131st MEETING OF THE INDEPENDENT POLICE COMPLAINTS COUNCIL (IPCC) MEETING WITH THE COMPLAINTS & INTERNAL INVESTIGATIONS BRANCH (C&IIB) HELD AT THE IPCC SECRETARIAT OFFICE AT 1602 HOURS ON THURSDAY, 24 JANUARY 2008

Present:	Mr Ronny WONG Fook-hum, SC, JP Mr YEUNG Yiu-chung, BBS, JP Dr LO Wing-lok, JP Mr Edward PONG Chong, BBS, JP Prof Benjamin TSOU Ka-yin, BBS Dr TSE Tak-fu, BBS Mrs Helena YUEN CHAN Suk-yee Dr Lawrence LAM Chi-kit, MH Mr Clement TAO Kwok-lau, BBS, JP Mrs Brenda FUNG YUE Mui-fun, Secy IPCC Mrs Philomena LEUNG, Secy IPCC (Des) Ms Angela HO, SGC IPCC	(Chairman)
	Mr Brandon CHAU, Deputy Secy IPCC Mr Michael B. DOWIE, DMS Mr Alfred MA Wai-luk, ACP SQ Mr Alan FAN Sik-ming, CSP C&IIB Mr J.P. RIBEIRO, SSP CAPO	(Joint Secretary)
	Mr CHEUNG Kin-kwong, SP CAPO HQ	(Joint Secretary)
In Attendance:	Mr Eddie WONG, SAS (PS) Mr Henry CHAN, SAS (1) Ms Fiona LI, SAS (2) Mr Bernard KAN, SAS (3) Miss Mary KWOK, AS (PS) 1 Mr Tony SIU Kit-hung, SP CAPO K Mr Eddy TONG Chi-chung, CIP CAPO HQ Mr Stephen MOK Hing-wing, CIP T2 CAPO K Ms CHAN Shuk-ming, SIP IPCC C&IIB Mr Kenneth LAM Chi-ping, SIP SUP CAPO	
Absent with Apologies:	Hon Daniel LAM Wai-keung, SBS, JP Dr Hon LUI Ming-wah, SBS, JP Dr Hon Joseph LEE Kok-long, JP Mr HUI Yung-chung, BBS, JP Dr Michael TSUI Fuk-sun Ms Priscilla WONG Pui-sze, JP Mr Barry CHEUNG Chun-yuen, JP Mr WONG Kwok-yan Ms Emily CHEUNG Mui-seung	(Vice-chairman) (Vice-chairman) (Vice-chairman)

PART A CLOSED MEETING

This was the Closed Part of the meeting for the IPCC and representatives of C&IIB to discuss matters of mutual concern. The minutes of the meeting will not be uploaded onto the IPCC Homepage.

PART B OPEN MEETING

OPENING ADDRESS

The Chairman welcomed all to the meeting.

I <u>CONFIRMATION OF THE MINUTES OF THE MEETING HELD ON</u> 22 NOVEMBER 2007 (Open Part)

2. The minutes of the last meeting (open part) were confirmed without amendment.

II <u>CAPO'S CRIMINAL AND DISCIPLINARY CHECKLIST</u>

3. <u>The Chairman</u> invited CAPO to brief the meeting regarding the CAPO's Criminal and Disciplinary Checklist covering the period between 1st November 2007 and 2nd January 2008.

4. <u>CSP C&IIB</u> informed the meeting that the checklist was as tabled and he had nothing to highlight.

5. <u>The Chairman</u> noted that there were several cases on the checklist, namely A35, A37 and A93 in which the officers concerned were advised to be tactful in communicating with members of the public during traffic enforcement actions. While the Council appreciated that officers conducting traffic enforcement actions had a difficult job to do as members of the public subject to those actions might feel agitated and some might turn uncooperative and vindictive, tactful communication skills might save officers from any misunderstandings or complaints. He would like to know if there was sufficient training on communication skills for officers taking traffic enforcement actions.

