establishments

SoCO is disappointed that the government in its public consultation has merely highlighted the issues to be included rather than writing in more detail about the content of its submission to Human Rights Committee. Had it for instance summed up its measures and policy on how it ensures that the rights of people in custody are protected, the public would be in a much better position to comment on the adequacy of the consultation document.

There is a strong need to thoroughly review whether the rights of people in custody are properly protected.SoCO would therefore like to draw the attention to the following issues:

**SoCO’s major concerns**

***a. Prison complaints system:***

The Complaints Investigation Unit (CIU) of the Correctional Services Department (CSD) has seen a rise in the number of cases. While the number was 94 cases in 2014, it was 120 in 2016. The major complaints in 2016 concerned misconduct of staff (38%), abuse of authority (23%), and use of unnecessary force (13%). However, the number of cases substantiated has remained low over the years. For a five year period (2012-16), 579 cases were investigated by the CIU but only 3 were substantiated. In 2016, 120 cases were investigated with zero cases substantiated.

The CIU is an internal mechanism and lacks independence. The government has all along pointed to the fact that the Justices of Peace (JP) who visit custodial institutions represent an independent mechanism to receive complaints. In 2016 JPs made 426 visits to institutions under the CSD, and in 2015 the JP’s received 106 complaints from inmates against the CSD, while the number was 128 complaints in 2016. However, it is important to keep in mind that most complaints are referred back to the CSD instead of conducting independent investigations into complaints. Thus of the 128 complaints in 2016, 95 were referred to the institution or to CIU, while in the rest of the cases, no further action was taken.

As for the Ombudsman, in 2016 it received 63 complaints about the CSD, of which 24 inquiries were made, and where 2 cases were found with inadequacies. In most cases the Ombudsman will merely make inquiries to the CSD about the content of a complaint, and

Because prisons are enclosed system with the prisoners being under full control of the CSD, many prisoners are fearful of complaining, especially if it concerns abuse of authority. The fear of retribution is widespread and many have reported of being placed in solitary confinement, reported for a disciplinary offences, being beaten by either CSD staff or other inmates for having complained. The lack of an independent mechanism to investigate claims of abuse or other complaints means that only very few claims are substantiated and that most people in fact do not complain. The number of complaints received by the CIU is therefore just the tip of the iceberg.

Recommendation

SoCO calls on the government to set up an independent monitoring mechanism with investigative powers and to ensure that complainants are separated from the persons complained against to avoid retaliation. It should inspect all custodial facilities and be able to make unannounced visits.

SoCO also recommends improving the record keeping of the CSD to save evidence, including CCTV in more non-private areas of prisons and keeping CCTV recording for at least half a year instead of the current practice of just keeping recordings for one month.

***b. Solitary confinement still widely used:***

Solitary confinement refers to the act of placing a prisoner in a special housing unit, wherein the prisoner is segregated from other prisoners. In this small cell, the prisoner is isolated for 23 hours a day – having only one hours of exercise. The prison rules that govern on solitary confinement are extremely vague and under-regulated – and there is no independent third-party reviewing the details of any cases. The estimated average number of solitary confinement cases in Hong Kong is at about 8.000 cases every year from 2000-2015. On average this means that there is at least one person sent to solitary confinement once every hour of the day – 365 days a year.

Solitary confinement should be properly controlled and reduced to a minimum, because it poses is a health hazard: The list of health risks includes everything from panic attacks to suicide, anxiety, self-mutilation, unprovoked anger, insomnia, hallucinations, paranoia, psychosis and many more. Particularly, prisoners that are not informed about the reason and duration and those who already have a mental illness are extremely vulnerable to solitary confinement.

The Human Rights Committee has commented that “solitary confinement is a harsh penalty with serious psychological consequences and is justifiable only in case of urgent need; the use of solitary confinement other than in exceptional circumstances and for limited periods is inconsistent with [ICCPR]” and that it may amount to torture or cruel, inhuman or degrading treatment or punishment[[3]](#footnote-3).

SoCO’s analysis of the relevant prison rules reveal the following:

1. **Administrative**: Most of the rules permit the use of solitary confinement as a purely administrative decision and by discretion of the Superintendent, except for Rule 63(b). No hearings or written detailed reasons for special unit confinement are required. Especially Rule 68B provides for wide discretion to the Superintendent to place a prisoner in isolation since “good order”, “discipline”, and “interest of prisoner” are rather vague terms and provides for the risk of arbitrary use of the rules.
2. **Judicial oversight:** None of the rules requires judicial oversight for placing a person in solitary confinement, except for Rule 63(b), which requires a disciplinary hearing. However, the hearing is internal and not conducted by an independent judicial body. No legal representation is allowed.
3. **Medical certification:** Some of the rules do not require the medical officer to certify that the prisoner it fit for removal and that daily visits from a medical officer will be conducted (Rules 58, 68, 68A). No rules specify that a mental health specialist should monitor the isolation.
4. **Time limit:** Only rule 63(b), where solitary confinement can be imposed as a punishment, specifies an upper time limit of 28 days. All the other rules do not have any upper time limit for isolating a prisoner.
5. **Appeal:** Only Rule 63(b) has a formal appeals procedure if a prisoner wants to appeal the results of the disciplinary hearing. The appeals mechanism is not independent however.
6. **Regular review:** Only Rule 68B includes a Board of Review to review the cases on a monthly basis. However, the Board of Review is not independent.

