SURUHANJAYA HAK ASASI MANUSIA MALAYSIA

HUMAN RIGHTS COMMISSION OF MALAYSIA

SUHAKAM

HAK ASASI UNTUK SEMUA

REPORT OF SUHAKAM PUBLIC INQUIRY INTO THE DEATH IN CUSTODY OF S.HENDRY 17 & 18 FEBRUARY 2006

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Chapter 1

THE SITTING OF THE PANEL OF INQUIRY

1. Pursuant to section 12 of the Human Rights Commission of Malaysia Act 1999, the Human Rights Commission of Malaysia (SUHAKAM) established a Panel of Inquiry to conduct a public inquiry into the death in custody of S. Hendry. The Panel of Inquiry comprised of Dato' Haji Hamdan Adnan (Chairperson), Dato' Siva Subramaniam and Dato' Muhammad Shafee Abdullah.

2. The Inquiry commenced on 17 February 2006 and concluded on 18 February 2006. During the proceedings of the Inquiry, witnesses who had given a statement to officers of SUHAKAM prior to the Inquiry were read their statement and were asked to verify the veracity of the facts of the statement. Each witness was then examined by the Panel of Inquiry and their statements were admitted as evidence. Witnesses who did not give a statement prior to the Inquiry were also examined by the Panel of Inquiry.

3. The Panel of Inquiry called 27 witnesses and received 32 exhibits during the course of the proceedings. The **Inquiry Witness List** and **List of Exhibits** are at **Appendix 1** and **2**, respectively.

4. The Panel of Inquiry also visited the cell at the *Pusat Pemulihan Akhlak* Simpang Renggam where S. Hendry was detained and later found hung.

5. At the conclusion of the Inquiry, the Panel of Inquiry invited persons who were not subpoenaed who might have information relevant to the Inquiry to approach the Panel of Inquiry to give evidence. No one came forward with additional information.

THE TERMS OF REFERENCE

6. The terms of reference of the Panel of Inquiry were to:

   a) Inquire into the cause of death of S. Hendry;
   b) Inquire into the circumstances surrounding his death; and
   c) Review the system in the *Pusat Pemulihan Akhlak Simpang Renggam*, in particular matters pertaining to young persons' detention.

7. It must be clarified at the outset that an analysis of the Emergency (Public Order and Prevention of Crime) Ordinance 5, 1969 (POPOC) is not within the terms of reference of this Panel of Inquiry. A public inquiry is not the proper forum for this research. Findings and recommendations in this report should not, in any way, be construed as endorsing or legitimising the POPOC. Suffice to say that SUHAKAM has always taken the stand that detention without trial constitutes a violation of human rights.

BACKGROUNDER

8. On 19 November 2005, the body of S. Hendry s/o Sreedhran was found hanging with a blanket around his neck at the *Pusat Pemulihan Akhlak* Simpang Renggam hours after he was sent there.

9. In a statement in The Star newspaper on 21 November 2005, Kluang OCPD Asst. Comm. Malik Abdul Harun stated that the case had been classified as sudden death because the post-mortem results showed that the victim had committed suicide.

10. Subsequent events raised the question as to the cause of death of S. Hendry. In particular, S. Hendry's father, Mr. Sreedhran a/l Henry (IW2) lodged a Police report at the Brickfields Police Station on 6 December 2005 (Police Report No. SPG RENGAM/002914/05). In the Police report, Mr. Sreedhran a/l Henry stated that he was suspicious as to the cause of death of S. Hendry because:

    a) When he saw S. Hendry's body, he saw bruises on the head, face and other parts of his body;
    b) One day before his death, S. Hendry was in good health;
    c) Kluang OCPD Asst. Comm. Malik Abdul Harun's statement (that S. Hendry had committed suicide) in The Star newspaper on 22 November 2005, three days after the death of S. Hendry was too short a duration to determine the cause of death of S. Hendry.

11. On 25 November 2005, SUARAM submitted a memorandum to SUHAKAM, highlighting, amongst others, the death of S. Hendry. On 16 December 2005, the Youth Movement, Parti Keadilan Rakyat, also submitted a memorandum to SUHAKAM highlighting the same.

12. On 13 December 2005, SUHAKAM announced that it would conduct a public inquiry into the death in custody of S. Hendry.

Chapter 2

13. This part of the report sets out the facts established by the evidence presented to the Panel of Inquiry during the proceedings on 17 and 18 February 2006. The evidence includes the testimonies of 27 witnesses heard by the Panel of Inquiry and 32 exhibits put in evidence. The subsequent chapters of the report will consider the issues which arise from the established facts, together with the Panel of Inquiry's findings and recommendations.

EVENTS BEFORE 18 NOVEMBER 2005

14. According to the evidence of three Investigation Officers, S.Hendry was allegedly linked to three cases – two murder cases and an armed robbery case. Four remand orders were issued against S.Hendry and in total, he was remanded for a period of 29 days.

15. Prior to his arrest on 22 August 2005, S.Hendry had disappeared for a year, his whereabouts or whether he held a job during that time was not known to his father.

First remand order

16. On 22 August 2005, around 12.00 noon, S. Hendry was arrested and was remanded for 10 days from 23 August 2005 to 1 September 2005. The remand order was issued by Tuan Harmi Thamri bin Mohamad@ Shaharudin (IW6), Magistrate, Kajang Magistrates' Court. The remand order was based on S. Hendry's involvement in the murder case.

17. On 26 August 2005, at approximately 11.30 a.m., ASP Wong Yuen Chuan (IW3), Investigation Officer for the first murder case linked to S.Hendry, interrogated S. Hendry. In his evidence to the Panel of Inquiry, ASP Wong stated that S. Hendry confessed to the murder. During the interrogations, ASP Wong did not notice anything extraordinary from the behaviour of S. Hendry. ASP Wong remarked that S.Hendry was in fact, a cooperative suspect, in that, he (S.Hendry) was willing to give the Police a cautioned statement.

18. S.Hendry was detained at the Kajang Police station lock-up during the first period of remand.

19. The Police confirmed that although S.Hendry allegedly confessed to the murder, but because there was insufficient evidence, S.Hendry was detained under the POPOC and not charged in Court.

20. S.Hendry had no prior arrests or convictions although ASP Wong qualified that because S.Hendry was 18 years old at the time of arrest, the Court may have discharged after admonition instead of inflicting a term of imprisonment and thus his records would not have reflected actual prior convictions.

21. ASP Wong was not aware whether S.Hendry was given a medical check-up and he confirmed that S.Hendry did not complain of any illness.

Second remand order

22. On 1 September 2005, ASP Azizan Haji Mohamad Isa (IW4), Investigation Officer of the second murder case linked to S.Hendry was informed by Lans Koperal Krishnan that he had arrested one S.Hendry involved in the murder case that was investigated by ASP Azizan.

23. On 2 September 2005, ASP Azizan brought S.Hendry before Tuan Harmi, Magistrate, Kajang Magistrates' Court to be remanded. Tuan Harmi granted a remand order against S. Hendry for 10 days, from 2 September 2005 until 11 September 2005.

24. S.Hendry was detained at the Kajang Police station lock-up during the second period of remand.

25. During interrogations and while recording a section 112 of the Criminal Procedure Code (CPC) statement from S.Hendry, ASP Azizan remarked that S.Hendry was a quiet person, cooperative but he looked worried ("*runsing")*. S.Hendry did not explain to ASP Azizan the cause (if any) of his worry.

26. During the 10 days, ASP Azizan was not informed and was not aware that S.Hendry had suffered any injury. There was no record whether S.Hendry was a drug addict. ASP Azizan confirmed that a medical check-up was not performed on S.Hendry and he was never brought to hospital. The Panel of Inquiry viewed the statements made by S.Hendry under sections 112 and 113 of the CPC and came to a decision that the contents of the statements were irrelevant to the Inquiry.

27. Similarly, S.Hendry was not charged in Court as ASP Azizan was informed by the Deputy Public Prosecutor's office that there was insufficient evidence.

28. ASP Azizan could not confirm whether anyone had informed S.Hendry of the possibility of being detained for two years under the POPOC and the possibility of the two year detention being renewed for a further two years.

29. According to notes referred to by Tuan Harmi, S.Hendry did not complain of any incidents of abuse or beating and he did not notice any unusual behaviour on the part of S.Hendry. S.Hendry only asked for a shorter remand period.

Third and fourth remand orders

30. On 11 September 2005, S. Hendry was once more arrested but this time for alleged involvement in an armed robbery in Mantin, Negri Sembilan Mantin (report no. 708/05). Inspector Yusrizal bin Mohammad Ghazali (IW5) was the Investigation Officer.

31. Two remand orders were issued against S.Hendry by the Magistrates' Court, Seremban. The first remand order was from 12 September 2005 to 16 September 2005 and the second remand order was from 16 September to 20 September 2005.

32. Inspector Yusrizal interrogated S.Hendry twice and on both occasions, he noted that S.Hendry was physically well and had sustained no injuries. Although S.Hendry was initially uncooperative, Inspector Yusrizal remarked that he later cooperated during interrogations. Inspector Yusrizal did not notice anything unusual in the behaviour of S.Hendry.

33. On 20 September 2005, at approximately 9.00 a.m., S.Hendry was released unconditionally. S.Hendry was not charged in Court in relation to the armed robbery.

34. In his evidence, Inspector Yusrizal confirmed that no medical check-up was carried out on S.Hendry during his remand in Seremban.

Detention under the Emergency (Public Order and Prevention of Crime) Ordinance 5, 1969

35. On 20 September 2005, S. Hendry was arrested under section 3(1) of the POPOC. The order to detain S.Hendry under section 3(1) of the POPOC was issued on 16 September 2005. S.Hendry was detained for 60 days under the POPOC, at the Kajang Police station lock-up.

36. Chief Inspector Ahmad Izuddin bin Mohd. Juhari (IW7), officer in Division D7, Police (vice and gangsterism), first came into contact with S.Hendry on 20 September 2005, when he was arrested under section 3(1) of the POPOC.

37. According to records that were referred to by Chief Inspector Ahmad Izuddin, during the 60 days, S.Hendry was interrogated three times by Detective Lans Corporal Raju (No. 117044) and Detective Lans Corporal Jalil (No. 118686). Interrogations were carried out in the morning, from 10.00 a.m. until 12.00 noon and in the afternoon from 2.45 p.m. until 5.00 p.m.

38. Chief Inspector Ahmad Izuddin did not notice any unusual behaviour on the part of S.Hendry and he characterised S.Hendry as a cooperative, quiet ("*diam"*) and gloomy ("*murung"*) person. Chief Inspector Ahmad Izuddin was not aware of any complaint lodged with the Police of any abuse or ill-treatment of S.Hendry. Mr. Sreedhran confirmed that he did not make any complaint to the Police or lodg any report to the Police of any Police abuse. No medical check-up was carried out on S.Hendry.

39. S.Hendry told Chief Inspector Ahmad Izuddin that he did take drugs prior to his arrest.

40. Subsequently, S. Hendry was detained for two years pursuant to an order by the Minister under section 4(1) of the POPOC[1]. The said order cited S.Hendry's involvement, with two others, in an alleged murder case on 12 August 2004, in Semenyih, Selangor, as grounds of the detention. According to Chief Inspector Ahmad Izuddin, the two alleged accomplices were already detained at the *Pusat Pemulihan Akhlak* Simpang Renggam.

41. During the three months when S.Hendry was detained, Mr. Sreedhran[2], i.e. S. Hendry's father, visited his son five times at the Kajang Police station lock-up. Each visit lasted between 30 and 45 minutes.

42. Mr. Aritharan a/l Raman[3] (IW8), a detainee at the *Pusat Pemulihan Akhlak* Simpang Renggam, was detained at the Kajang Police station from 13 July 2005 to 1 October 2005. He spent approximately two weeks with S.Hendry in the same lock-up at the Kajang Police station. In the course of general conversations with S.Hendry, Mr. Aritharan recounted S.Hendry having told him that he was detained because he was linked to an alleged murder and that he would be detained at the *Pusat Pemulihan Akhlak* Simpang Renggam for two years. S.Hendry did not complain of any physical or mental problems or that he was being threatened by anyone. In his evidence, Mr. Aritharan narrated that before he was transferred to the *Pusat Pemulihan Akhlak* Simpang Renggam, S. Hendry had requested that he deliver a message to one Mr. Lorans a/l Anthony (who was detained at the *Pusat Pemulihan Akhlak* Simpang

[1] Exhibit P-10(a) – Perintah tahanan; Exhibit P-10(b) – Alasan-alasan perintah tahanan.
[2] Exhibit P-8 – Statement of Sreedhran a/l Henry.
[3] Exhibit P-12 – Statement of Aritharan a/l Raman.

Renggam), a childhood friend of S. Hendry, the message being that he (S. Hendry) would be coming to the *Pusat Pemulihan Akhlak* Simpang Renggam.

43. In narrating his own experience when he first arrived at the *Pusat Pemulihan Akhlak* Simpang Renggam, Mr. Aritharan testified that during the initial 14 days, he was placed in cell D4B with 12 other detainees. During the 14 days, he was never placed alone in a cell.

44. When asked by the Panel of Inquiry whether he was shocked when he learned that S.Hendry had committed suicide, Mr. Aritharan expressed his disbelief.

45. On 18 November 2005, Mr. Sreedhran visited his son before S. Hendry was transferred to the *Pusat Pemulihan Akhlak* Simpang Renggam. Mr. Sreedhran gave him RM 30 and brought food for him. During the said visit, S. Hendry told his father that his detention would only be for two years, which would go by quickly and told his father not to worry about him. He also promised his father that he would turn over a new leaf after his release. Mr. Sreedhran did not notice any unusual behaviour on the part of S.Hendry and his son did not complain of any pain, sadness, problems or threats by any person.

THE REGISTRATION AND RECEPTION OF S.HENDRY AT THE *PUSAT PEMULIHAN AKHLAK* SIMPANG RENGGAM

46. On 18 November 2005, at approximately 6.50 p.m., S. Hendry arrived at the *Pusat Pemulihan Akhlak* Simpang Renggam. Upon arrival, S. Hendry was received by Encik Ramesh a/l Subramaniam[4] (IW10) at the record office.

47. According to Encik Ramesh, he registered S. Hendry's particulars into the registration book ("*buku daftar tahanan*"). Encik Ramesh then proceeded to explain the detention order and the grounds of detention to S. Hendry. He recalled that he informed S. Hendry that his detention under the POPOC was for two years and the detention order was based on his alleged involvement in a murder case. S. Hendry indicated that he understood the grounds of detention, acknowledged that he was linked to the said murder and that he would be released in two years. Encik Ramesh confirmed that he did not inform S.Hendry that it was possible for his detention order to be extended for a further two years. (This being an answer to a specific question put by the Panel of Inquiry)

[4] Exhibit P-14 – Statement of Ramesh a/l Subramaniam.

48. Encik Ramesh recorded the biodata of S. Hendry, took the prints of all 10 fingers of S. Hendry, underscored the importance of adherence to the rules of the *Pusat Pemulihan Akhlak* Simpang Renggam and the consequences of contravention of the rules. Encik Ramesh also informed S. Hendry that he would be brought back to the office the next day for further registration.

49. Encik Ramesh also took the clothing that S. Hendry was wearing when he arrived and gave him the following items:

    a. 1 shirt;
    b. 1 pair of shorts;
    c. 1 pair of slippers;
    d. 1 dark blue blanket;
    e. 1 cup;
    f. 1 soap;
    g. 1 toothbrush; and
    h. 1 spoon.

50. Encik Ramesh asked S.Hendry to remove his shirt for a body check. Encik Ramesh did not find contraband articles on S.Hendry. Encik Ramesh noticed that S.Hendry's body had tattoos and scars, with no suspicious marks or bruises.

51. During the registration process, Encik Ramesh recalled the conversation he had with S. Hendry. He stated that S. Hendry had told him that he had two uncles working in Simpang Renggam and had asked whether his family members would be able to visit him. Encik Ramesh answered in the affirmative and assured him that his relatives could visit him as early as the next day. Encik Ramesh did not notice anything out of the ordinary from the behaviour of S. Hendry. In fact he remarked that S.Hendry appeared happy and was smiling.

52. When Encik Ramesh received the news that S.Hendry had committed suicide, he was surprised, as S.Hendry seemed normal the night before.

EVENTS OF THE NIGHT OF 18 NOVEMBER 2005 AND EARLY MORNING OF 19 NOVEMBER 2005

53. There were four shifts between 9.00 p.m. on 18 November 2005 and 7.15 a.m. on 19 November 2005:

    a. Shift 1: 9.00 p.m. – 11.30 p.m.
    b. Shift 2: 11.30 p.m. – 2.00 a.m.

c. Shift 3: 2.00 a.m. – 4.30 a.m.
d. Shift 4: 4.30 a.m. – 7.00 a.m.

54. Each shift was for a period of two and a half hours, with two officers on duty during each shift. In sum, four officers were on duty from 9.00 p.m. till 7.00 a.m. - Encik Nordin bin Yunus (IW11), Encik Abdul Rahim (IW12), Encik Abu Bakar bin Ishak (IW13) and Encik Lasiman bin Jahim (IW14). Officers worked in pairs and took alternate shifts.

Shift 1: 9.00 p.m. – 11.30 p.m.

Officers on duty: Encik Nordin bin Yunus & Encik Abdul Rahim bin Kahar

55. At around 9.50 p.m., Encik Nordin bin Yunus[5] and Encik Abdul Rahim bin Kahar[6] received S. Hendry at the isolation block ("*blok asingan"*). The warders proceeded to perform a general check on S. Hendry, the objective of which was to see whether S. Hendry was in possession of any prohibited articles. The officers then gave S. Hendry a black pail for his body excretions.

56. During the brief encounter with S.Hendry (approximately 10 minutes), Encik Nordin and Encik Abdul Rahim asked S. Hendry which Police station he was transferred from and under which law he was detained. S. Hendry answered that he was from Kajang Police station lock-up and he was detained under the POPOC. According to the two officers, S. Hendry appeared normal and did not display any extraordinary behaviour.

57. The warders then placed S.Hendry in cell C4 *bawah* (hereinafter referred to as "cell C4B"). Encik Nordin identified box marked 'C' in **Exhibit P-3** as the cell where S.Hendry was placed. There were no other detainees placed in the same cell. Encik Abdul Rahim clarified that cell C4B was specifically used to detain young detainees.

58. With only two officers on duty during the two and a half hour shift and the number of units and cells in the isolation block (four units, each with two floors), Encik Nordin affirmed that there was sufficient time for officers to patrol twice by each cell, although he acknowledged that the gap between the first and the second patrol could be between two and two and a half hours which gave considerable time for untoward incidences to occur. Encik Nordin also testified that each time the officers patrolled by each cell, they would take only a fleeting look into the cells – "*...kalau kita buat rondaan pun sekali lalu kita tengok sekali lalu".*

Shift 2: 11.30 p.m. – 2.00 a.m.

Officers on duty: Encik Abu Bakar bin Ishak and Encik Lasiman bin Jahim

[5] Exhibit P-15 – Statement of Nordin bin Yunus.
[6] Exhibit P-16 – Statement of Abdul Rahim bin Kahar.

59. At 11.30p.m., Encik Abu Bakar bin Ishak[7] and Encik Lasiman bin Jahim[8] took over from Encik Nordin and Encik Abdul Rahim.

60. Both officers testified that they patrolled the isolation block three times and at all three times, they saw S. Hendry sleeping on the floor of cell C4B.

61. In his evidence, Encik Abu Bakar explained that patrolling meant making sure that detainees were in the cell - "*Jalan dan kita pastikan orang-orang dalam sel itu*".