6. <u>CSP C&IIB</u> responded by saying that he also noted those mentioned cases in which officers taking traffic enforcement actions were complained of having a poor attitude or being impolite. Although all those complaints were unsubstantiated, it was the Force's commitment to strive for continuous improvement in service quality. Pursuing continuous improvement in service quality had been the Force's vision and mission. All along, the Commissioner of Police would like to ensure that all officers executed their duties properly and politely, and that would be emphasized in both induction trainings and on the job trainings to officers. In order to enhance frontline officers' service quality and professionalism, officers would be reminded of such during CAPO's liaison visits and complaints prevention talks. The issue would also be highlighted in the 'Matter of Interest' of the CAPO's Monthly Report to remind them to pay attention to their attitude when taking traffic enforcement actions. Those cases would also be referred to the Complaints Prevention Committee so that more effort could be spent in this regard.

III <u>CAPO'S MONTHLY STATISTICS</u>

7. CSP C&IIB briefed the meeting that 226 complaints were received in October 2007, an increase of 20.2% (+38 cases) when compared with the statistics of the previous month. For the month of November 2007, 220 complaints were received, which was a decrease of 2.7% (-6 cases) when compared with the statistics of the previous month. For the month of December 2007, 227 complaints were received, which was an increase of 3.2% (+7 cases) when compared with the statistics of the previous month.

8. The number of 'Neglect of Duty' complaints received in October 2007 was 85 cases, an increase of 3.7% (+3 cases) when compared with the statistics of the previous month. For the month of November 2007, the number of 'Neglect of Duty' complaints received was 91 cases, which was an increase of 7.1% (+6 cases) when compared with the statistics of the previous month. For the month of December 2007, the number of 'Neglect of Duty' complaints received was 91 cases, which was an increase of 7.1% (+6 cases) when compared with the statistics of the previous month. For the month of December 2007, the number of 'Neglect of Duty' complaints received was 97 cases, which was an increase of 6.6% (+6 cases) when compared with the statistics of the previous month.

9. The number of 'Misconduct/Improper Manner & Offensive Language' complaints received in October 2007 was 68 cases, an increase of 30.8% (+16 cases) when compared with the statistics of the previous month. For the month of November 2007, the number of 'Misconduct/Improper Manner & Offensive Language' complaints received was 62 cases, which was a decrease of 8.8% (-6 cases) when compared with the statistics of the previous month. For the month of December 2007, the number of 'Misconduct/Improper Manner & Offensive Language' complaints received was 66 cases, which was an increase of 6.5% (+4 cases) when compared with the statistics of the previous month.

10. The number of 'Assault' complaints received in October 2007 was 35 cases, a decrease of 5.4% (-2 cases) when compared with the statistics of the previous month. For the month of November 2007, the number of

'Assault' complaints received was 34 cases, which was a decrease of 2.9% (-1 case) when compared with the statistics of the previous month. For the month of December 2007, the number of 'Assault' complaints received was 36 cases, which was an increase of 5.9% (+2 cases) when compared with the statistics of the previous month.

11. In the year of 2007, a total of 2,569 complaints were received. It represented an increase of 2.3% (+ 58 cases) when compared with 2,511 cases of the same period in 2006.

12. The total number of 'Neglect of Duty' complaints received in the year of 2007 was 1,063 cases. It represented an increase of 14.3% (+ 133 cases) when compared with 930 cases of the same period in 2006.

13. The total number of 'Misconduct/Improper Manner & Offensive Language' complaints received in the year of 2007 was 717 cases. It represented an increase of 4.2% (+ 29 cases) when compared with 688 cases of the same period in 2006.

14. The total number of 'Assault' complaints received in the year of 2007 was 467 cases. It represented a decrease of 13.7% (- 74 cases) when compared with 541 cases of the same period in 2006.

15. Overall speaking, there was a slight increase in the complaint figures of 2007 when compared with those of 2006 which was the lowest since the commencement of the declining trend in 2003. So, the slight increase in 2007 continued to remain in a relatively low level and was still lower than the figures of 2005.

16. <u>The Chairman</u> noted with appreciation of the drop of 74 cases in 'Assault' complaints.