Recommendation:

(Referring to the Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment[[4]](#footnote-4)):

1. Develop alternative disciplinary sanctions to avoid the use of solitary confinement

2. Abolish the use of solitary confinement for juveniles and persons with mental disabilities.

3. Indefinite solitary confinement should be abolished.

4. Prolonged solitary confinement, in excess of 15 days, should be subject to an absolute prohibition.

5. Solitary confinement should be used in only very exceptional circumstances, as a last resort, and for as short time as possible.

## Appendix 1: Statistics on the use of solitary confinement (2000-2015)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Year | Rule 58 | Rule 63 (1) (b) | Rule 68B | Rule 68 | Rule 68A | **Total Number** | Prison Population |
| 2001 | N/A | ~3428 | N/A | N/A | N/A | **3428\*** | N/A |
| 2002 | N/A | ~3428 | N/A | N/A | N/A | **3428\*** | N/A |
| 2003 | N/A | ~3428 | N/A | N/A | N/A | **3428\*** | N/A |
| 2004 | N/A | ~3428 | N/A | N/A | N/A | **3428\*** | N/A |
| 2005 | N/A | ~3428 | N/A | N/A | N/A | **3428\*** | 12 390 |
| 2006 | N/A | ~3428 | ~626 | N/A | N/A | **4054\*** | 11 849 |
| 2007 | N/A | ~3428 | ~626 | N/A | N/A | **4054\*** | 11 601 |
| 2008 | N/A | ~3428 | ~626 | N/A | N/A | **4054\*** | 10 882 |
| 2009 | 3744 | ~3000 | 1452\*\* | N/A | N/A | **8196** | 10 615 |
| 2010 | 3360 | ~3000 | 1668\*\* | N/A | N/A | **8028** | 10 196 |
| 2011 | 3648 | 2477 | 1856\*\* | N/A | N/A | **7865** | 9 702 |
| 2012 | 3360 | 2508 | 1671\*\* | N/A | N/A | **7538** | 9 285 |
| 2013 | N/A | 2423 | 1382\*\* | N/A | N/A | **3805\*** | 9 240 |
| 2014 | N/A | 2715 | 1417\*\*\* | N/A | N/A | **4132\*** | 8 830 |
| 2015 | N/A | 2905 | 1267 | N/A | N/A | **4172\*** | N/A |
| 2016 |  | 3297 | 1255\*\*\*\* |  |  | **4552** |  |

**Notes:**

1. The data is combined from UN CAT’s report on Hong Kong and CSD.
2. \*Important to note that the data of the table in no way accounts for the total number of solitary confinement cases, as the government does not regularly maintain statistics on Rule 58, Rule 68 and Rule 68A of the prison rules. Again showcasing how unregulated the practice of solitary confinement is in Hong Kong.
3. Rule 58: Prisoner awaiting disciplinary hearings.
4. Rule 63(b): Punishment for prisoners found guilty in disciplinary hearing.
5. Rule 68B: Removal from association.
6. Rule 68: Temporary confinement of refractory or violent prisoner.
7. Rule 68A: Medical officer ordering prisoner to protected room.
8. Prison population refers to the daily average prison population a given year.
9. \*\*For 2009-2012 under prison rule 68B regarding the duration of solitary confinement, the percentage of cases were the following: 60% of the cases lasted for 72 hours or less, 30% of the cases lasted for 72 hours – 1month, 10% of the cases lasted for more than 1 month, and 3 of the cases lasted for were 4 months or more.
10. \*\*\*Duration: 63% of the cases lasted 72 hours or less and 35% between 72 hours-4 months.
11. \*\*\*\* In 2016, for cases under rule 68B, there were 817 cases which lasted 72 hours or less, while 438 lasted more than 72 hours. During 2012-16, there were 120 cases where removal from association lasted for four months or above.

***C. Deaths in custody of police and the Correctional Services Department***

In May 2017 a male suspect was arrested for rape and later found to have committed suicide in Sau Mau Ping police station, which led to discussions about whether the police had properly prevented him from self-harm while in custody.