62. Encik Abu Bakar further explained that patrolling was not only concentrated at S.Hendry's cell as there were many critical cases in the isolation block. The isolation block housed detainees who were abused (later clarified as detainees who had violated the rules at the *Pusat Pemulihan Akhlak* Simpang Renggam and whose punishment included reducing the detainee's food ration), detainees with psychiatric problems and detainees who were brought back from Court were all placed at the isolation block to be quarantined. Encik Abu Bakar recalled that on that particular night, attention was concentrated on one detainee who was on hunger strike and warders on duty were required to inspect that particular cell every 15 minutes. Encik Lasiman confirmed this and added that at 11.55 p.m., he and Encik Abu Bakar attended to a detainee who was brought back from Hospital Kluang.

Shift 3: 2.00 a.m. – 4.30 a.m.

Officers on duty: Encik Nordin bin Yunus & Encik Abdul Rahim

63. At 2.00 a.m., Encik Nordin bin Yunus and Encik Abdul Rahim resumed their duty. Both Encik Nordin and Encik Abdul Rahim testified that between 2.00 a.m. and 4.30 a.m., they patrolled three times, twice past S. Hendry's room and on both instances, they saw S. Hendry sleeping on the floor. Encik Nordin and Encik Abdul Rahim both identified the location where they saw S.Hendry sleeping as the position marked with a shirt diagram in **Exhibit P-2**.

64. In his evidence, Encik Nordin stated that he made his first round at approximately 2.15 a.m. and the second round at approximately 3.30 a.m. Encik Nordin testified that on both times, he saw the white shirt of S.Hendry at the corner of the cell. Encik Nordin was certain he saw the shirt as it was white in colour and hence visible from the five-foot way. On both instances, Encik Nordin assumed that S.Hendry was sleeping although on further questioning from the Panel of Inquiry, he was uncertain whether there was a body in the shirt that he saw or it was merely a shirt on the floor.

[7] Exhibit P-17 – Statement of Abu Bakar bin Ishak.
[8] Exhibit P-18 – Statement of Lasiman bin Jahim.

65. As regards Encik Abdul Rahim's testimony, when asked by the Panel of Inquiry whether he saw a white shirt only or S.Hendry's body in the white shirt, Encik Abdul Rahim's answers were inconsistent. At times Encik Abdul Rahim was certain that when he looked into cell C4B from the grill door, he saw the body of S.Hendry in a white shirt sleeping on the floor. At other times, he testified that he saw only a white shirt. Encik Abdul Rahim agreed with the Panel of Inquiry that if had he seen S.Hendry sleeping in a white shirt on the floor, he should have also seen the light green shorts and the blanket. However, Encik Abdul Rahim later explained that he could not see the blanket because "*keadaan tak cukup cahaya... samar-samar*". Encik Abdul Rahim testified that he last saw S.Hendry sleeping at 3.30 a.m. The Panel of Inquiry found the testimonies of both Encik Nordin bin Yunus and Encik Abdul Rahim unimpressive in their claim of having sighted S.Hendry sleeping at about 3.30a.m.

Shift 4: 4.30a.m. – 7.00a.m.

Officers on duty: Encik Abu Bakar bin Ishak & Encik Lasiman bin Jahim

66. Encik Abu Bakar bin Ishak and Encik Lasiman bin Jahim resumed the next shift at 4.30 a.m. According to both warders, they patrolled three times. Encik Abu Bakar testified that they patrolled at 4.30 a.m. (upon assuming their shift), then at 5.00 a.m. and finally at 6.30 a.m. In all three instances, they claimed that they saw S. Hendry sleeping on the floor and they recalled that the situation of the isolation block was satisfactory.

67. Encik Abu Bakar did not hear any noise when he made his rounds although he qualified that he could have been in another unit in the isolation block, far from cell C4B. Encik Abu Bakar gave contradictory answers when he was asked whether he saw a white shirt only or a body in the white shirt when he looked into cell C4B. On one hand, Encik Abu Bakar asserted that he saw S.Hendry sleeping or pretending to sleep but when asked further by the Panel of Inquiry, Encik Abu Bakar maintained that he saw the shirt only.

68. At approximately 5.00 a.m., Encik Lasiman walked by cell C4B and saw S.Hendry lying down on the floor, as if S.Hendry was sleeping. Encik Lasiman observed as follows, "*Subjek berbaring, objek putih, seperti subjek sedang tidur"*. He did not suspect anything was amiss.

69. At 6.30 a.m., both Encik Abu Bakar and Encik Lasiman testified that they saw S. Hendry sleeping on the floor. This claim by both of them was remarkable. The Panel of Inquiry can clearly conclude that this claim was inconsistent when viewed against the state of S.Hendry's body when found hanging at 7.10 a.m.

Sounds heard by detainees

70. Some of the detainees, who were detained in cells beside cell C4B, had heard noises in the early morning of 19 November 2005. Four detainees (Encik Kasilingam Nadar a/l Kanipan (IW15), Encik Anil Rajagopal a/l Muniandy (IW16), Encik Faisal bin Mohd. Husin (IW17) and Mr. Pang Neng Hua (IW22) heard sounds akin to someone kicking the wall. Two detainees (Encik Zohari bin Hasan (IW18), Mohamad bin Yusoff (IW21)) heard a scream, one detainee (Encik Jeffridin bin Yusoff (IW20)) heard a scream of "tolong". Their testimonies are as follows:

Evidence of Encik Kasilingam a/l Kanipan[9]

71. Between 3.00 a.m. and 4.00 a.m., Encik Kasilingam a/l Kanipan heard noises akin to someone kicking the wall. According to the evidence of Encik Kasilingam, the noise was rather loud and it was as if someone was kicking a brick wall without shoes. The noise was for approximately two minutes. The noise emanated from the right side although later, Encik Kasilingam could not confirm which wall or which room the noise originated from. Three other detainees were also awoken by the same noise.

72. Encik Kasilingam did not hear any other noise and did not hear anyone going into S.Hendry's cell.

73. As to the time that he heard the noise, Encik Kasilingam could not say for certain that it was between 3.00 a.m. to 4.00 a.m.

Evidence of Encik Anil Rajagopal a/l Muniandy[10]

74. According to Encik Anil Rajagopal, at approximately 3.00 a.m., he heard noises similar to someone kicking the wall without shoes, from the next cell. The noise that he heard was not that loud and it lasted for a short time only. Encik Anil informed the Panel of Inquiry that he appreciated the difference between someone kicking a wall with and without shoes. However, Encik Anil was uncertain as to whether the noise he heard was someone kicking a wall or the floor. Apart from that, he did not hear anything else and did not hear anyone enter S.Hendry's cell.

75. As regards the time when he heard the noise, Encik Anil could not say for certain that it was 3.00 a.m. He was merely estimating the time as there was no clock in the cell.

[9] Exhibit P-20 – Statement of Kasilingam Nadar a/l Kanipan.
[10] Exhibit P-21 – Statement of Anil Rajagopal a/l Muniandy.

Evidence of Encik Faisal bin Mohd. Husin[11]

76. At approximately 3.00 a.m., Encik Faisal heard sounds of someone kicking on the wall. He could not remember if the noise was gradually louder or softer. He did not hear any other noise or anyone going into S.Hendry's cell. However, upon further questioning, Encik Faisal was unsure whether the noise he heard was someone kicking a brick wall or an iron grill window.

Evidence of Mr. Pang Neng Hua

77. On 18 November 2005, at approximately 11.00 p.m., Mr. Pang heard someone walking around and someone saying "*orang baru datang*". He spoke to S.Hendry and recalled that S.Hendry had asked him for a cigarette lighter. Mr. Pang responded that this was a lock-up and lighters were not allowed. Mr. Pang then asked him (S.Hendry) the reasons of his detention and the nature of his case. Through further conversations with S.Hendry, Mr. Pang found out that S.Hendry was underage and that he was from Kajang.

78. Mr. Pang went to sleep at approximately 12.00 midnight.

79. At around 4.30 a.m. or 5.30 a.m., Mr. Pang heard sounds akin to a wall being hit. Mr. Pang described the hitting as loud initially and then gradually softer. The strikes were for about three or four times and lasted less than a minute. Mr. Pang was unsure whether the noise was caused by a leg or hand hitting the wall. However, he was certain that the noise emanated from the left side of the cell (if standing in the cell and facing the five-foot way) as his cell was the last cell in the row and hence there was no cell on the right. According to Mr. Pang, the noise was clearly audible as it was very quiet at that time. Moreover, he was alone in his cell. Mr. Pang was fully awake at that time when he heard the noise.

80. After that, he did not hear any other noise. The Panel of Inquiry is of the view that Mr. Pang's testimony was credible but cautioned that in view of the lack of a watch/clock, Mr. Pang's estimation of time may not be accurate.

Evidence of Encik Zohari bin Hasan[12]

81. According to Encik Zohari bin Hasan, between 3.00 a.m. to 4.00 a.m., he heard a noise that sounded like a scream from a male voice. In his evidence, he said that he thought nothing of the scream as it was usual for detainees to joke around in the evening. Encik Zohari did not hear any other noise, such as kicking on the wall nor did he hear anyone going into S.Hendry's room.

[11] Exhibit P-22 – Statement of Faisal bin Mohd. Husin.
[12] Exhibit P-23 – Statement of Zohari bin Hasan.

Evidence of Encik Jeffridin bin Yusoff[13]

82. Encik Jeffridin testified that at approximately 3.30 a.m., he heard someone scream out "*tolong*". He heard the scream once from the left of his cell. In his opinion, Encik Jeffridin thought the scream was from an Indian man. However, Encik Jeffridin could not be certain of the time he heard the scream as he was only estimating the time. The Panel of Inquiry did not find the testimony of this witness inspiring.

Evidence of Encik Mohamad bin Yusoff[14]

83. Encik Mohd. Yusoff testified that between 3.00 a.m. and 4.00 a.m., he heard a scream from the adjacent cell. Encik Mohd. Yusoff described the scream as "eeeeeiii...." And he heard it only once. The scream was not loud.

84. He did not hear any other noise nor did he hear any person going into S.Hendry's cell that night.

85. Encik Mohd. Yusoff was uncertain as to the time as there was no clock in the cell.

THE DISCOVERY OF THE BODY OF S.HENDRY

86. Two officers had assumed the morning shift of 7.00 a.m. to 2.00 p.m., i.e. Encik Norazwan bin Mamat[15] (IW23) and Corporal Md. Aini bin Hassan[16] (IW24).

87. On 19 November 2005, at 7.00 a.m., Encik Norazwan began his shift and proceeded to count the detainees. No other warder was with Encik Norazwan at that time. Encik Norazwan explained that it was the usual practice for one warder to count the detainees at the lower floor and the other warder to count the detainees on the upper floor.

88. He approached cell C4B from the right, from the direction of the guard's sleeping room. The first time he walked past the diamond-shaped grill window of cell C4B, he did not notice the body of S.Hendry hanging. Encik Norazwan stopped at the grill door of cell C4B and looked into the cell. He saw a white shirt on the floor, on the shirt was the detention letter ("*surat tahanan*") and a toothbrush. He did not see any detainee in that cell. He then continued to the next cell to count the other detainees. He then did a double take and went back to cell C4B again and when he

[13] Exhibit P-26 – Statement of Jeffridin bin Yusof.
[14] Exhibit P-27 – Statement of Mohamad bin Yusoff.
[15] Exhibit P-28– Statement of Norazwan bin Mamat.
[16] Exhibit P-29– Statement of Md. Aini bin Hassan.

walked to the diamond-shaped grill window, he saw S.Hendry in a hanging position, with a blanket[17] around his neck. It was approximately 7.10 a.m. at that time.

89. Encik Norazwan did not enter cell C4B. He looked at the body of S.Hendry from the grill door. He saw S.Hendry in shorts only, there was nothing extraordinary on the shorts or his hand or legs and there was a black pail on the floor. He could not see S.Hendry's face and he did not touch S.Hendry's body. Encik Norazwan did not take S.Hendry's pulse to verify whether S.Hendry was still alive or dead. Encik Norazwan was outside cell C4B for approximately 10 minutes.

90. Thereafter, Encik Norazwan went to inform his colleague, Corporal Md. Aini and both warders went to see the body again. Subsequently, Encik Norazwan reported the incident to Inspector Zulkifli Che Soh (IW25). Encik Norazwan remained at the scene and waited for further instructions.

91. Encik Norazwan's evidence in relation to the above was as follows:

[18 September 2005, morning session, page 66]

En. Norazwan : Masa saya masuk bekerja pagi kali pertama saya melalui bilik mangsa saya tak nampak. Saya teruskan untuk kiraan disebelah bilik seterusnya. Patah balik lagi sekali saya membuat pemeriksaan. Sampai di tepi dinding jerajak. Saya mendapati yang mangsa dalam keadaan tergantung.

Prof Hamdan : Boleh nampak?

En. Norazwan : Boleh nampak.

…

[18 September 2005, morning session, pages 67 – 72]

Dato' Shafee : Encik Norazwan, bila you buat Encik Norazwan…bila you buat rondaan you seorang atau berduaan?

En. Norazwan : Saya ketika itu berseorangan.

Dato' Shafee : Kebiasaannya keduaan kan? atau..

En. Norazwan : Kebiasaan di blok sana 2 tingkat. Satu kira bawah dan satu kira atas.

Dato' Shafee : Jadi satu pengawal akan membuat rondaan di tempat-tempat yang dibahagikan yang di antara kamu berdua. Malam tersebut cuba…cuba lihat ataupun pagi tersebut. Cuba lihat gambar-gambar ini. Saya nak tunjuk P-4. P-4 Saya tunjuk P-4. Cuba lihat P-4(d). You nampak P-4(d). Now, seperti you lihat gambar itu seperti you lihat gambar itu. You datang dari arah kanan atau arah kiri?

En. Norazwan : Dari arah kiri.

[17] Exhibit P-6(a) & Exhibit P-6(b).

Dato' Shafee : Kali pertama.
En. Norazwan : Kali pertama dari arah kanan.
Dato' Shafee : Arah kanan, jadi dari...
En. Norazwan : Dari arah kanan jadi saya.
Dato' Shafee : Kamu tahu ada bilik pengawal di sebelah kanan.
En. Norazwan : Ah Ah.
Dato' Shafee : Jadi kamu datang dari arah bilik pengawal.
En. Norazwan : Ya.
Dato' Shafee : Jadi berlalu, kamu ada tengok bilik C4.
En. Norazwan : Saya tengok Dato'.
Dato' Shafee : Kali pertama?
En. Norazwan : Tak perasan.
Dato' Shafee : Tak perasan apa.
En. Norazwan : Tak perasan suspek dalam keadaan tergantung.
Dato' Shafee : Ok. Tapi kamu ada lihat tak sama ada ada orang dalam bilik tersebut.
En. Norazwan : Tak ada.
Dato' Shafee : Kamu tanya?
En. Norazwan : Saya lihat memang tak ada orang. Sebab saya tak perasan dari awal kan?
Dato' Shafee : Kamu lihat. Kamu lihat. Kamu lihat macam mana. Seimbas lalu? Atau kamu ke pintu dan lihat betul-betul.
En. Norazwan : Jaga juga ...(unintelligible)
Dato' Shafee : Jadi kamu pergi kat pintu? Jerejak tersebut. Pintu eh?
En. Norazwan : Ah. Pintu uh pintu masuk.
Dato' Shafee : Pintu masuk ke bilik.
En. Norazwan : Di jerejak ini daripada saya mula masuk saya tak perasan, saya terus buat kiraan depan uh ...
Dato' Shafee : Takde takde. Satu per satu. Bila you lalu bilik C4, kamu ada berhenti atau tidak dekat dengan pintu dia?
En. Norazwan : Ya saya berhenti.
Dato' Shafee : Dekat pintu bilik?
En. Norazwan : Ya Dato'.
Dato' Shafee : Jadi di pintu kamu lihat dalam bilik?
En. Norazwan : Lihat Dato'.
Dato' Shafee : Dan apa yang kamu nampak?
En. Norazwan : Saya nampak uh baju muster.
Dato' Shafee : Ok.
En. Norazwan : Uh yang di uh dilamparkan di atas simen dengan "charge form".
Dato' Shafee : Bersama dengan?
Seh Lih : Charge form.
En. Norazwan : Charge form.

Dato' Shafee : Apa dia charge form?
En. Norazwan : Surat tahanan. Surat-surat tahanan.
Dato' Shafee : Ok. Atas lantai juga.
En. Norazwan : Atas baju atas lantai.
Dato' Shafee : Ok. Lagi?
En. Norazwan : Berus gigi.
Dato' Shafee : Berus gigi atas baju juga?
En. Norazwan : Ah... atas baju juga.
Dato' Shafee : Kemudian?
En. Norazwan : Tak ade lagi.
Dato' Shafee : Oh! Okay. Jadi kamu pasti yang kamu nampak benda-benda ini
Dato' Shafee : Baju, charge form dan berus gigi.
Dato' Shafee : Berus gigi atas charge form? Berus gigi atas charge form?
En. Norazwan : Atas baju lah.
Dato' Shafee : Ya.Ya. Tapi surat itu atas baju. Adakah berus gigi itu atas surat?
En. Norazwan : Berus gigi atas baju.
Dato' Shafee : Jadi bukan atas surat.
En. Norazwan : Atas baju Dato'.
Dato' Shafee : Jadi kamu nampak ini semua?
En. Norazwan : Yang itu saya nampak.
Dato' Shafee : Tapi tak nampak orangnya.
En. Norazwan : Orang tak nampak tapi dari pintu masuk dia saya nampak.
Dato' Shafee : Dan kemudian, kamu terus pergi?
En. Norazwan : Terus pergi untuk buat kiraan ke bilik hadapan.
Dato' Shafee : Kenapa kamu terus pergi? Kenapa tidak kamu khuatir di mana dia ini
En. Norazwan : Sebab niat saya, se sesudahnya saya kira dua lagi ...
Dato' Shafee : Datang balik?
En. Norazwan : Ah. Datang balik ingin buat maklumkan kepada korporal lagi sekali, saya tergerak hati untuk membuat pemeriksaan dan mendapati mangsa dalam keadaan tergantung.

92. When Inspector Zulkifli Che Soh[18] arrived at cell C4B, he saw S.Hendry in a hanging position. He did not go into the cell. Inspector Zulkifli proceeded to touch the back of S. Hendry's body (from outside the cell) through the diamond-shaped grill window and felt that his body was cold. Inspector Zulkifli also noticed that S.Hendry's left hand appeared blue and from the waist up, S.Hendry's body looked pallid.

[18 September 2005, morning session, pages 81-82]

[18] Exhibit P-30 – Statement of Mohd. Zulkifli Che Soh.

Insp. Zul : ... Semasa Korperal Aini bawa masuk, saya tidak masuk ke biliknya. Hanya ke lorong tempat kejadian dan saya cuma melihat daripada luar bilik.

Dato' Shafee : Dan memegang?

Insp. Zul : Dan memegang melalui lubang diamond tu.

Dato' Shafee : Jadi sejuk?

Insp. Zul : Sejuk.

Dato' Shafee : Dah rasa sejuk?

Insp. Zul : Dah rasa sejuk.

Dato' Shafee : Dan ada tangan dia tu kebiruan. Itu boleh nampak?

Insp. Zul : Itu yang saya boleh nampak. Satu lagi, semasa saya mencari Tuan Halim itu, terlebih dahulu saya mencari Timbalan Penguasa bertugas, Tuan Kamal tapi semasa itu, dia tak ada sedang mengambil muster di blok tahanan. Jadi uh... Oleh kerana dia tak ade, saya terus cari Tuan Halim.

Prof Hamdan : Saya tanya tadi yang, boleh masuk jari ke nak tahu sejuk ke tidak huh?