IV <u>A COMPLAINT CASE FOR DISCUSSION</u>

17. <u>Secy/IPCC</u> briefed the meeting that the complaint stemmed from a case of 'Person Fell From Height'. On the material day, the body of the Complainant (COM)'s elder brother (the Deceased) was found lying on the podium directly underneath the open living room window of his (the Deceased's) residential flat. The Deceased was rushed to hospital and was certified dead upon arrival. Police discovered the incident in response to a report made by the Deceased's employer (Mr. A) who visited the flat to find the main door locked from inside with nobody answering the door. 18. Upon COM's application for a waiver of autopsy on the Deceased, and having considered the relevant materials, the Coroner directed that no Death Report would be called for, and no investigation into the death of the Deceased was required. The Police concluded that the death of the Deceased was not suspicious, and curtailed the case. Accordingly, no statement was taken from COM and the Deceased's relatives. COM was informed of the investigation result by a Death Enquiry Constable (COMEE 2) of Formation X.

19. At the time of the Deceased's death, he was covered by a number of insurance policies. Two insurance companies subsequently sent letters to the Miscellaneous Enquiries Sub-unit (MESU) of Formation X enquiring the cause of death of the Deceased, particularly on whether suicide was involved. The letters of enquiry were handled by a Senior Inspector of the MESU of Formation X (COMEE 3). COMEE 3 replied to the insurance companies stating that 'the Deceased had called Mr A the day prior to his death expressing that he was unhappy due to job pressure', and 'it was believed that the Deceased had ended his own life by jumping down from the building of his flat'.

20. The two insurance companies then notified COM's mother that no compensation would be paid in respect of the Deceased's case since the cause of his death was suicide. A copy of COMEE 3's reply to these insurance companies was attached to the respective notification letters issued by the insurance companies to COM's mother. COM considered the decision of the insurance companies in not paying compensation was a result of the inaccurate information stated in COMEE 3's replies to the insurance companies, and thus lodged a complaint with CAPO comprising the following allegations:

- (i) the Police had failed to interview and take statement from COM and the family members of the Deceased in the course of the investigation of the death of the Deceased [Allegation (a) 'Police Procedures'];
- (ii) COMEE 2 had failed to notify COM or his family members that the Coroner had directed that no investigation should be conducted into the death of the Deceased, and hence deprived them of their right to appeal against the decision of the Coroner and to have a full investigation into the death of the Deceased [Allegation (b) – 'Neglect of Duty (NOD)];
- (iii) COMEE 3 was negligent in stating in his letters to the insurance companies that 'the Deceased had called Mr A one day prior to his death expressing that he was upset due to job pressure' since Mr. A had confirmed that he had not received the alleged telephone call from the Deceased, and hence the

information quoted by COMEE 3 in his letters to the insurance companies was factually wrong [Allegation (c) – 'NOD']; and

(iv) COMEE 3 should not have stated in his letters to the insurance companies that '*the Deceased took his own life*' since there was no substantive evidence supporting that the Deceased had committed suicide [Allegation (d) – 'NOD'].

21. Regarding allegation (a), CAPO's investigation found no suspicious circumstances were detected in the course of police investigation at the scene. Since the decision as to whether the Police should conduct an investigation into a death report is solely one for the Coroner if no suspicious circumstance is found associated with or arising from the death of a deceased, and the Coroner directed that no police investigation into the death of the Deceased was required in the instant case, CAPO considered that there was no negligence on the part of the Police for not taking statements from the properly interested persons in the investigation of the death of the Deceased. Therefore, CAPO classified allegation (a) – 'Police Procedures' as 'No Fault'.

22. In response to allegation (b) – 'NOD', COMEE 2 stated that he had telephoned COM to inform COM that the case of the Deceased's death would be closed since the Coroner had decided that no investigation into the death of the Deceased was required. CAPO's investigation confirmed that COMEE 2 had recorded his action of informing the Deceased's relative of the Coroner's decision in the Death Investigation File, though COMEE 2 had not specified the time of his call as well as the name of the person he had contacted in the relevant file minutes. With the support of the record of the file minute in the Death Investigation File, and in the absence of other concrete evidence to prove or disprove the veracity of either side's version, CAPO classified allegation (b) – 'NOD' as 'Unsubstantiated'.

23. Concerning allegations (c) and (d), COMEE 3 explained that as he was not in the post at the material time and did not take part in the investigation of the death of the Deceased, he had to rely on the available information contained in the Death Investigation File in handling the enquiries on the cause of death of the Deceased from the insurance companies. Taking into account the facts revealed in the documents contained in the Death Investigation File, COMEE 3 formed the conclusion that the most possible cause of the Deceased's death was suicide, and thus stated in his replies to the two insurance companies that '*it was believed that the Deceased ended his own life by jumping down from the building of his flat*', and also mentioned in these replies that '*the Deceased had called Mr A the day prior to his death expressing that he was unhappy due to job pressure*' based on a report made by a Police Constable (PC Y) to the Police

Console on the material day as recorded in the relevant incident log of the '999' Console.