Also, 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.

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.

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)

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

**CSD:**

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).

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.

Recommendation

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

**Police:**

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.

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, an 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. Thus 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.

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 and the Coroners’ Court.

Recommendations

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.

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.

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 should be asked the arrested person. The Police should also indicate factors that should be considered when identifying high risk groups.

Also, it should 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.

Lastly, 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.

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.

**Summary of recommendations:**

1. The government should set up a human rights institution according to the Paris Principles to promote and protect human rights. It should make recommendations on law reform and be able to hear individual complaints.

2. SoCO calls on the government to set up an independent monitoring mechanism with investigative powers and to ensure that complainants are separated from the persons complained against to avoid retaliation. It should inspect all custodial facilities and be able to make unannounced visits.

3. Develop alternative disciplinary sanctions to avoid the use of solitary confinement. Abolish the use of solitary confinement for juveniles and persons with mental disabilities, and abolish indefinite solitary confinement. Prolonged solitary confinement, in excess of 15 days, should be subject to an absolute prohibition. Solitary confinement should be used in only very exceptional circumstances, as a last resort, and for as short time as possible.

4. The Police should develop guidelines and amend the Police General Orders to include a more detailed risk assessment of arrested persons. Also, it should 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.

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**Case illustrations on solitary confinement**

**Mr. Chan’s account of his experience of solitary confinement**

*1. Lack of psychological and physical assessment before, during and after solitary confinement.*

When I was in solitary confinement I felt emotionally unstable. I felt as if I was an animal in a cage, without any freedom. I felt very depressed, anxious, bored, angry and isolated. Also I didn’t sleep well because people placed in the cells next to my cell were making noise.

Especially since I had been placed under the medical observation list by Lai Chi Kok Reception Centre, when entering Siu Lam Psychiatric Centre, I should not have been placed in solitary confinement. According to recommendations by the United Nations, no people with mental health issues are fit to stay in solitary confinement.

*2. Lack of social interaction and access to news: Solitary confinement deprived me from* participating in religious fellowships, additional family visits, social interaction, team working in workshop, watching TV.

*3. Unreasonable grounds for being placed in solitary confinement:*

There was a management failure to investigate whether solitary confinement was warranted each time. Also there was a failure to explore alternatives to solitary confinement

1. Complaining: I was placed in solitary confinement under the excuse that I had breached the Prison Rules. However, I am persuaded that solitary confinement was used instead as a revenge punishment because I had complained about the illegal acts, conduct and behavior of prisoners and staff.

2. Disciplinary hearing: Also, on one occasion I was placed in solitary confinement for nearly 1 ½ months because I was going through a pro-longed disciplinary hearing. The disciplinary hearing was pro-longed because I had asked for CCTV and witnesses. It is unfair that I had to stay in solitary confinement just because the disciplinary hearing took so long.

**3.** Urine test: I was sent to Siu Lam on a Friday and because they didn’t conduct any urine test over the weekend, I had to stay in solitary confinement to wait for the urine test. This is unfair as I was just waiting for a urine test and hadn’t breached any Prison Rules.

*4. Inhumane physical conditions*

In Siu Lam Psychiatric Centre there was a lack of natural daylight in the solitary confinement cell. The window had been blocked by wooden blanks. Also, the fluorescent lights were on 24 hours a day, and were not dimmed during the evening. I had to use blankets, which were dirty, to cover my face in order to be able to sleep.

Also, I was not allowed to do any 1 hour indoor and outdoor exercise in Siu Lam as stated by law.

I couldn’t sleep well. There was a bed, but the cell was very noisy, because next door there were other cells. This is of course also the fact in normal cells, but because the other prisoners will be tired from working in the workshop, they will sleep at night. However, in solitary confinement everyone is bored and they will be noisy.

There was just a low mattress and no bed, no chair and table was provided in Siu Lam solitary confinement. During day time they will remove your blankets during the day, only the mattress is left. The mattress is low on the floor. There was no bed, chair or table. At that time my leg was also painful. When I needed to get up from the mattress it was very difficult, especially because I have walking disability

*5. No independent monitoring*

There is no independent monitoring body specifically focused on monitoring the use of solitary confinement, nor was there any review of whether I was mentally or physically fit to stay in solitary confinement.

*6. No time limit*

I was once placed in solitary confinement under Prison Rule 68B, referring to the fact that the CSD wanted to protect me against other prisoners. However, after 28 days, it was renewed and I didn’t know when I would be released. The uncertainty and lack of time limit added severely to my stress of being placed in solitary confinement.

*7. No due process*

I was placed in solitary confinement due to different reasons:

1. While a disciplinary hearing was ongoing

2. After a disciplinary hearing, imposed as a punishment

3. As so-called protection against assault from other prisoners.

4. While waiting for a urine test to be conducted

On no occasions was I offered a lawyer, nor did I appear before an independent tribunal.