Insp. Zul : Boleh masuk Dato'.

Prof Hamdan : Badannya tak hempil sangat kepada.

Insp. Zul : Badannya rapat sangat dengan jerejak.

Dato' Shafee : Badan dia rapat atau terkena jerejak.

Insp. Zul : Terkena jerejak.

Dato' Shafee : Terkena.

Insp. Zul : Ya.

Prof Hamdan : Jadi.. menurut kenyataan ini uh... Encik Zulkifli telah menyatakan uh... Tuan menyentuhkan belakang badannya. Jadi tempat anda berdiri, boleh menyentuh belakangnya?

Insp. Zul : Ya boleh Dato'.

Dato' Shafee : Saya nak tanya. Satu soalan yang belum lagi ditanya pada mana-mana saksi pun. Daripada gambar yang saya lihat ini, nampaknya seolah-olah subjek berkemungkinan terkencing dalam seluar. Ada nampak atau tidak?

Insp. Zul : Itu saya tak nampak.

Dato' Shafee : Tak nampak eh. (pause) Tapi pasti badannya sejuk?

Insp. Zul : Pasti Dato'.

Dato' Shafee : Pasti ya?

Insp. Zul : Pasti.

...

[18 September 2005, morning session, pages 83 – 84]

Dato' Shafee : Ok. Daripada dalam, siapa yang meneliti mayat itu? Dengan cara memegang atau mengambil nadinya? Siapa yang buat? Ada orang buat atau tidak?

Insp. Zul : Itu tiada buat Dato'.

Dato' Shafee : Takda buat. Sesiapa pun tidak pegangnya?
Insp. Zul : Tak pegang.
Dato' Shafee : Ok. Jadi kira Encik saja seorang yang memegang yang pastikan badannya sejuk.
Insp. Zul : Uh..
Dato' Shafee : Orang lain tak pegang?
Insp. Zul : Saya ingat semasa Tuan Halim ada... dia ada pegangnya.
Dato' Shafee : Jadi ada kemungkinan yang Tuan Halim pegang.
Insp. Zul : Tapi saya tak pasti lah.
Dato' Shafee : Alright. Tapi walau bagaimanapun, semua orang pasti yang ah badan yang tergantung itu sudah mati.
Insp. Zul : Semua dah pasti Dato'.

93. Encik Rosli Daud, Medical Assistant, who was on stand-by, was not called to the scene.

94. Inspector Zulkifli reported the incident to Tuan Kamal and Tuan Halim. At approximately 7.30 a.m., Tuan Halim arrived at cell C4B. He proceeded to open the cell and asked the warders and officers not to do anything and to wait for instructions from Tuan Kamal, Timbalan Penguasa Penjara Bertugas Pagi. Tuan Halim was the first person to open cell C4B.

95. Tuan Mohd. Zawawi bin Abdul Rahim (IW19), Director of the *Pusat Pemulihan Akhlak* Simpang Renggam arrived at the scene between 8.00 a.m. and 9.00 a.m. He saw the body of S.Hendry in a hanging position and instructed Inspector Zulkifli to lodge a Police report at the Kluang Police station.

Police investigations

96. At approximately 9.40 a.m. on 19 November 2005, Inspector Alimuddin bin Usman (IW1) and Detective Corporal Roslan (Police No. 97095) arrived at the scene. Inspector Alimuddin acted upon a Police report No. 2773/2005[19] that was lodged at the Kluang Police Station at 9.00 a.m. on 19 November 2005 by an officer from the Prisons Department.

97. Inspector Alimuddin identified the place where S.Hendry's body was found as cell "C4 bawah" or C4B, located in the isolation block of the *Pusat Pemulihan Akhlak* Simpang Renggam. There were four cells in the same row as cell C4B, that is, cells C2, C3, C5 and C6 and a room for Prison warders to rest in between their shifts. On the

[19] Exhibit P-1.

right of cell C4B was a toilet and on the left of cell C4B was cell C5. Cell C4B measured approximately 2.94 meters in height, 8.4 meters in length and 5.4 meters in width. Inspector Alimuddin observed that there was one door leading into cell C4B on the left of the cell and on the right side of the door were two diamond-shaped iron grill windows. At the back of the cell, there were two, slightly smaller, diamond-shaped iron grill windows. In front of cell C4B was a five-foot way[20].

98. Inspector Alimuddin described what he saw when he inspected S.Hendry's body as follows:

[17 September 2005, morning session, pages 22 – 28]

Insp Ali : Siasatan di dalam tempat kejadian, saya telah mendapati seorang banduan, iaitu seorang lelaki India….tinggi lebih kurang 172 sentimeter.
Dato' Shafee : 172?
Insp Ali : Ya, saya.
Dato' Shafee : cm ya?
Insp Ali : Dalam keadaan tergantung tidak bernyawa.
Dato' Shafee : Tergantung dan tidak bernyawa?
Insp Ali : Ya, saya. (pause) Di sudut sebelah kanan.. sel berhampiran dengan dinding…di mana tergantung dengan sebuah kain blanket…
Prof Hamdan : Selimut?
Insp Ali : … iaitu selimut berwarna biru gelap yang dibekalkan oleh pihak penjara.
Dato' Shafee : Kain selimut warna apa tadi?
Insp Ali : Berwarna biru gelap.
Dato' Shafee : Biru gelap?
Insp Ali : Ya.
Dato' Shafee : Ok.
Insp Ali : Yang mana saya dapati hujungnya telah terikat….blanket tersebut terikat pada …
Dato' Shafee : Hujung ke atas.
Insp Ali : Ya, saya.
Dato' Shafee : Hujung ke atas?
Insp Ali : Ya. Pada tingkap besi bilik kurungan iaitu, tingkap besi bergril berbentuk 'diamond' di sebelah kanan berhampiran dengan dinding.
Dato' Shafee : Di ikat di jerejak tingkap ya?
Insp Ali : Ya, saya.
Dato' Shafee : Di jerejak tingkap yang err…yang di tepi kaki lima?
Insp Ali : Di tepi sebelah kanan berhampiran dengan dinding tempat kejadian.
Dato' Shafee : Ya, err.. tingkap itu yang…yang …yang tepi kaki lima?

[20] Exhibit P-2 - *Rajah Kasar Tempat Kejadian*; Exhibit P-2K – *Kunci bagi* P-2; Exhibit P-3 – *Rajah Kasar Keseluruhan Tempat Kejadian;* Exhibit P-3K – *Kunci bagi* P-3.

Insp Ali : Ya, ya.
Dato' Shafee : Seperti yang ter-...tertera dalam P2?
Insp Ali : Ya, saya.
Dato' Shafee : Ya? Alright, teruskan.
Insp Ali : Dan hujung blanket satu lagi tersimpul.....pada... .
Dato' Shafee : Tersimpul?
Insp Ali : Ya, tersimpul, pada leher lelaki India tersebut.
Dato' Shafee : Ok.
Insp Ali : Laki yang tersebut saya andaikan sebagai si mati, mana simati tidak berpakaian.
Dato' Shafee : Jadi sekarang kita gunakan perkataan 'Si Mati' untuk lelaki India yang tergantung.
Insp Ali : Ya.
Dato' Shafee : Tidak berpakaian..... apa maksud Inspektor?
Insp Ali : Dia hanya memakai seluar.
Dato' Shafee : Seluar pendek?
Insp Ali : Ya, saya. Seluar pendek berwarna hijau muda....err, jenis kain...
Dato' Shafee : Hijau muda ya?
Insp Ali : Ya, saya.
Dato' Shafee : Ya?
Insp Ali : Yang dibekalkan oleh pihak penjara.
Dato' Shafee : Yang dibekalkan....oleh penjara.....ya?
Insp Ali : Dan saya kemudian telah memeriksa keadaan fizikal simati yang mana keadaan simati iaitu kedua belah mata terbuka separuh.
Dato' Shafee : Ini.. ini semasa dia masih tergantung?....
Insp Ali : Ya semasa tergantung.
Dato' Shafee : ....atau telah diturunkan.
Insp Ali : Semasa tergantung.
Dato' Shafee : Masih tergantung? (pause) Ya?
Insp Ali : Err.. mulut terbuka sedikit, menampakkan lidah seperti hendak terjelir.
Dato' Shafee : Nampak lidah seperti hendak....?
Insp Ali : Terjelir.
Dato' Shafee : Terjelir. Ok.
Insp Ali : Di mana lidah berwarna pucat.
Dato' Shafee : Sorry?
Insp Ali : Lidah berwarna pucat.
Dato' Shafee : Teruskan ...teruskan.
Insp Ali : Kepala Si Mati mengiring ke sebelah kanan.
Dato' Shafee : Ya.
Insp Ali : Err. Kedua-dua belah kaki, berwarna agak gelap kebiru-biruan.
Dato' Shafee : Berwarna gelap?

Insp Ali : Agak gelap.
Dato' Shafee : Agak gelap. Kebiruan?
Insp Ali : Kebiru-biruan.
Dato' Shafee : Ya.
Insp Ali : Terjuntai ke bawah.
Dato' Shafee : Terjuntai ke bawah?
Insp Ali : Tidak menyentuh lantai.
Dato' Shafee : Ke-...kedua-dua kaki tidak menyentuh.. .
Insp Ali : Tidak. Kedua-dua belah kaki tidak menyentuh lantai ataupun sebarang benda.
Dato' Shafee : Alright.
Insp Ali : Jarak hujung kaki Si Mati, dengan lantai lebih kurang 28 cm.
Dato' Shafee : Jarak apa ini? Jarak kaki....
Insp Ali : Jarak hujung..
Dato' Shafee : Hujung?
Insp Ali : Hujung kaki...kedua-dua belah kaki dengan lantai, lebih kurang 28 cm.
Dato' Shafee : Boleh teruskan.
Insp Ali : Err. Kedua-dua tangan terjuntai ke bawah, di mana hujung kedua-dua belah tangan berwarna kebiru-biruan.
Dato' Shafee : Hujung sebelah tangan... adakah Inspektor maksud hujung jarinya atau tangannya?
Insp Ali : Di bahagian pergelangan tangan hingga ke hujung jari.
Dato' Shafee : Ok. Kedua-dua belah tangan?
Insp Ali : Ya, saya.
Dato' Shafee : Ya, teruskan.
Insp Ali : Er.. pemeriksaan selanjutnya pada fizikal Si Mati, saya tidak menemui sebarang kecederaan luaran kepada badan Si Mati.
Dato' Shafee : Tidak ada....apa dia itu? Apa-apa pun... .
Insp Ali : Sebarang kesan kecederaan. Maksud saya kecederaan yang baru.
Dato' Shafee : Sorry?
Insp Ali : Maksud saya kecederaan yang baru.
Dato' Shafee : I see. Ya.
Insp Ali : Dan hanya terdapat kesan parut jerawat.
Dato' Shafee : Hanya kesan parut ya?
Insp Ali : Ya, saya.
Dato' Shafee : Jerawat.
Insp Ali : Pada muka Si Mati ...
Dato' Shafee : Ya.

99. In the area surrounding the body of S.Hendry, Inspector Alimuddin found a black pail, the height of which was approximately 22 centimeters, in an overturned position. The

black pail[21] was presented to the Panel of Inquiry by Inspector Alimuddin and measured and confirmed to be 22 centimetres in height. During his testimony, Inspector Alimuddin, at the request of the Panel of Inquiry, stood on one foot on the said pail bringing his entire body weight on it. This was to ensure that the pail was able to take the average human load. The Panel of Inquiry was satisfied that the pail was capable of that. Inspector Alimuddin testified that the black pail was the pail provided by the *Pusat Pemulihan Akhlak* Simpang Renggam.

100. Upon further examination of cell C4B, Inspector Alimuddin saw a white shirt (clarified as the shirt provided by the *Pusat Pemulihan Akhlak* Simpang Renggam) at the far left corner of cell C4B. Near the shirt, there was a grey plastic cup, a grey plastic *kole*, a grey plastic spoon, a bar of orange soap, a tube of toothpaste, a green toothbrush, its end shortened (clarified as shortened by the *Pusat Pemulihan Akhlak* Simpang Renggam) and a pair of blue rubber slippers.

101. Inspector Alimuddin identified the body as that of Hendry a/l Sreedhran, I.C. No.: 870128-08-5613, as recorded in the Police report. Inspector Alimuddin then instructed Detective Corporal Roslan to take photographs of the body as it was found hung[22].

102. Thereafter, Inspector Alimuddin was directed by the Magistrate, Kluang Magistrates' Court (via mobile phone) to bring the body down and to send the body to Hospital Kluang. The body of S.Hendry was brought down, at approximately 11.30 a.m. Inspector Alimuddin recalled that the body was hard and there were no marks around the stomach area of the body.

103. At 1.30 p.m. on 19 November 2005, the requisite form for examination of the body was issued.

104. At approximately 3.20 p.m. on 19 November 2005, the body of S.Hendry arrived at Hospital Kluang. Dr. Thet Naing Aye, A&E doctor on duty at the material time received the body of S. Hendry. Dr. Thet described his observations as follows - "... history of alleged hanging in prison, with no respiration, no pulse rate, no blood pressure, fixed and fully dilated pupils, not reacting to light". When asked what were his observations with regard to the physical appearance of S. Hendry's body, Dr. Thet could not remember whether he saw a blanket around S. Hendry's neck or whether there was bruising[23].

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[21] Exhibit P-7.

[22] Exhibit P-4 (a)-(h); Exhibit P-4(an)-(hn) – Negatives of P-4(a)-(h).

[23] The Panel of Inquiry wishes to point out that Dr. Thet was not called as a witness and his statement was given to a SUHAKAM officer in an interview on 3 January 2006, at 2.45 p.m., at Hospital Kluang.

TUAN MOHD. ZAWAWI'S DISCUSSIONS WITH MR. SREEDHRAN ON 19 NOVEMBER 2005

105. On the morning of 19 November 2005, Tuan Mohd. Zawawi telephoned Mr. Sreedhran, S. Hendry's father and informed him of the death of S. Hendry. He also informed Mr. Sreedhran that he could come and see him (Tuan Mohd. Zawawi) and the Prison authorities would do its best to assist Mr. Sreedhran. Mr. Sreedhran informed Tuan Mohd. Zawawi that he had to contact his daughter in Teluk Intan and could not confirm whether he would be able to go to Simpang Renggam on 19 November 2005.

106. According to Mr. Sreedhran he was informed that his son, S. Hendry had committed suicide. He was also informed that his son was placed in a cell alone and was given a blanket. The following morning, the Prison warders discovered that his son had hung himself with the blanket.

107. Mr. Sreedhran testified that he went to Simpang Renggam on 19 November 2005 with the intention of seeing his son's body but was not allowed. He was informed that it was a Saturday and there was no one working at the hospital. Upon meeting the Police, the Police informed Mr. Sreedhran that he was not allowed to see his son's body as this was not a Police case but a case under the purview of the Prison authorities. When Mr. Sreedhran contacted Tuan Mohd. Zawawi bin Abdul Rahim, Director of the *Pusat Pemulihan Akhlak* Simpang Renggam, he was again informed that he could not see his son's body and was told to return the following Monday, 21 November 2005.

108. According to Tuan Mohd. Zawawi, he, together with Inspector Alimuddin, had met with Mr. Sreedhran at the Kluang Police station on 19 November 2005. Tuan Mohd. Zawawi recalled that Inspector Alimuddin informed Mr. Sreedhran that the case had been reported to the Police and hence had become a Police case. Since the coroner had yet to examine the body, Mr. Sreedhran was not allowed to see the body of his son. It was Tuan Mohd. Zawawi testimony that it was not the Prisons Department that had disallowed Mr. Sreedhran to see his son's body.

EVENTS AFTER 19 NOVEMBER 2005

Identification of the body of S.Hendry

109. On 21 November 2005, Mr. Sreedhran, identified the body of his son with one Mr. Ramachandran a/l Stanilos. When he identified the body of his son, Mr. Sreedhran described that there was a soft black cloth tied around his son's neck. Mr. Sreedhran

was informed that his son had used the said cloth to hang himself. Mr. Sreedhran also saw a black mark below the stomach area. When Mr. Sreedhran queried about the black mark, he was informed that the blood from the heart had gone down to the stomach area and clotted (Mr. Sreedhran could not remember who told him this particular information). He did not view other parts of the body and did not see any other markings on the neck.

110. Inspector Alimuddin testified that Mr. Sreedhran did not make any complain or comments to him when he identified his son's body.

111. During the Inquiry, Mr. Sreedhran was shown photographs of the body of S.Hendry taken as he was found in a hanging position in cell C4B and before the post mortem examination, in particular **Exhibit P-4(h)** and **Exhibit P-5(d)**. Although **Exhibit P-4(h)** showed the tongue of S.Hendry slightly protruding and **Exhibit P-5(d)** showed marks on S.Hendry's neck after the blanket was removed, Mr. Sreedhran felt that the photographs merely showed that someone had tied the blanket tightly. He stated that "*Dari gambar saya nampak ni, s-saya rasa dia bukan gantung diri. Macam ada orang yang ikat sampai kuat*"[24].

112. Mr. Sreedhran was also shown **Exhibit P-4(f),** a full body photograph of S.Hendry and Mr. Sreedhran identified that the place he saw the black mark was near the belly button of S.Hendry. Mr. Sreedhran later clarified that the black mark was more of tiny black spots around the belly button area. This is a significant explanation of the fact as will be apparent later.

113. After the post mortem examination was performed, Mr. Sreedhran was informed that his son's body had no bruises or injuries. Mr. Sreedhran testified that a Malay doctor also informed Mr. Sreedhran that because his son had held his breath when he hung himself, his tongue did not protrude. Mr. Sreedhran could not remember which doctor had told him that information.

The post mortem examination

114. On 21 November 2005, at 11.00 a.m., Dr. Shahidan bin Md. Noor (IW26), forensic pathologist from Hospital Sultanah Aminah, Johor Bahru carried out the post mortem examination of the body of S.Hendry, at the mortuary of Hospital Kluang. The date of the post mortem examination was determined by Dr. Shahidan. Dr. Shahidan explained in his evidence that he had set the date of 21 November 2005 as 19 November 2005 was a Saturday.

[24] 17 February 2006, morning session, page 76.

115. The Police took photographs of the body of S.Hendry prior to the post mortem examination[25].

116. In relation to the physical and internal examination of the body of S.Hendry, Dr. Shahidan gave the following evidence[26]:

[18 February 2006, morning session pages 88-90]

Dr. Shahidan : Ya, saya telah menjalankan bedah siasat sebenarnya melalui pemeriksaan luaran pada mulanya. Pemeriksaan saya menunjukkan seorang lelaki India yang kurus. Tingginya 173 cm.

Dato' Shafee : One seven three.

Dr. Shahidan : Uh huh dan pada saya, dia berkerangka sederhana lah. Dia mempunyai rambut yang pendek dan misai yang halus dan ada juga janggut. Sedikit janggut. Dia hanya berpakaian seluar pendek hijau yang pada saya pucat lah. Hijau pucat dan terdapat uh.. uh apa ini tanda-tanda muntah kuning dari hidung dan mulutnya lah. Di sudut mulut.

Dato' Shafee : Tanda-tanda apa itu?

Dr. Shahidan : Muntah. Pada saya muntah. Benda kuning yang datang dari mulut dan hidung…

Dato' Shafee : Dari mulut dan hidung?

Dr. Shahidan : Yes. Ah...matanya agak tenggelam dan dilehernya terdapat satu kain, saya fahamkan adalah selimut biru yang nipis yang sa.. saya tak buka saiz dia tapi saya difahamkan dia sebesar cadar sehingga cadar dan diikat di belakanglah ada knot belakang. Saya memang masa me..me mengeluarkan benda itu saya telah memotong dia di hadapan makna dia saya preserve apa tu ikatan. Untuk tujuan pemeriksaan dan uh uh.. Leher si mati berukuran 31 cm berlilit dan kulitnya di kawasan apa ni.. uh helcomb blanch sikit dan ada slip lah especially helcomb kiriya.