24. With regard to allegation (c) - 'NOD', upon CAPO's further enquiry, Mr A denied that the Deceased had expressed to him by telephone in the evening prior to the Deceased's death that he (the Deceased) was upset by work pressure. PC Y also flatly denied that he had made a report about the telephone contact in question between Mr A and the Deceased to the '999' Console on the material day as recorded in the relevant incident log of the Console. Since COM lodged the instant complaint to CAPO almost ten months after the incident, the relevant audio tape record of the '999' Console pertaining to the Deceased's death report ostensibly made by PC Y as recorded in the incident log had already been erased in accordance with normal practice. Therefore, CAPO was unable to verify the record of the incident log in question. However, CAPO considered that an incident log is a real time record of information that was reported to the Police in an incident, which is 'accurate' as long as it contains information exactly as it is reported regardless of its veracity. Taking into account the fact that there was no independent evidence to prove what actually transpired during the conversation between Mr A and the Deceased, that there was no reason to doubt the accuracy of the initial records contained in the incident log, and police officers are entitled to quote information from incident logs without further verification because these are 'routine records of events and non-events innocently made in the normal course of business', CAPO considered that COMEE 3 had no negligence in quoting the information from the incident log in his replies to the insurance companies, and hence classified allegation (c) – 'NOD' as 'No Fault'.

25. Regarding allegation (d) – 'NOD', CAPO found that despite the evidence available to COMEE 3 at the time when he compiled the replies to the insurance companies suggested that the Deceased was likely to have committed suicide, the possibility of an accidental fall from the window had never been ruled out. More importantly, no death inquest was held in respect of the Deceased's death, and the police enquiry had never concluded that it was a case of suicide even though it revealed no suspicious circumstances. In light of this, CAPO commented that while COMEE 3 felt that he was obliged to comment on the possibility of suicide upon the insurance companies' specific requests, he should have known that the Deceased's insurance polices were at stake and should have been more prudent in constructing his replies. He should have indicated clearly in his replies that it was his own judgement rather than an official conclusion. view of the fact that the comment on the cause of death of the Deceased made by COMEE 3 in his replies to the insurance companies was not fully accurate, CAPO classified allegation (d) - 'NOD' as 'Not Fully Substantiated', and COMEE 3 would be advised without divisional record file entry to be more prudent in giving his comments when an individual's

interest is at stake.

26. Upon examining the investigation result of COM's complaint, regarding allegation (a), the IPCC requested CAPO to further elaborate the police procedure in handling a case of 'Person Fell From Height', and to explain under what circumstances would the Police take statements from related persons.

27. The IPCC also had reservation about the classifications for allegations (c) and (d) against COMEE 3, and also considered that CAPO had not properly addressed COMEE 2's negligence disclosed in the course of CAPO's investigation into allegation (b) – 'NOD'.

- (i) the crux of allegation (c) 'NOD' was that the information about 'the Deceased expressing to Mr A that he was unhappy due to his own job pressure during a telephone conversation one day before his death' as quoted in COMEE 3's replies to the insurance companies was factually wrong, rather than challenging the reliability of the source of information that COMEE 3 relied on in quoting the information in question in his replies to the insurance companies;
- (ii) CAPO's justification on the 'No Fault' classification for allegation (c) could only serve as an explanation for COMEE 3 to rely on the incident log in quoting the information in question, rather than any evidential proof of the veracity of such information. This explanation was not fully geared to the locus of COM's allegation. Since both Mr A and PC Y had denied to have given the information in question contained in the incident log, the record of the incident log as an accurate and reliable evidence to prove that the Deceased had said the words in question to Mr A is cast in doubt. CAPO also agreed that there was no independent evidence to prove what actually transpired during the alleged telephone conversation between Mr A and the Deceased, allegation (c) – 'NOD' became a typical one-against-one situation in the absence of objective evidence to prove or disprove the veracity of the information in question. The IPCC therefore considered it more appropriate to re-classify the allegation as 'Unsubstantiated', instead of 'No Fault';
- (iii) In accordance with Force Procedures Manual (FPM), COMEE 3 should have replied to the insurance companies with factual information only. However, COMEE 3 commented in his replies to the insurance companies that '...the deceased ended his own life by jumping down from the building of his flat...' even when the fact was there was no