*8. No written records of reasons of solitary confinement given to me.*

Except once, I did not receive any written statement stating under which Prison Rule I was placed in solitary confinement, nor was I given the reasoning behind my solitary confinement.

**Case illustrations on making complaints inside prison**

Case 1:

Mr. C made a complaint to CIU about an incident of staff misconduct: an officer (Officer A) forced him to fabricate a submission explaining why he did not make the scheduled visit to the hospital. On the day of the pre-scheduled medical visit, Mr. C discovered that he was arranged to make the visit on a “category-A” security bus. From his own experience, Mr. C claimed that he will get dizzy and unwell if traveling on that type of bus, thus, he asked to change the bus or else he would opt to miss the visit.

According to CSD guidelines, inmates missing these medical visits for any reasons will need to meet with a Medical Officer and explain their reasoning behind missing the visit, as well as ensure they are informed of the possible consequences of missing those medical checks. In addition, inmates will have to write a submission explaining the reason for absence. Therefore, Mr. C wrote the first submission based on the reasons mentioned above.

However, after Officer A read Mr. C’s original submission, Officer A immediately told Mr. C that he cannot write like that and has to rewrite according to Officer A’s intentions. Then, Mr. C involuntarily rewrote his submission under Officer A’s coercion. The second submission, which stated that Mr. C opted out of the scheduled medical visit because he thinks that he has recovered and will not need the visit, was ultimately accepted by CSD officers and submitted to relevant prison authorities. The hard copy of the first submission was kept by Mr. C.

After the receipt of Mr. C’s complaint, the CIU met with the relevant officers and prisoners present that day for testimonies. All officers unanimously testified that there was no violation of rules during the submission-writing process, and that they have not seen any other staff coercing Mr. C to fabricate a submission that day. As for the prisoners, all testified that they could not recall what happened that day due to the lapse of time.

As for physical evidence, no CCTV records have been referenced or mentioned in the complaints investigation report, nor has the first submission been consulted for the purpose of references and validation of Mr. C’s claims. More importantly, the complainee (Officer A) left CSD before the receipt of the complaint, and the CIU has done nothing other than sending the complainee double-registered mail twice asking for his version of the incident. Ultimately, due to the absence of the complainee’s response to CIU’s letters and hence the lack of crucial testimony, the complaint was classified as “not pursuable” and the case was closed.

Case 2:

Mr. Wong coughed when taking medicine at the dining hall, after which an inmate spoke foul language to him. He asked a staff whether he could help tell the prisoner not to speak impolitely to him, but the staff told him to contact a higher ranking officer. He was then told by that higher ranking officer to write a statement. However, when he handed it to the officer, the officer didn’t accept it and asked him to write another one. He initially wrote: “When I was eating, the other prisoner spoke foul language, and when I asked staff to help, the staff told me to contact a higher ranking officer.” However, the officer didn’t accept this statement, and told Mr. Wong to re-write the statement to include that Mr. Wong spoke loudly to the staff.

After handing in the rewritten statement, Mr. Wong was reported for a disciplinary offence and therefore placed in solitary confinement on 29/10/17 awaiting disciplinary hearing. At the same time he made a complaint to the Correctional Services Department Complaints Investigation Unit. On 31 October 2017 he attended the disciplinary hearing where he pleaded not guilty. Because of this and his case was being investigated by the CIU, he was placed back in solitary until he was released on 6 November 2017. He spent 9 days in solitary confinement.

1. Constitutional and Mainland Affairs Bureau December 2017: “An outline of the topics to be covered in the fourth report of the Hong Kong Special Administrative Region in the light of the International Covenant on Civil and Political Rights” extracted from: <http://www.cmab.gov.hk/doc/en/documents/policy_responsibilities/the_rights_of_the_individuals/ICCPR4_Outline_Full-e.pdf> [↑](#footnote-ref-1)
2. United Nations Human Rights Committee: “Concluding observations on the third periodic report of Hong Kong, China, adopted by the Committee at its 107th session (11-28 March 2013) , CCPR/C/CHN-HKG/CO/3 extracted from: <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2fCHN-HKG%2fCO%2f3&Lang=en> [↑](#footnote-ref-2)
3. Human Rights Committee, Concluding Remarks on Denmark. 31/10/2000. CCPR/CO/DNK [↑](#footnote-ref-3)
4. United Nations General Assembly. Note by the Secretary- General: Torture and other cruel, inhuman or degrading treatment or punishment. Sixty-sixth session. Item 69 (b) of the provisional agenda (document A/66/268) [↑](#footnote-ref-4)