Dato' Shafee : Sorry can you repeat that?

Dr. Shahidan : Kulit dia ter… ter.. terangkat dia kulit dah slip ya. Kulitnya rapatkat ni. After some…

Dato' Shafee : Slip?

Dr. Shahidan : Dia terkoyak

Dato' Shafee : Oh..

Dr. Shahidan : Dia slip dan mukanya agak pucat termasuk juga…

Dato' Shafee : Muka pucat.

Dr. Shahidan : Dan..uh petiki[27] ataupun perdarahan bertompok-tompok terdapat dari pusat ke bawah. Pusat…

[25] Exhibit P-5(a)-e); P-5(an)-(en) – Negatives of P-5(a)-(e).
[26] Exhibit P-31 – Post mortem examination report.

Dato' Shafee : Perdarahan?

Dr. Shahidan : Ah.. tompok-tompok kalau kalau jelaskan muka pun ada tuk...tapi yang ini dari pusat ke bawah dan uh terdapat lebih apa dekat ketingnya lah dekat depanni. Kat keting yang titik-titik.

Dato' Shafee : Di mana?

Dr. Shahidan : Dia dari...

Dato' Shafee : Sorry keting tu mana pulak?

Dr. Shahidan : The shin.

Dato' Shafee : Oh the shin sorry sorry.

Dr. Shahidan : So pusat ke bawah.

Dato' Shafee : Bintik-bintik itu lebih di keting?

Dr. Shahidan : Lebih ketara di keting. (pause) Pada pada masa yang sama di tangan uh di anggota atas uh tangan uh apa ni hypostasis[28] nampak pada lengan kana ke bawah lah dan hujung ni biru kebiruan..hujung jari. Hujung jari kebiruan cyanosed[29] ia. Tidak ada tanda traumalah pada tubuh si mati...

...

[18 February 2006, morning session, pages 90 - 92]

Dr. Shahidan : .... memenuhi dan hypostasis kat belakang dah tak ada.

Dato' Shafee : You sebut hypo?

Dr. Shahidan : Hypostasis adalah uh keadaan darah...

Dato' Shafee : Yang menurun.

Dr. Shahidan : Ahh... ter apa tu?

Dato' Shafee : Yang menakung.....

Dr. Shahidan : Yang menakung ya....di belakang tak adalah.

Dato' Shafee : Tak ada takung di belakang...

Dr. Shahidan : Tak adalah... dan, err, seterusnya, saya telah menjalankan siasatan dalaman dengan melakukan 'dissection', dan kerana ia melibatkan leher, Saya telah membuka bahagian kepala dahulu lah. Pemeriksaan kepala menunjukkan kulit kepala pucat dan tidak cedera, err..

Dato' Shafee : Dan tiada ada cedera ya?

Dr. Shahidan : Tengkorak pun begitu juga...err, selaput otak, pun biasa, dan otak pun dalam keadaan baik. Manakalala di bahagian leher uh tidak ada kecederaan kerana saya telah memeriksa bahagian tu dahulu, di in situ, makna saya supaya bila saya buka benda tu, saya tidak mahu

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[27] Petechiae (eng). Petichiae is defined as "a minute reddish or purplish spot containing blood that appears in skin or mucous membrane as a result of localised haemorrhage", *http://www2.merriam-webster.com*

[28] Hypostasis is defined as "the settling of blood in relatively lower parts of an organ or the body due to impaired or absent circulation", *http://www2.merriam-webster.com*

[29] Cyanosis is defined as "a bluish or purplish discolouration of the skin and mucous membranes due to an increase in the amount of deoxygenated hemoglobin in the blood or a structural defect in the hemoglobin molecule", *http://www.online-medical-dictionary.org*

kecederaan itu dilakukan semasa bedah siasat, saya telah menoreh, membuat diseksi di leher, kemudian mengeluarkan organ-organ di leher, dan memeriksanya semula di meja lah ah.. . Tidak ada, apa ni, err...kelainan di sana, ataupun kecederaan. Manakala di bahagian dada, saya juga tidak mendapati apa-apa kelainan, melainkan terdapat sedikit makanan yang terkeluar keluar daripada gullet ataupun esophagus, masuk ke bahagian awal leher. Err...pemeriksaan organ dalaman di dalam dada juga tidak menunjukkan apa-apa kelainan lah. Err, seterusnya saya memeriksa bahagian abdomen begitu juga dinding abdomen tidak ada kelainan, organ-organ dalaman pun tidak ada kelainan ataupun kecederaan. Saya telah mengambil darah dan saya masih tidak tahu hasil dia, dan pakaian-pakaian dan err.. selimut tadipun telah diambil, dan sedikit tisu telah diperiksa, dan tidak apa... tidak ada apa-apa kelainan yang saya dapati dari pemeriksaan itu. Akhirnya, apabila setelah selesai menjalankan bedah siasat ahh.., dan berdasarkan kepada fakta yang diberi oleh polis, saya telah memberi sebab kematian di akhir bedah siasat sebagai asphyxia[30] yang disebabkan oleh 'hanging' atau menggantung diri.

...

[18 February 2006, morning session, page 112]

Dato' Shafee : Ok. Just one more question, pertaining to this. Did you have the slightest evidence that Henry underwent through some kind of assault or battery, before he die?

Dr. Shahidan : I don't think so...

[18 February 2006, morning session, pages 112-116]

Dato' Shafee : You've examined the head?

Dr. Shahidan : Yes.

Dato' Shafee : There's no injury?

Dr. Shahidan : Yes, in fact, I think for any cases, especially with hanging, I informed the medical officer if they're handling it, to make sure that they open up the head. Because, that is the only way that the.... you can, what we call it, try...people try to hide it. Because once you are incapacitated, and become infirmed, they can only put this one, on the noose onto your neck.

Dato' Shafee : Correct.

Dr. Shahidan : Otherwise it would be difficult, even if you know, a lynch, a mob would come and lynch you, you will fight with your life, and definitely there will be a lot more marks on your person. So, ...

[30] A lack of oxygen or excess of carbon dioxide in the body that is usually caused by interruption of breathing and that causes unconsciousness, *http://www2.merriam-webster.com*

Dato' Shafee : Defensive wounds and all that? No defensive wounds, nothing?

Dr. Shahidan : Nothing. Ya.

Seh Lih : Urm, doctor, following up from that, I was wondering if you saw any bruises or abrasions to the heel of his feet, or, any part of his feet?

Dr. Shahidan : In fact, I don't think I could find any marks of trauma of this person.

Seh Lih : If someone was kicking the wall with the heel of his feet, for a minute as you said, would that leave any bruises or abrasions?

Dr. Shahidan : Kalau heel for instance, very difficult lah, if once or twice, because heel is thick with (inaudible), in fact, kalau orang nak torture pun, dia boleh buat torture dekat heel lah, there won't be any mark at all. But if you were doing this to this one, there is other areas that maybe telling lah. That's a good place to hit on the limb.

Seh Lih : So it wouldn't leave any abrasions or bruises, for a hitting of a minute or so?

Dr. Shahidan : I don't think so. No.

Seh Lih : Can a person hanging in that condition, be sreaming the word 'tolong', or anything like that?

Dr. Shahidan : Err... Unless he had a problem, he doesn't hit, or he doesn't want to end himself, I think this kind of action usually is a sign to ask for help. But many a time, in cases like hanging, most of them are successful, so I don't think they would like to call for help. In fact, in a planned one, they make sure that everything is closed, they have a right to this one and quietly when everybody is away, and they do the final act.

Dato' Shafee : Yes. Well, can there be...err...some kind of involuntary noise like, you know, wheezing, loud wheezing sound? Like someone said, they heard "eeiii" kind of sounds...

Dr. Shahidan : Err...well, I...I think probably there is....err....there'll be something like that, Dato', but, err...I've not much experience, suppose. I think I'm sure, because our body have ... things like that, there is a sudden vibration or what, I think, some some sound may be...produced, lah.

Seh Lih : Urm...just, just to, err... ask on the part where you said that the heel were not, have any abrasions or bruises. How about other parts of the feet? The side of the feet? If you knock for a...minute or so, would it, would it leave any mark? And did you notice any of the markings?

Dr. Shahidan : In fact, in a living person, err....if the contact was short, err...I don't think we would be able to say, unless the person tell you he hits here, it's still painful. That kind of thing.

Seh Lih : Right.

Dr. Shahidan : Otherwise, we won't be able. So, in the case of a deceased person, kalau contact dia short, and it never, err... pass the threshold, I don't think we'll find anything there.

...

[18 February, morning session, pages 115 – 116]

Seh Lih : Were there, urm...any significant post mortem changes? Urmm...That is, say changes on the body which had taken place since death, until the time you perform the post mortem? Would there be significant changes?

Dr. Shahidan : Aaa...well, err...since the remain has been kept in the freezer in the mortuary so I think most of the changes, would be retarded. So, I think it's as good as when we see the body was fresh. But, without the freezer I suppose when we examine it on a Monday, some..err...some 40 hours have lapsed, the body will be in...err...start to decomposed, lah. Aaa...

117. As to the estimate time of S.Hendry's death, Dr. Shahidan gave the following evidence:

[18 February 2006, morning session pages 93-96]

Dr. Shahidan : Kebanyakan masa, apa, Dato'...kalau seseorang itu telah mati, jasadnya tidak ada lagi degupan jantung, darah akan bertakung. Dan bertakungnya darah ni kadang-kadang membantu pihak kita. Err jadi...bila jasad itu, kebanyakan masa akan terbaring, selalunya, hypostasis, atau takungan darah selepas mati itu akan lebih jelas. Dan dalam...dalam...err...kematian Henry ini, dia kurang. Kuranglah, tidak jelas. Sebabnya dia lebih banyak kepada, dekat err...tadi...err....

Dato' Shafee : Dari lengan tangan?

Dr. Shahidan : Dari lengan tangan, sampai ke kaki, dari, dari pusat, sampai ke bawah, dan dari lengan tangan ni, sampai ke hujung...Kita boleh nampak.

Dato' Shafee : Takungan sedemikian, yang dijumpai ke atas jasad Hendry, apa conclusion yang Dr. boleh buat daripada takungan sedemikian?

Dr. Shahidan : Takungan itu menunjukkan...err... jasad itu, ter... err... kedudukan jasad itu adalah sedemikian... maknanya dalam...err..kes si Henry ni, kemungkinan besar dia lama tergantunglah, dan dia kemudian hanya sebab... err... bila dia dah dijumpai baru kita letakkan. Dan darah tu... err... apa ni... ada masanya beku, beku semula dan menjadi bendalir semula, dan sebab keadaan Hendry ni mungkin tergantung agak lama, dia agak jelas di 'extremities' tadi, dibanding dengan dibelakang. Jadi kalau apa si Hendry mungkin tidak ter...berkedudukan begitu, dia terbaring kebanyakan masa, saya rasa hypostasis dia lebih jelas di belakang.

Dato' Shafee : Ok. Jadi berdasarkan kepada takungan darah yang Dr. lihat, bolehkah kita kata...err...kematian Hendry ini, lebih konsisten bahawa dia mati, secara tergantung, atau sekurang-kurangnya secara terdiri?

Dr. Shahidan : Saya berpendapat, Dato', dia lebih tergantunglah.

Dato' Shafee : Tergantung? Ok, jadi, in that vertical position?

Dr. Shahidan : Yes.

Dato' Shafee : Jadi sebab tu, darah semua turn, sebab dia punya jantung dah stop?

Dr. Shahidan : Yes.

Dato' Shafee : Jadi semuanya turun ke bawah. That's what you're trying to tell us?

Dr. Shahidan : Ya.

Dato' Shafee : Dan,err, berapa lama, er Dr., untuk sesuatu jasad...err..bekuan darah akan jadi permanent? Yakni, let me clarify, let's say someone just died hanging, and then you bring down the body quickly, then you lay him down, berkemungkinankah darah tu kembali ke tempat, you know, liquid takes its own level, ya? That is possible kalau you bring it down immediately. How long do you think, err do you need, for such a thing not to happen....kalau badan tu tergantung?

Dr. Shahidan : Dalam hal begini, Dato', err...kadang-kadang agak sukar. Tetapi, jika seseorang itu ditemui mati tergantung, dan keluarkannya immediately, agaknya beberapa minit sahaja, saya rasa kita tidak, apa ni, dan...err....kematian ni, peristiwa kematian akan diberitahu, beberapa jam kemudian, saya rasa hypostasis akan terbentuk di belakang. Tidak ada langsung tanda yang seolah-olah dia tergantung. Dan fakta ini mungkin cuba disorokkan. Tetapi dalam peristiwa Hendry ni, saya berpendapat dia tergantung beberapa jam, sehingga memudahkan darah...err darah walaupun dia ada satu bendalir, dan jantung sudah berhenti untuk mengalirkan, darah itu ada komposisi yang memberi dia menjadi bendalir, ataupun membeku. Jadi dua fakta ni penting, Dato'. Supaya jadi dalam hal Henry ni, kemungkinan beberapa jam. Saya rasa lebih pada 4 jam, untuk menyebabkan peristiwa tu berlaku dan agak ketara.

Dato' Shafee : Lebih daripada 4 jam, ye?

Dr. Shahidan : Pada saya lebih.

...

[18 February 2006, morning session, page 115]

Seh Lih : Err...Were you able to estimate the time of death?

Dr. Shahidan : I, I think...err...the time of death would be rather difficult endeavour, but since the...err..because I examined it also, later part. Only on Monday, whereas the..the death itself has been reported on Saturday. So, by...by basing on the changes on the remain, I would say the body has been there for the last 12 hours, lah.

118. As to the cause of death, Dr. Shahidan stated the following in his evidence:

[18 February 2006, morning session, pages 96-98]

Dato' Shafee : ...Dr. juga ada beritahu, Dr. buat siasatan dia punya leher tu. You find internal organ of the leher...err...not injured. Not injured. Tapi ada trauma?

Dr. Shahidan : Tidak Dato'. Sebab apa yang saya katakan...err..leher adalah satu struktur yang penting di badan kita, walaupun mungkin kita akan, untuk dalam kes 'strangulation' contohnya, kejang. Tetapi nyata kita boleh tahu, sebab dia ada tekanan, yang si 'assailant' pun tidak pasti berapa kuat dia bagi, dan ada tandanya. Dan untuk kes yang hanging, selalunya, alat yang digunakan itu agak penting, kerana dia adalah fabrik yang lembut, berpermukaan luas, selalunya tidak ada tanda-tanda dan jika ia berlaku di tempat lain dan peristiwa bergantung itu tidak diketahui, atau cuba disorokkan oleh orang, kita tidak akan tahu, macam mana si mati ini mati.

Dato' Shafee : Jadi dia punya skin injury ni, dekat neck ni, you're saying it is quite superficial?

Dr. Shahidan : Aaa...Superficial and at times, takde. Yang ni, because of the..err...times...Dia slipped because bila dah decomposed, the skin just slipped.

Dato' Shafee : I see.

Dr. Shahidan : So dia sebab lama contact kat sini, dia slipped. That is not injury. The superficial layer, the epidermis, just slipped off.

Dato' Shafee : Okay, okay. But you concluded asphyxia, asphyxia that means, you're saying, dia mati disebabkan, oxygen is stopped.

Dr. Shahidan : Deprived.

Dato' Shafee : He is deprived of oxygen. Jadi kira macam dalam Bahasa Melayu kita mati tercekik lah. Not tercekik in that sense, but tercekik tak cukup oksigen. Different from judicial hanging. You have seen judicial hanging body?

Dr. Shahidan : Aaa..aaa...Not really Dato', tapi kita tahulah, dia punya mekanisma mati adalah lain.

Dato' Shafee : Yang itu, dia punya spinal cord is

Dr. Shahidan : Snapped.

Dato' Shafee : Yanked ....and..and...ok....So this is not such a case?

Dr. Shahidan : No.

Dato' Shafee : This is not such a case? Ok. Is this consistent or not consistent, with... a suicide hanging? What you discovered on Hendry?

Dr. Shahidan : I would say, it was consistent with one suicide hanging, Dato'.

Dato' Shafee : Ok. Now you interestingly mentioned that the lack of very prominent injury is because of the size, dia punya width of material, and the type of material. Can you...can you elaborate a little bit, whether you found this

kind of lack of injury, consistent with the selimut that you found around the neck?

Dr. Shahidan : Yes. In the first instance, Dato', selimut tu tidak di...diketepikan sewaktu bedah sisat dijalankan, ia ditunjuk. Jadi, err...saya mengatakan, maknanya disini, bukti tu tidak diapa-apakan. Tetapi jika ligature atau satu tali yang agak halus, kalau kita letak di leher dan digantungkan, ada kemungkinan dia akan boleh mencerut dan memutuskan, bergantung kepada berat jasad itu sendiri, Dato'.

Dato' Shafee : Berat jasad dan material?

Dr. Shahidan : Because yang kalau dia kecil, dia boleh memotong.

Dato' Shafee : Yes. You use nylon rope it would cut?

Dr. Shahidan : Yes.

119. Mr. Sreedhran received the post mortem report just before Chinese New Year 2006.

EXPERT EVIDENCE OF DR. BENJAMIN CHAN TECK MENG, CONSULTANT PSYCHIATRIST AND FORENSIC PSYCHIATRIST

120. The Panel of Inquiry invited Dr. Benjamin Chan Teck Meng (IW27), consultant psychiatrist from Hospital Permai to observe the proceedings of the Inquiry by being present when witnesses gave evidence and to testify as an expert witness on the issue of suicide and his assessment of whether S.Hendry's death was consistent with suicide. Dr. Benjamin Chan is a consultant psychiatrist and a forensic psychiatrist and has vast experience working in various psychiatrist institutions and prisons in the UK and Malaysia.

121. On general issues with regard to suicide, Dr. Chan stated in his evidence that factors indicating high risks of suicide would include a young person, someone who has a history of psychiatric disorders, with past history of suicidal attempts or who is known to have taken substances of abuse such as alcohol or drugs.

122. In prison settings, remand prisoners face higher risks of suicide than prisoners who have been tried. Also, lock-ups and short-term temporary small detention centres have higher suicide rates than big penitentiaries or prisons. This is caused by an array of factors – firstly, officers of lock-ups or temporary detention centres usually shoulder many responsibilities and duties which tend to suggest that the mental well-being of detainees is a part-time responsibility. In addition, there is usually no coherent monitoring or clear cut guidelines and very little accountability as to what to do, what to observe, how often to observe and where to record. Whereas in a prison, the services are more organised. The system of shifts of two and half hours each at the

Pusat Pemulihan Akhlak Simpang Renggam is a good case in point. The risk of suicides at such a detention centre would generally be lower.

123. Other risk factors of suicide include specific changes just before the incident such as food refusal, changes in mood, changes in behaviour, other emotional incidents and a breakdown in social support.

124. Dr. Benjamin Chan's assessment of S.Hendry was based on the testimonies of witnesses and limited interviews with Mr. Sreedhran, S.Hendry's father. Dr. Benjamin Chan has never met or treated S.Hendry.