official conclusion on the death of the Deceased, and the police enquiry had never concluded that the Deceased had committed suicide. It was clear that COMEE 3's above comment was inappropriate and had breached the requirement set out in the FPM. Since COMEE 3's negligence in respect of allegation (d) – 'NOD' had been fully proven, the IPCC suggested CAPO to re-classify the allegation from 'Not Fully Substantiated' to 'Substantiated'; and

(iv) for allegation (b) – 'NOD', CAPO's investigation revealed that COMEE 2 had only recorded his contact with the Deceased's relative, without specifying the date, time, and the particulars of the person he had contacted, in a minute sheet in the relevant Death Investigation File. The Secretariat considered that COMEE 2 had failed to make proper and detailed records of his action, and therefore suggested CAPO to properly address COMEE 2's negligence in this respect in the investigation report.

28. After discussion, CAPO clarified that there were no police orders, rules and guidelines or law governing the procedure for handling cases of 'Person Fell From Height'. The need for taking statements from relevant parties should be determined on a case-by-case basis. Under the relevant guidelines in the Force Procedures Manual, if any suspicious circumstances in connection with the death were found, the case would be referred to the crime unit for investigation and where necessary taking statements from the parties concerned. If not, it would be solely the Coroner's decision as to whether an investigation into a report of death should be conducted by the Police. In the instant case, as the Police had not found any suspicious circumstances and the Coroner directed no Death Report was required, CAPO believed that there was no negligence of the Police for not taking statements from the relevant parties and thus the classification of "No Fault" for allegation (a) remained appropriate.

29. CAPO also subscribed to the IPCC's comments and suggestions, and re-classified allegations (c) and (d) – 'NOD' as 'Unsubstantiated' and 'Substantiated' respectively. COMEE 3 would be advised to strictly observe the principle and guidelines on releasing information to insurance companies as stipulated in the relevant FPM when dealing with correspondence from insurance companies in future.

30. The negligence of COMEE 2 in compiling a proper and detailed record of his action, though not directly related to the allegations raised in the instant complaint, had also been addressed as an 'Outwith Matter' in line with established practice. COMEE 2 would be advised to improve his professionalism in this respect.

31. After considering CAPO's response to the IPCC's queries and suggestions, the Council endorsed the findings of CAPO's investigation report.

32. <u>The Chairman</u> invited the meeting to comment.

33. <u>Dr LO Wing-lok</u> requested CAPO to explain the working relationship between the Police and the Coroner.

34. <u>CSP C&IIB</u> replied that the Police role in unsuspicious death cases was simply to provide assistance to the Coroner. Should the Coroner decide that there was no need for investigation, the Police would declare the case closed.

35. <u>Dr LO Wing-lok</u> stated that he could not agree with the police defensive response by starting to talk about cases without suspicion. He hoped the Police to tell the general working relationship between the Coroner and the Police in handling death cases. He believed that the Police should frankly tell the public and the media that the Coroner would not check out personally how the death occurred. Whether it was suspicious or otherwise, the Coroner would rely on the report from the Police in deciding whether a death inquest should be held. He wished CAPO to confirm his understanding.

36. <u>CSP C&IIB</u> responded by saying that what Dr LO had mentioned was not totally correct because in each death case the doctor who certified the death should report to the Coroner about the death in accordance with the related legislation. After the dead body was conveyed to the public mortuary, the forensic pathologist of the mortuary would also submit an initial report to the Coroner. Therefore, the initial information gathered by the Coroner was not provided by the Police. Only when the Coroner found it necessary to conduct investigation in a death case, he would direct the police to conduct a formal investigation.

37. <u>Dr LO Wing-lok</u> went on to comment that the instant case was a case of 'Person Fell from Height' and he wished the Police to tell the meeting if the Police had compiled any report or if any report was submitted to the Coroner.