125. In his evidence, Dr. Chan listed the factors that disfavour suicide in S.Hendry's case as follows:

[18 February 2006, morning session, pages 121-123]

Dr. Chan : ... deceased seems to have been quite normal, aaa...and even described by P14 as 'ceria'. He seem to be able to interact with fellow detainees here, even before the few short hours there, he was moving around, and he seem to be able to establish the rapport with P14 for example...err...able to intimate the fact that he has relatives living nearby, the fact that he would like the father to visit him, and he's looking forward. So, he has this, err... many reasons to look forward to the next few days, at least. Aaa...the fact he has good social support despite the fact that he was arrested, and I have interviewed... aaa... the father yesterday and today, and the essential information has been made available, generally I would say it is acceptable, and reliable. So there's positive support in the sense that he has documented evidence, as well in the prison that he visited on a number of occasions, the fact that he has given money, he visited him the day before he was transferred, err.. the day he was transferred here in the morning, and gave him money for him to use when he come here. And he also promised not only to visit him, but to give the balance of the money that he asked. He asked for RM 300, and he was given about RM 30 only. Aaa... and the fact that when he first came, he made an arrangement to have the father to visit him, when he spoke to P14. There's no.... in his case, no known history of psychiatric disorders. There's no known history of attempted suicides. There's no family history of either psychiatric orders or attempted suicides. The deceased is known, to have, a close circle of friends, who may be, abusing illicit substances. But as far as he himself, aaa... the deceased father is not aware that he is in any way addicted. But he claimed he has not been treated for, substance addiction or sent to Pusat Serenti before,

or charged or convicted of any substan... errr, of any drug related offences. And, err... last 2-3 days of his life, there were no clues, no hints as to suicide. Aaa... we often see cases where people leave goodbye notes, writing a will, buying an insurance, making look, tying up loose ends. But there are no, not a single person, aaa... has mentioned this. Of course, there are some who are very determined to die, they would hide. But he has not been hiding, he has been communicating. Aaaa.... (pause). And, I..... was.... A general comment here, members of the learned Panel, is that the...I was not able to get very useful information from the testimony of the staff here, to assess the suicidal risk, changes in behaviour, partly because they are not very well trained, and partly because we get very standard replies with no details. As if it is rehearsed. And the term, 'see no evil, hear no evil, say no evil', so to make it unhelpful as for me to ascertain, whether the risk of suicidality and whether gradually he did die of suicide or not. Aaaa... the commotion that occur at about 3-4 am on the 19th, whether this are noises of suicidal attempt...aaa....does not sound typical of a suicidal attempt. People would be very quiet. After all they do not want.... to be interrupted in such suicidal attempts. And also the fact that...err....when somebody is hanged, there is this natural instinct to preserve life. So a serious person would plan it in such a way, that there is no means for they themselves to save their own lives. For example, in the middle of the hall where they cannot reach out to the wall or to the grill to grab when they are suffocating. Or they want to have a severe jolt so that they snapped the vital spine and die fast. So they kick the chair and there's no means of having support. In this case, there was no means of planning a very serious suicide in that room...aaa... standard precautions has already been taken, except for the pail where he could stand. There's nothing that could really support. Of course, aaa...there are exceptions where some cases are, who are extremely determined to die, we'll die as well in very difficult conditions. (Pause) And... the other part would be... the mention that there is food particles in the upper esophagus, err... in post mortem. A person who has planned his suicide would not be bothered to take food for the last 2-3 hours before his life.

...

[18 February 2006, morning session, page139]

Dr. Chan : It also appears that it's extremely difficult to implement what was shown in the picture. To climb up without anybody suspecting him, an area where the grill is so difficult to climb. And also there are sixteen others next door. So...

Dato' Shafee: Could have heard something, because tried to pull the blanket to that diamond shaped hole.

Dr. Chan : So.....I would say...I'm afraid more than that, my information is also speculation.

126. As for factors leaning towards the likelihood that S. Hendry may have taken his own life, Dr. Chan testified as follows:

[18 February 2006, morning session, page 124]

Dr. Chan : ... things that favour suicide would be, he's young. Number two, he was just transferred here, this is usual time. Number three, this is the time where he is most quiet twilight like, and very often, suicides do occur. Aaa...and thirdly, there is a....I think these are the only factors that support. As far as the charges are concerned, international studies have not confirmed where there's seriousness of charges, like in this case, he has not been charged at all. So that factor, aaa.. does not come into account. Except some patients, some prisoners facing serious charges like mur.... aaa... homicide, sexual offences, are more likely, aaaa....to attempt suicide.

Dato' Shafee : Why?

Dr. Chan : Aaa... Seriousness of the charge, uncertainty of the future. And, during the remand period, when they are... there is most uncertainty.

...

[18 February 2006, morning session, page 129]

Dr. Chan : Youngsters who are impulsive, who are abusing substances of addiction, aaa...people who are known to be temperamental....aaaa but it would be very applicable to patients, to people suffering from severe, major depression. They...would plan ahead what they want to do, and they would also make serious attempts so that they would take into considerations, possible interventions. For example, they may cut the phone line, they may lock their own door, they may tell the friends they're going somewhere, or sometimes they check into a hotel where nobody knows them, lock them, park the car far away, only then they attempt. So, these are the various factors that we take into consideration to evaluate. But to say that somebody who is out of the blue with no risks, and can just plan... change his mind and 'yes, I want to die', within an 16 hours or so and implement that pan...that plan in ex..tenuating circumstances where there's no means that would be highly unlikely.

[18 February 2006, morning session, pages 138-139]

Dr. Chan : Any form of impulsive suicide has very minimal planning, they make use of whatever is available.

Dato' Siva : No, no. Planning is one thing. Will it show, say in a normal room in a house, that it is an impulsive suicide, that the things in the room would indicate that it's impulsive? It's not orderly, not methodical.

Dr. Chan : I would say yes, then they'll leave behind less clues to suicidal risk. The clues like a farewell note, cutting phone wires, preparing...buying either the poison to be used or collecting the medication for overdose or buying the tools of suicide.

Dato' Siva : Because I'm asking this in relation to, he very orderly arranged the t-shirt....the shirt..on top of the shirt he put his detention orders, and then the side of the shirt, he place his toothbrush.

Dr. Chan : In general, young people suicides are not very orderly. Not very well planned.

Prof. Hamdan : Even the knots, maybe you have seen the picture, the knots to the neck seems to be very well done...sorry, my lack of better words, you would want to take a look...it's neat. It doesn't look like a fella kelam-kabut...he took his time to tie the knot neatly.

127. As to whether the fact that S.Hendry could have been told that his period of detention could be renewed for a further two years and so on and so forth, could be a factor to be considered when assessing whether S.Hendry took his own life, Dr. Chan gave the following evidence:

[18 February 2006, morning session, pages 124-126]

Dato' Shafee : In.. in this case, doctor, would it make a difference of the fact that he was investigated for two, cases of murder? Serious murder. And aaa...would it also assist in the finding of suicide and all, if he was told at the...at the beginning, that this is a two year's detention? And, it may not be just two years, because the minister has the discretion to extend it for a further two years, and two years? You know. It's almost indefinitely. If he was told that?

Dr. Chan : I would say, for a person who has been in detention for about 74 days, this information in a way...I would say is not very serious, because, perhaps he is even more relieved that he is not charged under 302 for the other two cases that they were investigating.

Dato' Shafee : Ya, but just a little correction, though. He has actually been detained for the last 60 days.

Seh Lih : 90.

Dato' Shafee : Before...sorry?

Seh Lih : 90 days.

Dato' Shafee : 90 days. In terrible condition because you know, Police lock-ups are worse. Prisons are much better.

Dr. Chan : Yes. In that sense, aaa... the risk of suicide in prisons could be as low as 1 ½ times of general population. 1 ½ times to 8 times.

Dato' Shafee : Yes.

Dr. Chan : Suicide rates in detention centres, lock-ups, could be between 8 times to 20 times the general population.

Prof. Hamdan : The prisons are lower?

Dr. Chan : Yes. Big prisons. Post conviction, are lower.

Dato' Shafee : Because of the facilities? And the certainty that he is going to be there?

Dr. Chan : They know they'll be here, 10 years, minus the bonus and holiday, so they start counting the days. They look forward to the date of release.

...

[18 February 2006, morning session, page 138]

Dr. Chan : ...You know for sure now you are not being charged with a serious thing, and just detained for two years. You look forward to release.

Prof Hamdan : Even if it might be more, it doesn't bother you really much?

Dr. Chan : Yes, if it's two and plus two, I think a young man perhaps is not too familiar with detention orders and how repetitive it is, would compare with that, the possibilities or outcome of section 302 charges rather than the 2 year detention order.

128. As regards the kicking of the wall and whether this would be consistent to suicide, Dr. Chan gave the following evidence:

[18 February 2006, morning session, pages 133-135]

Prof. Hamdan : Just one ya....His hand is not tied, his leg is free, urr....maybe he's so determined. But during the suspension when they jump, whatever, is there no such a thing as a reflex action of the hands suddenly grappling up....aaa...the rope, the legs...

Dr. Chan : Definitely...definitely. We have, aaa....you see...you see, in psychiatry, people who attempt suicide, especially the, those with more severe risks, are referred to psychiatry. So we see those who survived a lot more than come in....come across those who die. Those who die, perhaps unless they were psychiatric cases before. So, we follow-up, we're informed. So for those who survived, yes we have cases who came down with very severe hanging marks, but they hang on. They hang on to...to save their own dear lives.

Dato' Shafee : They changed their mind?

Dr. Chan : Yes... Ah, it's not that they changed their mind. It's a spontaneous survival instinct. It's a spontaneous survival instinct.

Dato' Shafee : So the kicking thing, if there was a kicking thing, would it be a survival instinct?

Dr. Chan : If we notice that he's hanging almost right against the grill and the wall, he could have just stretch out his hand to support his body weight, before he drops.

Prof Hamdan : Ya, and but he's facing the other side, rather than facing the grill.

Dato' Siva : But doctor, on the same question Dato' Shafee asked, was the kicking thing an attempt to save himself, bearing in mind we had the grills, where he can put his toes? Or his fingers.

Dato' Shafee : Or was it an involuntary reaction?

Dr. Chan : Involuntary reactions would just be a single, one or two jerks, and that's when the muscles, once is, the joints relaxed, the muscles is relaxed, and it stops. It doesn't keep on kicking, unless the person is suffering from a seizure attack. Convulsion. Chronic convulsion, they will repeatedly go into spasm, released spasm, then you have repeated ones, but in, last gulps, it's just one off.

Prof. Hamdan : Because there are sixteen is prison on one cell, and then another of person, aaa....where in one cell a lot of people two claim or three claims that they heard screams of some kind, and then aa...few others heard that someone was banging on the wall. And I supposed it might not be the heel, might be the ankle, whatever, because they are just kicking blindly, if there is such a thing, and surely there might be lesions or something not on the heel as such, but it has to be the.... the ankle part.

Dr. Chan : I would say the scream and the kicking perhaps not really be compatible with suicides as such, but more for struggling attempt, perhaps, rather than suicide.

Prof. Hamdan : With regard with what I asked just now, because, I don't know, err....the hands would automatically, without even the mind thinking, go up, to...to hold ....

Dr. Chan : To grab the rope so that the person can breathe.

Prof. Hamdan : He won't be thinking isn't it?

Dr. Chan : He won't be thinking. It's...it's reflex.

Prof. Hamdan : Just a reflex?

Dr. Chan : Just...just a survival instinct.

129. With regard to the possible effects of prolonged detention prior to S.Hendry's transfer to Simpang Renggam, Dr. Chan gave the following evidence:

[18 February 2006, morning session, page 136]

Dr. Chan : It is certainly very stressful, lots of uncertainties in the future, loss, damage to self-esteem and family honour, but we have to bear in mind that there are tens of thousands of detainees. How many would end up actually killing themselves? So, the risk is higher. Suicides in detention centres,

lockups, some 8 to 20 times higher. But in each individual case, like in this particular one, we still have to arrive at a specific conclusion. So, in general, it is stressful, it may lead to people attempting suicide. That's a general answer.

130. As to the overall conclusion of Dr. Chan as to whether or not S.Hendry committed suicide, Dr. Chan qualified that his opinion was based on specific aspects of the criteria and was not a conclusion that suicide did or did not occur. Dr. Chan's observation was as follows:

[18 February 2006, morning session, page 131]

Dr. Chan : My answer is, it is possible, but not probable...not very probable considering all the underlying family history, past history, err...and the past 90 days behaviour in the prison.

Dato' Shafee : So more of an impulsive thing, you're saying? If it is a suicide, it is more of an impulsive thing?

Dr. Chan : Yes, yes.

Dato' Siva : No, the same thing, you know, because at 10.30, he asks for a lighter, that's according to what the warden has said. No..the detainee said. And if you look at it according to the doctor's explanation, the body could have been there for...6 hours. But within.....within the short period of time, the whole thing was executed, without a cry or without anything else, so is it possible at this juncture to happen?

Dato' Shafee : The question is, would it be possible to have committed suicide within that frame of time?

Dr. Chan : Yes.

131. Apart from an assessment of S.Hendry, Dr. Chan elaborated on three aspects of the mental health of detainees that warrant serious consideration. Firstly, the need to formulate a policy on prevention of suicide and self-harm. Dr. Chan observed that there are no definite policies, guidelines or standards, whether national or institutional with regard to the handling of offenders or detainees. For young detainees, they are isolated to protect them from being abused or sodomised by adult detainees. Dr. Chan recommended that a policy or guideline should include a standard of accountability, routine inquiries and forums for prison staff to vent out their frustration and the risk they face. The policy should seek to not only protect the detainees but also empower the staff.

132. The second aspect is the need for training. Dr. Chan observed that there is no system of identification of suicide risks, containment and referral i.e. where officers are trained to make observations of disturbed behaviour that would indicate the

increased risk of disturbance or mental disorder. This is to facilitate speedy medical and psychiatric assistance for such detainees.

133. The third area that needed to be considered is the design. After visiting half a dozen prisons in Malaysia, Dr. Chan observed that there is a need to take prevention into account in the planning stage so that blind corners, suicide hotspots could be identified and removed. Improvements in this area besides the use of CCTV, have been forthcoming. As regards the use of CCTV, Dr. Chan cautioned that the over dependence on CCTV could lead to a situation where guards treat the CCTV like TVs and in so doing, they fail to monitor the conditions of the detainees. Dr. Chan recommended compulsory lighting with dimmers in high risk areas, even when detainees sleep. When dimmers do not work because of manipulation or other reasons, this should trigger built in alarms. Further, implementation of a sensor system may be helpful where the sensor system automatically pinpoints how many times a guard has patrolled the block, the time and the exact location of the guard. This protects the staff where if the guard is lying down or if there is no movement for 20 minutes, it means the officer is being attacked and the alarm will sound itself.

134. Dr. Chan recommended that these improvements be carried out in current detention centres and not implemented only in new detention centres. Present detention centres should be renovated and upgraded. Dr. Chan also recommended a comprehensive review at the national level of such measures to upgrade the facilities in detention centres to prevent suicide and self-harm.

THE *PUSAT PEMULIHAN AKHLAK* SIMPANG RENGGAM INTERNAL INQUIRY INTO THE DEATH OF S.HENDRY

135. An internal inquiry was undertaken to look into the death of S.Hendry (the "PPA Simpang Renggam Internal Inquiry"). The PPA Simpang Renggam Internal Inquiry was headed by Encik Sazali bin Ismail, Penguasa Penjara, assisted by Encik Mohamad Kamal bin Shamsuddin, Timbalan Penguasa Penjara and Encik Abdul Halim Osman, Penolong Penguasa Penjara.

136. In the report of the PPA Simpang Renggam Internal Inquiry[31], the members found that there was no foul play in the death of S.Hendry. The finding was based on the following reasons:
    a. S.Hendry was placed alone in cell C4B according to established procedures;
    b. There were no evidence of physical injuries inflicted on S.Hendry; and

[31] Exhibit P-24.

c. The post mortem report showed that the cause of death of S.Hendry was asphyxia due to hanging.

137. The PPA Simpang Renggam Internal Inquiry however, determined that there was an element of negligence with regard to the night duty staff as:
   a. Even if they had patrolled as they claimed, the times of patrolling of Prison warders in the isolation block were not recorded in the Daily Log Book (*Buku Pengharian*[32]); and
   b. The fluorescent light in the five-foot way was sufficiently bright to illuminate cell C4B although the light in cell C4B was not on or functioning. This was confirmed by a visit to cell C4B on 20 November 2005 at 12.35 at night by members of the PPA Simpang Renggam Internal Inquiry.

138. Apart from the warders in the isolation block, there were night duty personnel (*Pegawai Duti Malam*) stationed at the particular area who were required to patrol cell C4B. The two night duty officers did not follow the required security procedures and rules which required them to patrol every zone at least once during every shift. At the relevant time, there were approximately 4,000 detainees in three zones at the *Pusat Pemulihan Akhlak* Simpang Renggam.

[32] Exhibit P-19 – *Buku Pengharian Pusat Pemulihan Akhlak Simpang Renggam.*

Chapter 3

139. This chapter and the subsequent chapters will analyse the evidence presented to the Panel of Inquiry, with findings and recommendations of the Panel of Inquiry. Five main issues that arise from the evidence are:

    I. Issues relating to the detention of S.Hendry prior to being sent to the *Pusat Pemulihan Akhlak* Simpang Renggam;
    II. Issues arising on the night of 18 November 2005 and early morning of 19 November 2005;
    III. The cause of death of S.Hendry;
    IV. Issues relating to the system of detention for young persons at the *Pusat Pemulihan Akhlak* Simpang Renggam; and
    V. Issues relating to a prompt, effective and independent death inquiry.

ISSUES RELATING TO THE DETENTION OF S.HENDRY PRIOR TO BEING SENT TO THE *PUSAT PEMULIHAN AKHLAK* SIMPANG RENGGAM

140. The issues that arise for consideration are between the period of 23 August 2005 and 17 November 2005, the time that S.Hendry was remanded and subsequently detained under the POPOC in the Police station lock-ups in Kajang and Seremban.

The issue of 29 days in remand

141. The Panel of Inquiry is satisfied that four remand orders were issued against S.Hendry, totalling up to 29 days in remand. **Although the remand orders were obtained because of S.Hendry's involvement in different cases, the Panel of Inquiry finds that a continuous period of 29 days in remand, particularly for a young detainee was excessive and too lengthy.**

142. Section 117 of the CPC empowers a Magistrate to remand a person not exceeding 15 days (including the day of arrest) if investigations cannot be completed within 24 hours of arrest. In this regard, the Panel of Inquiry recommends that the practice of lengthy remand periods, even for different cases amounts to violation of the human rights and abuse of the powers in section 117 of the CPC.

143. The problem of lengthy remand periods is a long standing problem and its effect on the mental health of a detainee was pointed out by Dr. Benjamin Chan where he testified that the risk of suicide in lock-ups could be between 8 times to 20 times the general population. **As such, seeing that the risk of suicide is higher in lock-ups due to the stressful situation, uncertainties in the future and loss to self-esteem, particularly**

for young persons, it is perhaps worthwhile for the Panel of Inquiry to reiterate all of SUHAKAM's recommendation, aimed at tackling the problem of lengthy remand periods:

a. **Introduce a legal provision setting a custody time limit to avoid an accused person languishing in jail for an excessively long period[33];**
b. **Strict compliance with section 117 of the CPC that a remand order can only be granted if "investigation cannot be completed within 24 hours" *and (emphasis added)* there are "grounds for believing that the accusation or information is well founded";**
c. **That the Police be advised of the circular of the then Chief Justice, Tun Mohamed Dzaiddin bin Haji Abdullah, issued in 2003 advising Magistrates that the onus is upon the Police to satisfy the Magistrate that more time is needed to complete investigations, bearing in mind the obligation to submit a diary of proceedings in investigations under section 119 of the CPC and if remand is necessary, short remand periods are to be given[34]; and**
d. **Amend section 117 of the CPC to provide that the Magistrate who makes a remand order, must be satisfied, that upon material produced by the Police, there is sufficient justification linking the detainee to the offence being investigated.**

144. To add, although the Panel of Inquiry notes the Chief Justice's Practice Direction No. 3/2003 with regard to remand applications, the Panel of Inquiry finds that the Practice Direction is insufficient as it only requires the Magistrate to take note whether the remand application is a new application or an extension of a previous remand order. The obligation does not require the Magistrate to take into consideration any previous remand orders. The Practice Direction reads *"Pada permulaan pendengaran permohonan itu, Majistret hendaklah menentukan samada permohonan ini adalah permohonan baru atau permohonan lanjutan".* **As such, the Panel of Inquiry recommends that the Chief Justice issue a circular requiring Magistrates to take into consideration the entire period of remand and inclusive of different remand orders, the remand period should be no more than necessary in each distinct cases. Distinct cases having the nexus of 'in the same transaction' ought to be treated as a single distinct case for purposes of remand.**

The issue of S.Hendry's medical check-up

145. Prior to being sent to the *Pusat Pemulihan Akhlak* Simpang Renggam on 18 November 2005, S. Hendry had spent a total of 88 days in detention, 79 days in the Kajang Police station lock-up and nine days in the Seremban Police station lock-up.

[33] SUHAKAM Report of the Forum on the Right to an Expeditious and Fair Trial (2005), at pp. 26 – 28.
[34] SUHAKAM Kundasang Public Inquiry Report, at pp 79 – 80.

146. The evidence of ASP Wong Yuen Chuan, indicated that it was highly probable that S.Hendry was not given a medical check-up between 23 August 2005 and 1 September 2005 whereas ASP Azizan Haji Mohamad Isa, Inspector Yusrizal bin Mohammad Ghazali and Chief Inspector Ahmad Izuddin confirmed that S.Hendry was not given a medical check-up between 1 September and 18 November 2005.

147. As such, the Panel of Inquiry is satisfied that S.Hendry was not given a medical check for the entire duration of 88 days in custody. **The Panel of Inquiry finds that the failure to give S.Hendry a medical check-up between 23 August 2005 and 18 November 2005 contravenes Rule 10 of the Lock-up Rules 1953 which places an obligation on the Medical Officer to conduct a medical check-up on a detainee.** Although Rule 10 of the Lock-up Rules 1953 requires the medical check-up to be performed as soon as practicable, the Panel of Inquiry is of the opinion that 88 days in detention is ample time. The failure to give a medical check-up to S.Hendry for 88 days clearly falls foul of the threshold of "as soon as practicable".

148. The Panel of Inquiry wishes to underscore the importance of giving detainees a medical check-up, particularly young detainees. A medical check-up could bring forth any illness or any psychological or mental trauma to the attention of the Medical Officer.

149. **To provide a clearer guideline as to the timeline for a medical check-up, the Panel of Inquiry recommends that Rule 10 of the Lock-up Rules 1953 be amended to provide that detainees be given a medical check-up within three days from the day of remand or detention**.

The issue of S.Hendry arriving at the *Pusat Pemulihan Akhlak* Simpang Renggam late in the evening

150. S. Hendry arrived at the *Pusat Pemulihan Akhlak* Simpang Renggam at approximately 6.50 p.m. on 18 November 2005. The time of arrival was pointed out as inappropriate by Tuan Mohd. Zawawi, Director of the *Pusat Pemulihan Akhlak* Simpang Renggam. Tuan Mohd. Zawawi stated that sending detainees to the *Pusat Pemulihan Akhlak* Simpang Renggam after office hours, some arriving as late as midnight has caused problems for the *Pusat Pemulihan Akhlak* Simpang Renggam as the officers were not able to assess the state of mind of the detainee and at such a late hour, the *Pusat Pemulihan Akhlak* Simpang Renggam was only managed by skeletal staff.

151. The Panel of Inquiry takes cognisance of the problems that were caused by sending S.Hendry after office hours, in particular that the process of reception and registration that a detainee would have to undergo upon arrival at the *Pusat Pemulihan Akhlak*

Simpang Renggam could take up a few hours. **As such, the Panel of Inquiry finds that sending S.Hendry to the *Pusat Pemulihan Akhlak* Simpang Renggam late, where he arrived after working hours was imprudent.**

152. Rule 20 of the Lock-up Rules states that detainees should be in the lock-up 6.30 p.m. S. Hendry arrived at the *Pusat Pemulihan Akhlak* Simpang Renggam at 6.40 p.m. **The Panel of Inquiry finds that there has been a failure to adhere to Rule 20 of the Lock-up Rules 1953. As such, taking into consideration that the registration process is likely to take a few hours, the Panel of Inquiry recommends that detainees be sent to the *Pusat Pemulihan Akhlak* Simpang Renggam earlier and in all cases, to arrive at the *Pusat Pemulihan Akhlak* Simpang Renggam before 5.00 p.m.**

Chapter 4

ISSUES ARISING ON THE NIGHT OF 18 NOVEMBER 2005 AND EARLY MORNING OF 19 NOVEMBER 2005

153. The issues which arise on the night of 18 November 2005 and the early morning of 19 November 2005 are:

a. The estimate time of death of S.Hendry;
b. The light in cell C4B and the fluorescent light along the five-foot way;
c. Whether the warders patrolled the isolation block, particularly along cell C4B; and
d. Whether the warders on duty on the night of 18 November 2005 and the early morning of 19 November 2005 carried out their duties diligently.

<u>The issue of an estimate time of death of S.Hendry</u>

154. In order to consider the subsequent issues, it is perhaps necessary to determine an estimate time of death of S.Hendry. A number of observations of S.Hendry's body when it was found at 7.10 a.m. and the findings of the post mortem examination was particularly useful in determining an estimate time of death of S.Hendry.

155. In his evidence, Inspector Alimuddin bin Usman described his observations when he brought the body of S.Hendry down on the morning of 19 November 2005:

[17 February 2006, morning session, page 42]

Insp. Ali : Pada pemerhatian keadaan mayat memang dah keras lah.
Dato' Shafee : Keras?
Insp. Ali : Ya.
Dato' Shafee : Jadi bila nak...nak masukkan dalam plastic, err.. boleh nampak kekerasan mayat itu?
Insp. Ali : Ya, ya.
Dato' Shafee : Boleh nam-...boleh... jelas ya?
Insp. Ali : Jelas..jelas.

156. Furthermore, Inspector Zulkifli Che Soh testified that when he found S.Hendry's body at approximately 7.15 a.m., the body was cold.

157. Inspector Zulkifli noticed a blue tinge on the left arm of S.Hendry. Inspector Alimuddin also testified that upon arrival at the scene, he observed that the hands and legs of

S.Hendry were blue. This seems to be consistent with the finding of the post mortem examination that the fingertips of S.Hendry were cyanosed.

158. In addition, Inspector Zulkifli observed that from the waist up, S.Hendry's body looked pallid. The Panel of Inquiry takes cognisance that **Exhibit P-4(f)**, a photograph of S.Hendry's body in a hanging position in cell C4B, showed that the lower half of S.Hendry's body, particularly his legs were darker than his upper body of S.Hendry, consistent with the evidence of Inspector Zulkifli. The post mortem examination report also stated that S.Hendry's "face was rather pallid and the conjunctivae pale" and there was "hypostasis present from the wrists downwards".

159. Dr. Shahidan Md. Noor testified that there was minimal hypostasis at the back of S.Hendry's body but there was hypostasis and petechiae from the navel downwards to the lower limbs, particularly on the shins and hypostasis from the wrists downwards. According to Dr. Shahidan, these were indicative factors that S.Hendry's body was in the hanging position for a period of four to 12 hours before his body was brought down. S.Hendry's body was brought down at approximately 11.30 a.m. on 19 November 2005 and based on Dr. Shahidan's testimony, this would place the time of death approximately between 11.30 p.m. and 7.30 a.m. It is also worth noting that the PPA Simpang Renggam Internal Inquiry stated that it was likely that S.Hendry died between 12.00 midnight and 3.00 a.m., before the 4.30 a.m. shift.

160. As regards the testimonies of seven detainees who were placed in cells beside cell C4B, the Panel of Inquiry is of the opinion that the testimony of Mr. Pang Neng Hua who heard sounds (decreasing in intensity) akin to someone kicking or hitting a brick wall without shoes was convincing. Moreover, the evidence of Encik Kasilingam a/l Kanipan, Encik Anil Rajagopal a/l Muniandy and Encik Faisal bin Mohd. Husin confirmed what Mr. Pang heard. As regards the evidence of Encik Zohari bin Hasan, Encik Jeffridin bin Yusoff and Encik Mohammad bin Yusoff, the Panel of Inquiry does not discount the fact that the screams could have originated from another cell, not necessarily cell C4B. Furthermore, Encik Zohari did testify that it was usual to hear screams of that nature as it was usual for detainees to joke around in the evening. **The Panel of Inquiry finds that it was possible that the kicking sounds that the detainees heard could have come from cell C4B. However, the Panel of Inquiry finds that it was possible that the screams could have emanated from cells other than C4B.**

161. As regards the time, the detainees testified that they heard the sounds or screams between 3.00 a.m. and 5.30 a.m. on 19 November 2005. All seven detainees seemed to be sure of the time although their cells did not have a clock. **The Panel of Inquiry finds that the detainees were merely estimating the time and as such, is not**

convinced that the time the detainees heard the noises were between 3.00 a.m. and 5.30 a.m.

162. Taking the testimonies of Inspector Zulkifli, Inspector Alimuddin, Dr. Shahidan and the findings of the post mortem examination as a whole, the evidence seems to indicate that S.Hendry died a few hours prior to him being found at 7.15 a.m. **As such, The Panel of Inquiry places the time of death of S.Hendry in the early morning of 19 November 2005, most likely between 12.00 midnight and 5.00 a.m.**

The issue of the light in cell C4B and the fluorescent light along the five-foot way

163. During the Inquiry, one issue that arose was that the light in cell C4B was not on whereas the light in the adjacent cells were switched on. The Panel of Inquiry takes note that in **Exhibit P-4(d)**, the photograph showed that the switch for the lights were not switched on. Encik Norazwan confirmed that the switch was for the light in cell C4B.

164. Encik Abu Bakar, Encik Nordin and Encik Abdul Rahim confirmed that the light in cell C4B was not working. None of the officers could confirm as to how long the light in the cell was not working.

165. As to the adjacent cell, particularly the cell that housed 16 detainees, Encik Anil Rajagopal, Encik Faisal, Encik Zohari, Encik Mohd. Yusoff and Encik Zohari all testified that the light in their cell was on throughout the night. Only Encik Kasilingam testified that the light was not on in his cell. It was established that all these detainees were in the same cell on the night of 18 November 2005.

166. Tuan Mohd. Zawawi in his evidence, explained that the light in cells are usually switched off at 10.00 p.m. It was the practice at the *Pusat Pemulihan Akhlak* Simpang Renggam not to switch on the light in the cell throughout the night but to rely on the light in the five-foot way. Lights in the cell would only be switched on for violent detainees or detainees who needed special attention, for instance mentally unsound detainees.

167. As regards the light along the five-foot way, particularly outside cell C4B, Encik Anil Rajagopal and Encik Faisal testified that the light along the five-foot way was switched on on the night of 18 November 2005. Encik Nordin confirmed that one long fluorescent light was fixed along the five-foot way outside cell C4B and the lights in the five-foot way were switched on and in working condition on the night of 18 November 2005.

168. As such, the Panel of Inquiry finds that the evidence indicates that:

a. **Save for cell C4B, it was likely that the other cells were lighted. Although the discretion whether to switch on the light in the cell was upon the warders, the Panel of Inquiry is satisfied that the light in cell C4B was faulty and not because of subjective discretion of the warders not to switch on the light in cell C4B; and**
b. **The fluorescent light along the five-foot way outside cell C4B was functioning and switched on on the night of 18 November 2005 and the early morning of 19 November 2005. The presence of the lighted fluorescent light along the five-foot way is significant as it indicates that the claim by the warders that they could not be sure if S.Hendry was sleeping or not due to poor lighting cannot be easily accepted. It tends to indicate either a total lack of physical monitoring by the relevant guards or negligence.**

169. However, the Panel of Inquiry finds that there was a failure by the warders, to report that the light in cell C4B was not working and to fix the light in cell C4B

170. In addition, Rule 261 of the Emergency Ordinance (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 requires the Chief Officer[35] to "inspect every part of the place of detention at least twice a week between the hours of 11.00 p.m. and 5.00 a.m. and shall record in red ink in his journal... the condition of the place of detention". On the same note, rule 214 of the Emergency Ordinance (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 requires the Officer-in-Charge[36] to "visit all parts of the place of detention at an uncertain hour of the night at least once a week". **The Panel of Inquiry finds that if such an inspection was carried out by the Chief Officer and the Officer-in-Charge, the faulty light in cell C4B would have been detected and fixed. As such, the Panel of Inquiry finds that Rules 261 and 214 were either not followed or obligations therein were not carried out diligently.** Seeing that the isolation block houses new detainees and they are more likely to be in a vulnerable state of mind, greater diligence is required on the part of the warders and the officers of *Pusat Pemulihan Akhlak* Simpang Renggam to ensure that all lights and facilities are in working condition in the isolation block.

The issue of whether the warders patrolled on the night of 18 November 2005 and the early morning of 19 November 2005

[35] Rule 258 of the Emergency Ordinance (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 defines "Chief Officer" as the "principal discipline officer of the place of detention".
[36] Rule 1 of the Emergency Ordinance (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 defines "Officer-in-Charge" as "any officer not below the rank of Principal Officer who is in charge of any place of detention".

171. Before discussing the two subsequent issues, the Panel of Inquiry would like to first address the issue of whether the warders patrolled the isolation block on the night of 18 November 2005 and the early morning of 19 November 2005.

172. The four warders on duty testified that they made the rounds during their shifts. However, the Daily Log Book ("*Buku Pengharian"*) showed only the time the warders took over their shift. The times of patrolling were not recorded. Tuan Mohd. Zawawi explained that it was mandatory for warders to record the times of patrolling, any unusual things the warders see when they made their rounds and any extraordinary incidents in the Daily Log Book. The recording of only the times of each change of shift was insufficient.

173. The Panel of Inquiry is mindful that if entries in the Daily Log Book were relied upon to determine whether the warders patrolled on the night of 18 November 2005 and the early morning of 19 November 2005, it could be concluded that the warders did not do their rounds. However, it would not be reasonable to exclude the evidence of the four warders and to rely exclusively on the entries of the Daily Log Book. The testimonies of the four warders, Encik Nordin bin Yunus, Encik Abdul Rahim, Encik Abu Bakar bin Ishak and Encik Lasiman bin Jahim were carefully considered.

174. Whether the warders had carried out their patrolling responsibly and conscientiously (on the assumption that they patrolled), are matters which will be discussed further below. **At this juncture, the Panel of Inquiry is not satisfied that the four warders patrolled on the night of 18 November 2005 and the early morning of 19 November 2005. The Panel of Inquiry finds that the four warders had failed to make the proper entries into the Daily Log Book with regard to the times of their patrolling, including the fact that the light in cell C4B was not working, a significant factor towards the Panel of Inquiry's conclusion.**

175. Therefore, the Panel of Inquiry recommends that until the sensor system is put in place (see below), not only that the times of patrolling should be recorded but also upon receiving and handing over charge, the number of detainees should be recorded in the Daily Log Book.

The issue of whether the Prison warders on duty on the night of 18 November 2005 and the morning of 19 November 2005 carried out their duties diligently (on the assumption that they patrolled (alternative finding))

176. As regards the issue of whether the four Prison warders had performed their duties diligently on the night of 18 November 2005 and the morning of 19 November 2005, two contentious issues come to mind. Firstly, whether the four Prison warders saw for

certain S.Hendry sleeping on the floor of cell C4B. Secondly, the claim by the Prison warders that they did not see S.Hendry's body hanging in the far right corner of the diamond-shaped grill window of cell C4B.

Whether the Prison warders saw for certain S.Hendry sleeping on the floor of cell C4B

177. During the course of the Inquiry, particularly during the testimonies of the four Prison warders on duty on the night of 18 November 2005 and the morning of 19 November 2005, one issue was whether the warders saw for certain S.Hendry sleeping on the floor in cell C4B.

178. As the estimate time of death is placed between 12.00 midnight and 5.00 a.m., three shifts assume significance – shift 2: 11.30 p.m. – 2.00 a.m., shift 3: 2.00 a.m. – 4.30 a.m. and shift 4: 4.30 a.m. – 7.15 a.m.

179. During the 11.30 p.m. to 2.00 a.m. shift, Encik Abu Bakar and Encik Lasiman testified that when they patrolled the isolation block three times, at all three times, they saw S.Hendry sleeping on the floor of cell C4B.

180. During the 2.00 a.m. to 4.30 a.m. shift, both Encik Nordin and Encik Abdul Rahim's testimonies were incoherent, initially certain that they saw S.Hendry sleeping on the floor at the corner, but upon further questioning, they could not say for certain whether what they saw was a body in the shirt or merely a shirt on the floor. Similarly, for the 4.30 a.m. to 7.15 a.m. shift, Encik Abu Bakar's testimony was equally inconsistent. Encik Lasiman on the other hand was more certain that he saw S.Hendry sleeping on the floor of cell C4B.

181. At this juncture, the Panel of Inquiry notes the fact that the faulty light in cell C4B could have affected the warders' view of cell C4B. However, it cannot be ignored that there was evidence to suggest that the fluorescent light along the five-foot way was sufficiently bright to illuminate the cells. Encik Zohari bin Hasan testified that a person outside the cell could see clearly a detainee in the cell and whether the detainee was sleeping using a blanket or otherwise. Furthermore, a visit to cell C4B at night by members of the PPA Simpang Renggam Internal Inquiry, found that the light from the fluorescent lamp along the five-foot way was sufficiently bright to light up cell C4B.

182. The Panel of Inquiry also takes cognisance of the fact that the thick metal diamond-shaped grill window was such that the pattern may be too closely spaced (approximately once inch) that it could have made it difficult for the warders to clearly look into cell C4B. However, Encik Abu Bakar and Encik Abdul Rahim testified that the clearest view of the cell would be from the grill door as the grill was not so

closely spaced as compared to the diamond-shaped window grill. It was also Encik Abu Bakar's testimony that while he did his rounds, he would usually stand at the grill door to check on the condition of the detainee as it would give him a better view of the cell. However, Encik Abu Bakar did qualify that if the room was not lighted, he would not be able to see the detainee in the room from the diamond-shaped grill window.

183. Although, the Panel of Inquiry cannot discount the fact that the lack of lighting in cell C4B and the pattern of the diamond-shaped grill window could have made it more difficult for the warders to see clearly into cell C4B when doing their rounds, **the Panel of Inquiry finds that because of their inconsistent testimonies, the evidence of all four warders, Encik Nordin, Encik Abdul Rahim, Encik Abu Bakar and Encik Lasiman, with regard to what they saw when they looked into cell C4B cannot be relied upon.**

The claim by the Prison warders on duty on the night of 18 November 2005 and the morning of 19 November 2005 that they did not see the body hanging

184. The second contentious issue was the claim by the Prison warders that they did not see S.Hendry's body in the hanging position at the right corner of the diamond-shaped grill window with the body resting on the said window. The same extenuating factors were proffered.