38. <u>CSP C&IIB</u> replied that there were some documents accompanying the dead body when it was conveyed to the public mortuary. On the documents was some information which the Police had gathered from the initial investigation. The information would be examined by the forensic pathologist and would then be submitted together with other related documents to the Coroner.

39. <u>Dr LO Wing-lok</u> further enquired if it could be said that the Coroner was to rely on the police report in deciding if further investigation or a death inquest was necessary. He also enquired if the Coroner had in the instant case relied on the police report in making his decision that the case was unsuspicious and therefore did not call for an enquiry.

40. <u>CSP C&IIB</u> replied that he did not want to speculate on the reason for which the Coroner made his decision. Before the Coroner made his decision, he would have received the information which the police had provided to the forensic pathologist, the information provided by the forensic pathologist as well as the information provided by the doctor who certified the death.

41. <u>Dr LO Wing-lok</u> went on to say that his question was about in cases of 'Person Fell from Height' whether it was proper or reasonable for the police to make enquiry with the family members of the deceased to see if they felt the death suspicious.

42. CSP C&IIB replied that the police officers who attended the scene in the instant case had already made enquiry with the deceased's family members and friends present there to find out the background of the case. They had also conducted initial investigation and had examined the situation of the scene. They had recorded their investigation and findings in their police notebooks, and had input the information in the computer records maintained in the Police console. The police officers at the scene had already conducted a proper investigation that they could have done. As regards whether it was necessary to take statements from the concerned persons, it varied from case to case with no uniformed standard to follow. In the instant case, the investigation at the scene had been properly conducted and it was a regret that COMEE 3 had included his personal opinion in his replies to the insurance companies that he was not required to This was not in compliance with the requirement stipulated in the do so. FPM and in this regard COMEE 3 had committed a mistake but as far as the death investigation was concerned, there was no evidence showing that the investigation was conducted improperly. Besides, the information included in the replies was accurate facts with no evidence showing that the information was inaccurate but just that COMEE 3 had inappropriately made additional comment in his replies that he should not have made. In this regard, officers would be reminded that they should be particularly careful when handling enquiries from insurance companies.

43. <u>Dr LO Wing-lok</u> further commented that when a person suddenly discovered his family member to have plunged to his death, it was understandable that the person would not know how to respond. If the Police made a judgment solely replying on the initial investigation at the

scene, he felt that it might not be as comprehensive as what the Police had Besides, the consequences of the death might only surface later, asserted. such as the insurance claims. Since the Police would deal with the death case when it occurred, he believed that the Police should learn a lesson from that case instead of explaining the rationale of the actions taken. The Police should consider the shock on the family members of the deceased and took the opportunity to remind them that if they found any suspicion surrounding the death, it was very important that they should indicate the suspicion to the Police so as to bring it to the attention of the Coroner. He also felt that people in Hong Kong should understand that although the death itself was unfortunate, an autopsy would be very significant to the investigation. The Coroner might on compassionate ground have accepted the request not to order an autopsy on the body but that actually had affected the handling of the death investigation and created a lot of problems. He hoped that the Police should learn a lesson from the case. He agreed that COMEE 3 had included his personal opinion in his replies to the insurance companies and he felt that if the opinion was not expert opinion, it would be sufficient to only include in the replies the relevant facts, such as when and where the death occurred, etc.

44. <u>CSP C&IIB</u> responded by saying that CAPO had already elucidated its views on the death case in the related report. As regards the replies to the insurance companies, officers would be reminded to strictly comply with the related provisions in the FPM to avoid including their personal judgment in the replies.

V

ANY OTHER BUSINESS AND CONCLUSION OF THE MEETING

45. <u>The Chairman</u> informed the meeting that this would be the last Joint Meeting for <u>Mrs Brenda FUNG</u>, the Secy/IPCC, who would then proceed on retirement and he took the opportunity to wish her very best on her retirement.

46. <u>Mrs Brenda FUNG, the Secy/IPCC</u>, thanked <u>the Chairman</u> for his blessing and she would like to send her gratitude to the CAPO's colleagues for their cooperation.

47. There being no other business, the open part of the meeting concluded at 1647 hours.

(CHEUNG Kin-kwong)	(Brandon CHAU)	
Joint Secretary	Joint Secretary	
Complaints and Internal	Independent Police	
Investigations Branch	Complaints Council	