185. Encik Abu Bakar and Encik Abdul Rahim maintained that they could not have seen the body hanging when they were making their rounds because of the diamond-shaped grill window. According to Encik Abu Bakar there were occasions when he did not see detainees when they stood very close to the diamond-shaped grill window. Encik Norazwan explained that because S.Hendry's body was at the corner of the cell, near the wall and the space between the diamond-shaped grill was close, one would not be able to see the body from afar. Furthermore, the body was hung at a high position, higher than a person standing in the same location. Encik Nordin and Encik Abu Bakar cited the lack of lighting in cell C4B as a reason why they could not have seen S.Hendry in the hanging position in the right corner of the diamond-shaped grill window. Whilst Encik Nordin asserted that he or his colleague could not have seen S.Hendry in a hanging position as usually officers would usually stand in the middle of the cell when making rounds:

[17 February 2006, afternoon session, page 36]

En. Nordin : ... sudut yang kita datang kita tak kan nampak kan. Bila kita lalu di bilik tu secara automatic kita akan diri bahagian tengah kawasan cell tu. Lampu bilik tu pada malam tu... tak berfungsi

186. As before, the Panel of Inquiry takes cognisance of the fact that the lack of lighting in cell C4B and the diamond-shaped grill could have impeded the warders from seeing S.Hendry in a hanging position at the right hand corner of the diamond-shaped grill window. Upon a visit to cell C4B on 18 February 2006, the Panel of Inquiry noted that standing at the grill door, it would be difficult to see S.Hendry's body at the right hand corner of the diamond-shaped grill window. Nevertheless, the Panel of Inquiry noted that there was a long fluorescent light along the five-foot way. The position of the fluorescent light is rather significant as the fluorescent light is positioned right beside where S.Hendry's body was found hanging and evidence suggests that the fluorescent light was working that night. Furthermore, Encik Abdul Rahim described the five-foot way as well lit. **The Panel of Inquiry finds that the claim by the warders that they could not have seen S.Hendry's body hanging at the right hand corner of the diamond-shaped grill window is unsustainable, more so that the fluorescent light was positioned right beside the particular spot where S.Hendry was found in a hanging position.**

187. Therefore, the Panel of Inquiry finds that despite the extenuating circumstances of the light and the grill, it was likely that the warders took only a cursory glance into cell C4B during their patrolling and thus failed to carry out their patrolling duties diligently and conscientiously. As Encik Nordin testified, "*... kalau kita buat rondaan pun sekali lalu kita tengok sekali lalu".* Had they spent more than a fleeting look into cell C4B, they would have seen for certain whether S.Hendry was sleeping on the floor or whether it was merely a white shirt in the corner of cell C4B as there is considerable difference between a shirt lying on the floor and a person wearing a shirt lying on the floor. The warders would have also seen S.Hendry's body hanging at the right hand corner of the diamond-shaped grill window. Furthermore, the Panel of Inquiry finds that the warders could have stood at the grill door which would have given them a clearer view of cell C4B and the fluorescent light was sufficiently bright to illuminate cell C4B. (paragraphs 176 to 186 above also form the reasons for the Panel of Inquiry not accepting that the warders did in fact patrol during the relevant time)

188. As such, the Panel of Inquiry recommends that:

a. Until dimmers are fixed in the cells (discussed below), warders be supplied with torch lights during night patrols; and

b. Progressive implementation of a sensor system for warders, with motion detectors placed around the isolation block. The system would be able to record the number of times the warder patrolled the block and the time and the exact

location of the guard. If a warder is lying down or if there is no movement for 20 minutes, an alarm will sound[37].

The issue of frequency of patrolling

189. According to testimonies of the warders, they patrolled two or three times during each two and half hour shift, within which the interval of inspection would have been between 50 minutes and 150 minutes.

190. In this regard, Rule 297 of the (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 is relevant. Rule 297 of the Emergency (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 states that "subordinate officers shall be responsible for the safe custody of detained persons under their charge" and this responsibility is augmented by requiring warders to "... count the detained persons at least once every half hour and always on receiving charge of a party and on handing over charge...".

191. The Panel of Inquiry is satisfied that rule 297 of the Emergency (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 which requires counting of detained persons at least once every half hour is sufficiently clear to provide guidance as to the frequency of interval of each patrol. **As such, the Panel of Inquiry finds that the Prison warders failed to adhere to rule 297 of the Emergency (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 which requires warders to count detained persons at least once every half hour and always on receiving charge of a party, on handing over charge and on leaving any building or work.**

192. At this juncture, the Panel of Inquiry takes note of the inadequate number of staff at the *Pusat Pemulihan Akhlak* Simpang Renggam. According to Tuan Mohd. Zawawi, there were 106 detainees in the isolation block and the isolation block has two floors. Two warders would be on duty during each shift, one officer patrolling each floor. Tuan Mohd. Zawawi agreed that the number of officers is insufficient in comparison to the number of detainees and the various types of detainees placed in the isolation block. This is compounded by the fact that the *Pusat Pemulihan Akhlak* Simpang Renggam is the only detention centre in Malaysia for those detained under the POPOC. **Hence, the Panel of Inquiry recommends more warders be hired and deployed at the isolation block and that rule 297 be strictly implemented by the warders, where detainees are checked at intervals not greater than 30 minutes. By counting the number of detained persons, the warders would inadvertently check on the conditions of the detainees.**

[37] Dr. Benjamin Chan.

The issue of the response of the Prison warders and officers to an emergency situation

193. According to Encik Norazwan, when warders do their rounds, they would not bring along the keys to the cells and in an emergency situation, warders on patrol would have to go to the officer holding the keys. Keys to the cells are usually kept at the desk. According to Corporal Md. Aini, only upon the instruction of an officer could the warders open the cell. The cells in the isolation block also do not have any cell call bells or any means for detainees to attract the attention of the warders in cases of emergency. In fact, a detainee stated that detainees would usually bang the plastic cup on the floor to attract the warder's attention.

194. In addition, swift action is imperative in reviving detainees attempting suicide. Vigilant staff can prevent deaths. Prison staff "must never assume that death has occurred"[38]. The Panel of Inquiry notes that when the warders found S.Hendry in a hanging position, the first reaction of that warder was to call another warder and then they went to report the incident to an officer, who touched the body and then went to report the incident to a more senior officer. It was not until 7.30 a.m., a lapse of 15 minutes before cell C4B was opened. The Panel of Inquiry notes that not one of the warders or officers had checked S.Hendry's body for signs of life. Although in retrospection the cold body and the blue discolouration showed that S.Hendry must have died sometime ago, nevertheless **the Panel of Inquiry finds that:**

   a. **The response of the warders and officers was unjustifiable;**
   b. **The warders and officers lacked training in responding to an emergency situation in the isolation block; and**
   c. **The *Pusat Pemulihan Akhlak* Simpang Renggam lacked a response system in emergency situations in the isolation block. Reliance on detainees banging their plastic cup on the floor is particularly inadequate in view that the warder's desk is quite a distance away and warders are usually patrolling around the block.**

195. **Therefore, the Panel of Inquiry recommends that training be given to all staff of the *Pusat Pemulihan Akhlak* Simpang Renggam on how to respond to emergency situations like suicides, attempted suicides and fights. Warders should bear in mind that one should never assume that a detainee is dead. Rule 294 of the Emergency Ordinance (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 states that "no subordinate officer shall enter a detained person's cell at night without being accompanied by another officer except in cases of imperative necessity…". It**

[38] *Suicide is Everyone's Concern – A Thematic Review by HM Chief Inspector of Prisons for England and Wales* (May 1999) Her Majesty's Inspectorate of Prisons for England and Wales, *http://www.inspectorates.homeoffice.gov.uk,* at pg. 47.

must be instilled upon the warders that in cases of emergency, they are empowered to enter into the cell as allowed by rule 294. In any case, the Panel of Inquiry recommends for clear procedures to be drawn up which will enable the warders to open the cells as quickly as possible and not to wait for an officer to open the cell. In situations of attempted suicide, time is of the essence.

Chapter 5

THE CAUSE OF DEATH OF S.HENDRY

196. One of the most important terms of reference of this Panel of Inquiry is to inquire into the cause of death of S.Hendry.

197. Factors indicating that it was possible that S.Hendry took his own life are:

a. There were no defensive wounds and the post mortem examination report noted no mark of trauma on the body of S.Hendry, the scalp was uninjured, the vessels at the base of the brain were patent and intact, there were no injury in the structures and organs of the mouth, throat and neck, the chest wall and ribcage was intact and uninjured, the liver, spleen, kidneys, adrenal glands, pancreas and the intestines were intact, no bony injury seen or detected.

b. Dr. Shahidan concluded that S.Hendry had died of asphyxia due to hanging. This was based on his findings during the post mortem examination that S.Hendry's face was pale, hypostasis marked on the extremities with petechiae and there were no internal injuries on the head, limbs and neck structures.

c. Inspector Alimuddin's observation that the tongue of S.Hendry was pale and the findings of the post mortem examination that S.Hendry's conjunctivae was pale and face was pallid, are consistent with suicide.

d. Detainees testified that they did not hear anyone going into cell C4B after S.Hendry had been placed therein.

e. The fact that S.Hendry was just transferred to the *Pusat Pemulihan Akhlak* Simpang Renggam (a matter of mere hours).

f. Dr. Benjamin Chan's evidence that suicides often occur during the early hours of the morning and young persons are impulsive. Impulsive suicides usually involve very minimal planning, are not orderly and they make use of whatever is available.

198. On the other hand, the Panel of Inquiry had also considered the following factors:

a. There was no known history of mental illness or psychiatric disorders or attempted suicides. S.Hendry had not attempted suicide prior to this.

b. S.Hendry's past behaviour during the 88 days in the lock-up, particularly the last 2-3 days of his life does not seem to indicate any unusual or suicidal behaviour.

c. Dr. Benjamin Chan's testimony that S.Hendry seemed quite normal, was able to interact with detainees within a few short hours, he was able to intimate the fact that he has relatives living nearby, the fact that he would like his father to visit him and made arrangements for his father to visit him. These were reasons for S.Hendry to look forward to the next few days. In addition, his father gave him money and promised to give him a balance of the money he had asked for. He had asked for RM 300 but was only given about RM 30. S.Hendry does not have any prior record of substance abuse, he was not sent to the *Pusat Serenti* or charged or convicted for drug related offences. Furthermore, S.Hendry ate some food (evidence from food particles in the upper esophagus). According to Dr. Benjamin Chan, a person who is planning to commit suicide would not be bothered to take food for the last two to three hours before he takes his own life.

199. As to whether renewal of his two year detention could have influenced S.Hendry to take his own life, although Encik Ramesh confirmed that he did not inform S.Hendry that his two-year detention could be renewed, Dr. Benjamin stated that this fact was not a relevant or significant factor as:

a. He (S.Hendry) was previously detained for 88 days;

b. He was not charged under section 302 of the Penal Code for the other two cases that the Police were investigating;

c. The risk of suicide in prisons is much lower than in detention centres; and

d. Even if S.Hendry was informed that his two-year detention could be renewed for a further two years, it would be nothing in comparison with the possibilities or outcome of a charge under section 302 of the Penal Code.

200. <u>The Panel of Inquiry has given anxious consideration to the alternative views taken by Dr. Benjamin Chan. The Panel of Inquiry's views are as follows:</u>

a. <u>Not every case of suicide requires the precondition of mental illness or psychiatric disorders although their presence in a particular case may be 'presumptive';</u>

b. <u>There has not been an empirical collection of data pertaining to S.Hendry's past behaviour during the 88 days in the lock-up, particularly during the last three days. Testimonies of relevant witnesses related only to incidental observation of his behaviour. The 'source' of the evidence is therefore unreliable;</u>

c. **Similarly, all testimonies relating to S.Hendry's 'normal' behaviour are purely non-expert observations of the same. The evidence does not take the Panel of Inquiry anywhere towards any solution. To illustrate the Panel of Inquiry's point, it is equally difficult to rely on testimonies of witnesses who claimed that S.Hendry was "*muram*" during the period of his remand in the lock-up; and**

d. **The Panel of Inquiry feels that if S.Hendry had been informed that his detention may be extended for further period of two years at a time may have a bearing on his decision to commit suicide as:**
   - **His expectation of being released within two years may have been crushed so suddenly and without recourse to any counselling;**
   - **The fact that he may have escaped being charged under section 302 of the Penal Code may not be so relevant here as this was a fact he knew much earlier. His raised expectation of being released within two years was an expectation he acquired surely after he had learnt that there was no prospect of him being charged for murder. This seems to be clear from the testimonies of Police witnesses from the unfolding of the events pertaining to his Police remands.**

201. **Therefore, the Panel of Inquiry is satisfied that the fact that S.Hendry could have been told of possible renewals of his detention order may be a relevant factor in determining the cause of his death.**

202. **Intention to commit suicide, just like all other forms of criminal intentions need to be viewed from surrounding circumstances. As the saying goes "even the Devil does not know what's in the man's mind". It is only from the overt acts of an individual criminal intention can be gathered from. In this case the overt acts are clear:-**
   a. **The evidence irresistibly point to the fact that no one was with the deceased at all material time. He was alone;**
   b. **The medical fact of the deceased being in a state of hanging for several hours before discovery was conclusive of the fact that his death related to the medical finding of "death by asphyxia" by hanging. The state of the hypostasis of the blood in the lower extremeties of the body indicated death in a vertical position, supportive of death by hanging;**
   c. **Various noises heard, especially that of kicking on the wall by bare feet is supportive of struggles by the deceased in a state of hanging just before death;**
   d. **S.Hendry's careful arrangement of his shirt, charge order and other paraphernalia in the corner diagonally opposite the corner where his body was found was indicative of preparation. In fact the chosen corner too many indicate the deceased's intention of not being detected in his preparation to hang himself;**

e. **The circumstances of the hanging, the blanket used, the nature of the knot, the pail indicate that it is not improbable for the decased to have single handedly executed his plan for suicide.**

In the final analysis, the Panel of Inquiry finds that it is most probable that S.Hendry's death was due to homicide by suicide.

Chapter 6

ISSUES ARISING AFTER THE DEATH OF S.HENDRY

203. After the death of S.Hendry, a number of issues arose, particularly the black marks on the stomach area of S.Hendry's body, the fact that Mr. Sreedhran was not allowed to see his son's body until 21 November 2005 and the adequacy of information given to Mr. Sreedhran with regard to the post mortem examination itself and the findings of the post mortem examination.

The black marks on the stomach area of S.Hendry's body.

204. When Mr. Sreedhran was brought to the mortuary to identify his son's body, he testified that he saw a black mark near the belly button. Upon further questioning, Mr. Sreedhran clarified that he saw tiny black spots.

205. The evidence of Inspector Alimuddin and Dr. Thet Naing Aye could not shed further light on the issue as both could not remember whether they saw any mark around the stomach area of the body that resembled what Mr. Sreedhran had described.

206. When asked about the black marks, Dr. Shahidan explained that because S.Hendry had died and was left in the vertical position for a long period of time, gravity pulled the blood down and blood was localised at the lower part of the body. This created pressure on the surface capillary and caused the capillary to burst, showing pinpoint hemorrhages. As a result, the skin showed minute reddish or purplish spots containing blood. Dr. Shahidan stated the following:

[18 February 2006, morning session, pages 106-109]

Dr. Shahidan : Untuk kes seperti asphyxia juga, di mana tangan digunakan, manual strangulation, ataupun tali, kita akan dapat muka, selalunya asphyxia ni ditunjukkan oleh tiga benda lah Dato'. Satu, congestion muka sebab kita constrict leher, muka akan merah. Lepas tu, biru, sama ada bibir biru, dengan hujung, sebab darah tidak banyak oksigen. Dan lagi satu, petiki. Petiki itu, salur darah kapilari dekat muka ni, dia pecah. Aaa...itupun merupakan macam satu tanda, macam kalau kita dapat, aaa...demam denggi berdarah. Seluruh badan, generalised. Petiki masih sama. Tapi untuk yang cekik ni, untuk cekik bukan gantung, gantung selalu takde benda-benda macam ni. Petiki itu akan ada di atas untuk dicekik leher, atau tali. Manakala, untuk gantung punya, sebab kita tahu dia gantung agak lama, kapilari yang di luar tadi engorged, dan dia pecah. Itu yang kita nampak tu.

Dato' Shafee : Kapilari di luar....

Dr. Shahidan : Kapilari di tisu yang.. but yang lax, selalunya kat muka ni, kita punya tisu ni lex, sebab tu salur darah pun banyak, jadi kalau muka nak kita buat surgical, dia cepat sembuh sebab system darah dia bagus. Dan salur darah, sebab dia lax, salur darah dia halus-halus, yang hujung sekali tu mudah pecah kerana oksigen tak cukup ataupun pressure yang kuat, ditekan sekejap transient dia menyebabkan pecah. Dalam kes Hendry ni, sebab dia tergantung lama, dekat apa ni dari pusat ke bawah, salur darah yang halus-halus tu dia tak boleh store tempat lain, jadi dia pecah, jadi nampak pendarahan bintik-bintik...

Dato' Shafee : Dari pusat ke bawah?

Dr. Shahidan : Ya.

Dato' Shafee : Ok. Let me summarise sikit, sebab apa, I think, Mr. Raju, can you explain? And I'll.....This question is important to explain to the father. Aaa....Doktor, apa yang doctor sebutkan tadi ialah begini. You're saying, selalunya darah is distributed almost equally throughout the human body.

Dr. Shahidan : With the heart beating.

Dato' Shafee : That's right. Heart beating, it's distributed throughout the body, so there is no unnecessary pressure at a particular locality.

Dr. Shahidan : Yes.

Dato' Shafee : But when it is hanged

Dr. Shahidan : Hm...

Dato' Shafee : And he dies.

Dr. Shahidan : Uh huh.

Dato' Shafee : Process of gravity takes place.

Dr. Shahidan : Yes.

Dato' Shafee : Everything goes down, setakat mana yang boleh.

Dr. Shahidan : That's right.

Dato' Shafee : So everyone...a lot of this blood is loaded to the bottom half.

Dr. Shahidan : Yes.

Dato' Shafee : And it creates pressure on the surface capillary.

Dr. Shahidan : Yes.

Dato' Shafee : And it breaks.

Dr. Shahidan : It bursts.

Dato' Shafee : And it bursts.

Dr. Shahidan : And it shows pinpoint hemorrhages.

Dato' Shafee : That is what is caused here.

Dr. Shahidan : Yes.

Dato' Shafee : So it is consistent with the body hanging a long time?

Dr. Shahidan : Yes.

Dato' Shafee : Consistent?

Dr. Shahidan : Right.

Dato' Shafee : Anything suspicious about this?

Dr. Shahidan : Aaa...Problem dia, I think the good point is that selalunya kita tak dapat jugak apa ni.. bleed pinpoint hemorrhages atau petiki tadi, di bahagian bawah, kecuali seseorang memang tak...itu tergantung agak lama, dalam kes Hendry.

Dato' Shafee : So Hendry is an unusual case because you got a situation, where the body hanged for so long?

gDr. Shahidan : But I've seen a few other case macam ni yang tergantung agak lama, tapi bukan dalam tahanan lah, Dato'.

207. **The Panel of Inquiry finds that the explanation proffered by Dr. Shahidan was satisfactory and accepts his expert opinion with regard to the tiny black spots on the stomach area of S.Hendry**.

The issue of S.Hendry's father being denied from seeing his son's body on 19 November 2005

208. Mr. Sreedhran was not allowed to see his son's body when he arrived at Simpang Renggam on 19 November 2005. Requests by Mr. Sreedhran to see his son's body were met with negative responses from Hospital Kluang, the Police and the Prison authorities, all informing Mr. Sreedhran to return some two days later (21 November 2005).

209. Various reasons were given to Mr. Sreedhran as to why he was not allowed to see his son's body on 19 November 2005. The Police told Mr. Sreedhran that the case came under the purview of the Prison authorities, the Prison authorities said that the case was a Police case, personnel of Hospital Kluang said it was a Saturday and there was no one working in the hospital and that the coroner had yet to examine the body of his son.

210. The Panel of Inquiry finds that not allowing Mr. Sreedhran from seeing his son's body on 19 November 2005 was unjustifiable. A death of a loved one is a painful time for the friends and family members of the deceased and a death in a detention centre adds a further dimension to the pain and suffering of friends and family members as they are separated from the deceased and in conditions that the family members do not fully appreciate[39]. Therefore, all the more, family members should be allowed to see the body of the deceased immediately to minimise family anxiety. A delay of two days in this instance is unjustifiable, particularly that the different reasons given to Mr. Sreedhran on why he was not allowed to see his son's body seem to show that the

[39] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pg. 3.

authorities were trying to evade their responsibilities. The Panel of Inquiry is of the view that there are no reasonable grounds to disallow a family member to see the deceased's body immediately. In addition, the Panel of Inquiry wishes to highlight that any delay in allowing the family members to view the body raises suspicion. In addition, changes in the physical conditions of the body of the deceased may also bring about feelings of mistrust and suspicion. For instance, the tiny black spots that Mr. Sreedhran saw on 21 November 2005 did cause him to be suspicious. The black spots were later clarified by the forensic pathologist as a physical change that had taken place since death. **As such, the Panel of Inquiry recommends that family members of every death in custody be allowed to see the body of the deceased immediately. Family members would benefit from early information and identification of the deceased. Any concern that family members may contaminate the evidence by touching the body, can simply be surmounted by a reminder to the effect that family members are only allowed to see but not touch the body[40].**

The issue of lack of information regarding the post mortem examination

211. Mr. Sreedhran was notified of the date and time of the post mortem examination and after the post mortem examination, Mr. Sreedhran was informed that his son's body had no bruises or injuries. Mr. Sreedhran was not told any other information beyond that. **The Panel of Inquiry finds that notification of the date and time of the post mortem examination and scant information of the findings of the post mortem examination was insufficient information for the deceased's next-of-kin, especially in a case of death in custody.**

212. In the UK, Rule 7 of the Coroners Rules 1984 allows the deceased's family members to be represented at a post mortem examination by a legally qualified medical practitioner. The UK Coroners Rules 1984 was applied by the Malaysian Courts in the case of *Sara Lily & Satu Lagi v PP*[41]. Additionally, family members of the deceased should also be informed that if they are not satisfied with the findings of the first post mortem examination, they have the opportunity to appoint an independent pathologist for a second post mortem examination.

213. The Panel of Inquiry is of the view that more information should be given to family members and such information must be given timely, accurately and in an appropriate manner. **The Panel of Inquiry recommends that certain essential information should be told to the next-of-kin in cases of deaths in custody, including but not limited to:**

[40] Dr. Bhupinder Singh, *Workshop on "Inquests into Deaths in Police Custody"*, Bar Council, 1 April 2006.
[41] [2004] 7 CLJ 335.

a. **Date, time and place of the post mortem examination;**
b. **The right of family members to be represented by a legally qualified medical practitioner or a legal practitioner or a medical practitioner during the post mortem examination;**
c. **The right of family members to have a second post mortem examination. Should family members wish to have a second post mortem examination, they should be told not to remove the body from the mortuary. Thereafter, the Police have the responsibility of obtaining another pathologist or the family members, if they wish, can obtain a pathologist of their choice; and**
d. **A thorough explanation, in layman's language, of the findings of the post mortem examination.**

Chapter 7

ISSUES RELATING TO THE SYSTEM OF DETENTION FOR YOUNG PERSONS AT THE *PUSAT PEMULIHAN AKHLAK* SIMPANG RENGGAM

214. The Panel of Inquiry is also required to look into the system of detention for young persons at the *Pusat Pemulihan Akhlak* Simpang Renggam. The issues which the Panel of Inquiry feels warrant consideration are:
    a. Self-harm assessment at the registration and reception stage;
    b. The 14-day quarantine rule and the fact that S.Hendry was placed in the cell alone;
    c. The rehabilitation programme for young detainees at the *Pusat Pemulihan Akhlak* Simpang Renggam; and
    d. The need for a policy on prevention of suicide and self-harm for young detainees.

<u>The issue of self-harm assessment at the registration and reception stage</u>

215. In his evidence, Inspector Azamuddin bin Azim (IW9)[42] explained that upon arrival of a detainee at the entrance of the *Pusat Pemulihan Akhlak* Simpang Renggam, the officer-in-charge would verify the detention order and the identification card of the detainee. Thereafter, the detainee would be handed over to the Inspection Unit (*Unit Pemeriksaan*) where a full body search would be conducted. The officer-in-charge would then take prints of the detainee's 10 fingers and record the detainee's biodata. No photographs would be taken at this stage. Other information to complete the detainee's record would be obtained the following day. It was usual practice for officers to take the new detainee's belongings. A briefing would then be given to the detainees which included an explanation of the grounds of detention, the period of detention and the possibility that the detention order may be renewed for another two years. Thereafter, the detainee would be brought to the isolation block ("*blok asingan*") for quarantine.

216. **<u>From the above, the Panel of Inquiry finds that the *Pusat Pemulihan Akhlak* Simpang Renggam does not carry out an assessment to determine whether a young detainee is likely to self-harm at the reception and registration stage. Assessment, if any, is done on an ad hoc basis by untrained officers.</u>** This is consistent with Dr. Benjamin Chan's testimony that he could not glean useful information, on the state of mind of S.Hendry, from the testimonies of the warders and the officers of the *Pusat Pemulihan Akhlak* Simpang Renggam.

[42] Exhibit P-13 – Statement of Azamuddin bin Azim.

217. Reception remains one of the most crucial stages, marking a shift from community to custody[43]. Consequently, emphasis must be placed on the assessment of vulnerability and of personal worries and anxieties of new detainees, particularly young detainees and their ability to cope with their situation. In addition, young detainees who arrive at a detention centre should be given certain basic information such as the rules of the detention centre, what is expected of them and why and especially of how they can, at any time get help and advice[44].

218. Additionally, a risk assessment checklist proved crucial in identifying high risk behaviour in Victoria, Australia where an analysis of five deaths in custody by the Victorian Police Prisoner Medical Checklist showed that the checklist was not used in all these cases except for one[45].

219. **As such, the Panel of Inquiry recommends:**

a. **In addition to the current reception and registration procedures, an initial risk assessment[46] is carried out during the reception and registration stage for all detainees, particularly young detainees. Once a new detainee arrives at the *Pusat Pemulihan Akhlak* Simpang Renggam, the reception staff should have the responsibility of screening detainees for suicidal behaviour. Initial risk assessment could take the form of a risk assessment checklist;**
b. **That new young detainees be given the usual toiletries, reading material, a radio[47] and information on how they can obtain help and advice anytime. Reading materials are allowed by virtue of Rule 42 of the Emergency Ordinance (Public Order and Prevention of Crime) (Detained Persons) Rules 1970;**
c. **Training be conducted for all staff, particularly those involved at the reception and registration stage on how to identify high risk and suicidal behaviour; and**
d. **That any information concerning the behaviour of the detainee, any suicidal risks, should be conveyed to the *Pusat Pemulihan Akhlak* Simpang Renggam from Police personnel escorting the detainee.**

The issue of placing S.Hendry alone in cell C4B and the 14-day quarantine rule

220. Tuan Mohd. Zawawi explained that S.Hendry was placed alone in cell C4B in accordance with the established procedure of segregating young detainees from

[43] A Checklist for Governors and Senior Management, *Promoting the Health of Young People in Custody*, World Health Organisation, *http://www.euro.who.int*
[44] *Ibid.*
[45] Halstead, B., *Australian Deaths in Custody: No. 10 – Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study* (November 1995), Australian Institute of Criminology, *http://www.aic.gov.au*, at pg. 10.
[46] The initial risk assessment is based on the *Suicide is Everyone's Concern, loc.cit*, n.38, at pg. 55.
[47] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pg. 55.

adult detainees, in accordance with section 49(3) of the Prison Act 1995, Emergency (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 and Rule 6(1) of the Prisons Regulations 2000. Although all the legal provisions state that a young person is a detainee below the age of 17 years and S.Hendry was 18 years old at the time of detention, the Prison authorities felt that it would be in S.Hendry's best interest to treat him as a young detainee.

221. As regards the 14-day quarantine rule, Tuan Mohd. Zawawi confirmed that new detainees under the POPOC would be quarantined in the isolation block for 14 days before being placed in the proper detention block. Tuan Mohd. Zawawi explained that the 14-day quarantine rule is a rule of the *Pusat Pemulihan Akhlak* Simpang Renggam issued by the Headquarters, Prisons Department. The administrative rule reads as follows[48]:

"*Oleh kerana kawasan POPOC tidak mempunyai bilik kuarantin untuk tahanan baru, maka pengasingan orang tahanan baru kategori POPOC di Blok Asingan adalah selama 14 hari daripada tarikh masuk. PYM Blok Asingan perlu memastikan orang tahanan baru berkenaan diberi pengawasan sepenuhnya untuk memastikan tiada artikel larangan dapat diseludup dari Blok Asingan ke Blok Penginapan setelah tamat tempoh kuarantin".*

222. Apart from the space constraints of the area for the POPOC detainees and to prohibit contraband articles from being brought into the *Pusat Pemulihan Akhlak* Simpang Renggam, Tuan Mohd. Zawawi added that the 14-day quarantine rule was also needed to enable the *Pusat Pemulihan Akhlak* Simpang Renggam to carry out a urine test on new detainees to determine if detainees have any infectious disease. The urine test usually takes about seven days to be processed. Inspector Azamuddin added in his evidence that during the 14 days, the detainee would be sent to the clinic for a medical check-up and administrative procedures such as registration would be carried out.

223. Experts on suicide have advised that the environment in which a prisoner or detainee is placed should be as normal as possible, in particular new detainees[49]. An assessment on the use of isolation and seclusion in the UK brought forth complaints by prisoners themselves that being placed in an unfurnished room alone made them feel worse. According to Professor John Gunn, "seclusion is anti-therapeutic"[50]. In the UK, a review by the Chief Inspector of Prisons observed that "removal from association can involve the loss of various opportunities and advantages in addition

[48] See Appendix 3.
[49] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pg. 46.
[50] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pg. 47.

to the obvious deprivation of human contact... segregation can entail living under an impoverished and monotonous regime which may even be psychologically harmful"[51].

224. It cannot be denied that being placed alone in an unfurnished cell can be traumatising to a new detainee, in particular young detainees. In this instance, the Panel of Inquiry is aware of the conundrum posed by two seemingly incompatible principles where on one hand a young detainee should be segregated from adult detainees and on the other hand the shortcomings of placing a young detainee alone in a cell during the 14-day quarantine. The Panel of Inquiry commends the *Pusat Pemulihan Akhlak* Simpang Renggam for their astute decision to consider S.Hendry a young detainee, thereby segregating him from adult detainees. However, this also meant that S.Hendry was alone in cell C4B. The Panel of Inquiry observes that from the list of detainees that were received by the *Pusat Pemulihan Akhlak* Simpang Renggam on 18 November 2005[52], apart from S.Hendry there was one other detainee below 21 years of age.

225. **In view of the vulnerability of new detainees, particularly new young detainees, the Panel of Inquiry finds that:**

   a. **S.Hendry should not have been placed alone in cell C4B but should have been placed in the same cell as the other young detainee who was brought in on the same day; and**
   b. **The 14-day period for quarantine for detainees detained under the POPOC was too lengthy as the objectives of the 14-day quarantine rule could be achieved in a much shorter period of time. Urine tests and procedures employed to ensure contraband articles are not brought into the detention centres could be carried out in a shorter period of time.**

226. **The Panel of Inquiry recommends that:**
   a. **During the quarantine period, young detainees should not be placed alone in cells and should always be in shared accommodation with other young detainees unless the young detainee displays violent behaviour;**
   b. **The 14-day quarantine rule for new young detainees detained under the POPOC should be shortened;**

[51] *Review of the Segregation of Prisoners* (1985) in *Keenan v the United Kingdom* (Judgement of 3 April 2001), at para. 65.
[52] Exhibit P-13A – List of detainees received by *Pusat Pemulihan Akhlak* Simpang Renggam on 18 November 2005.

c. **All new young detainees should be placed under close observation by trained personnel for the entire initial period[53]. Inspection of detainees should be no greater than 30 minutes; and**

d. **During the initial period, new young detainees should be seen individually by trained personnel to assess detainees for suicide risks and be given essential information on how they will be treated and how to obtain help[54].**

The issue of the rehabilitation programme for young detainees at the *Pusat Pemulihan Akhlak* Simpang Renggam

227. The Panel of Inquiry is encouraged that a rehabilitation programme for young detainees[55] *("Program Pemulihan Banduan Muda – Model Pemulihan Putra")* has been drawn up and is being used at the *Pusat Pemulihan Akhlak* Simpang Renggam.

228. According to the said rehabilitation programme, the objectives of the rehabilitation programme are to increase awareness, knowledge and self-esteem (*"jati diri"*) so that young detainees are able to develop good attitude and character, to provide suitable welfare services to overcome prisoner problems and to maintain family relations, to ensure a healthy lifestyle for these young detainees and to enhance their vocational skills with a view to promote independence after release.

229. The main features of the rehabilitation programme include:

a. Marching;
b. Medical check-up;
c. Vocational training;
d. Sports and recreational activities;
e. Morning exercises;
f. Field and indoor sports;
g. Watching television;
h. Reading newspapers;
i. Awareness of self and society;
j. Counselling;
k. Spiritual well-being;
l. Monitoring drug use;

230. The rehabilitation programme is divided into four phases:

a. Phase 1 – Orientation

[53] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pg. 55.
[54] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pg. 55.
[55] Exhibit P-25.

This is carried out within the first three months of detention. The thrust of this phase is to instil discipline through marching and singing patriotic songs. Other activities include briefings on rules and discipline, medical check-up, the registration process, interviews with a Welfare officer and religious teacher, counselling and educational classes for detainees who intend to continue their studies. An assessment would be made during the last seven days of the orientation period.

b. Phase 2 – *Pengukuhan*
Young detainees would be given the choice of academic education (which includes vocational training), religious studies or therapeutic community. Young detainees would be given the opportunity to choose either one of the three options, depending on their interest and inclination. Problematic young detainees would be given counselling. Apart from the three areas above, young detainees would also be required to do sports and recreational activities. An assessment would also carried out at the end of the phase.

c. Phase 3 – Pre-release
This phase involves activities aimed at enabling young detainees to reintegrate themselves into society upon release. Activities are more intensive, with a focus on vocational, agricultural activities and religious studies. An assessment would be made at the end of the phase.

231. Young persons in custody should have the opportunity for healthy mental development. It is an inherent part of their human rights[56]. The World Health Organisation (WHO) developed the 'Healthy Prison' concept in which a healthy custodial environment consists of the following four premises:

a. Prisoners are held in safety;
b. Prisoners are treated with respect and dignity;
c. Prisoners are engaged in purposeful activities; and
d. Prisoners are prepared for resettlement.

232. **The Panel of Inquiry finds that the rehabilitation programme drawn up for young detainees provides the basal education, work training and rehabilitation aspects. Detainees seem purposefully occupied and are given the opportunity to improve themselves in areas of their interest and their employability. However, certain areas need to be added to elevate it to a health custodial environment for young detainees and to ensure conformity with article 10(3) of the International Covenant**

[56] Principle 1, *Promoting the Health of Young People in Custody*, World Health Organisation, *http://www.euro.who.int*

on Civil and Political Rights (ICCPR) which requires that the essential aim of treatment of prisoners should be their " reformation and social rehabilitation".

233. **Thus, the Panel of Inquiry recommends:**
    a. **Adoption of a policy on prevention of suicide and self-harm (this recommendation will be discussed in greater detail below);**
    b. **Inclusion in the orientation phase, a special programme for young detainees on how to adjust to life in the detention centre;**
    c. **Creating incentives to encourage young detainees who, at time of admission may be apathetic and lacking in motivation, to participate in and gain from the developmental opportunities available[57].**
    d. **Empowering the staff with skills to encourage detainees to take up the opportunities available to them and to provide staff with a healthy culture; and**
    e. **That staff be selected, resourced and trained so that young people in their care can take full advantage of opportunities in custody[58]; and**

The issue of a policy on prevention of suicide and self-harm for young detainees at the *Pusat Pemulihan Akhlak* Simpang Renggam

234. One pertinent issue highlighted by Dr. Benjamin Chan is the lack of a clear policy on prevention of suicide and self-harm. **The Panel of Inquiry finds that:**
    a. The *Pusat Pemulihan Akhlak* Simpang Renggam does not have a policy on prevention of suicide and self-harm. Officers merely use their intuition to identify detainees who are likely to commit suicide, at the reception stage and also during detention period;
    b. Risk assessment of young detainees is either absent or inadequate; and
    c. There is a lack of experienced staff dealing with young detainees who display suicidal behaviour.

235. The right to life is the most fundamental human right, within which no derogation is permissible. Guaranteed in article 5(1) of the Federal Constitution and recognised in article 3 of the Universal Declaration of Human Rights (UDHR), article 6 of the ICCPR, article 2 of the European Convention on Human Rights (ECHR) and article 6 of the Convention on the Rights of the Child, the right to life is a pre-requisite to all other human rights.

236. Article 2 of the ECHR which states that "everyone's right to life shall be protected by law" was interpreted by the European Court of Human Rights to include the positive

[57] *Ibid*.
[58] *Ibid.*

obligation to take steps to safeguard the lives of those within its jurisdiction[59]. The European Court of Human Rights stressed that persons in custody are in a vulnerable position and authorities are under a duty to protect them. Rule 297 of the Emergency (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 reiterates this duty that "subordinate officers shall be responsible for the safe custody of detained persons..."

237. Specifically to suicide and self-harm, the European Court of Human Rights interpreted the right to life to include the obligation of the State to take reasonable steps to prevent suicides and self-harm of those in state custody, particularly when the authorities are on notice of a real and immediate risk to life[60]. Prison authorities must discharge their duties in a manner compatible with the rights and freedoms of the individual. There are general measures and precautions which will be available to diminish the opportunities of self-harm, without infringing on personal autonomy[61]. In addition, article 2 of the ECHR also imposes upon the State the requirement to give appropriate training, instructions and briefing to its agents who are faced with situations where the deprivation of life may take place under their control or field of responsibility[62].

238. Undoubtedly, a death in custody is a human rights issue as it is "the state's duty of care to those whom it decides to detain"[63]. "There is a great responsibility on the police or prison authorities to ensure that the citizen its custody is not deprived of his right to life"[64]. "They must be protected against self-harm and reasonable care must be taken to safeguard their lives and persons against the risk of avoidable harm"[65].

239. The Panel of Inquiry notes that this is the first death in custody in the *Pusat Pemulihan Akhlak* Simpang Renggam but one death in custody is one too many. In this regard, the Panel of Inquiry recommends that a policy is adopted by not only the *Pusat Pemulihan Akhlak* Simpang Renggam but also extended to Police personnel as well as suicide rates are higher in lock-ups and during remand than in prisons or prison settings. S.Hendry was detained in Police custody for 88 days before being sent to the *Pusat Pemulihan Akhlak* Simpang Renggam and prolonged detention under any circumstance can have a detrimental effect on any person. The effect is even more profound in young persons as they are immature and impressionable.

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[59] *Osman v the United Kingdom* (Judgement of 28 October 1998), para. 115, *L.C.B. v the United Kingdom* (Judgement of 9 June 1998).
[60] *Keenan v the United Kingdom* (Judgement of 3 April 2001), at para. 82 – 90.
[61] *Keenan v the United Kingdom*, *loc. cit., supra* n. 61, at para. 90 - 92.
[62] *McCann v the United Kingdom* (Judgement of 27 September 1995), para. 151.
[63] Owers, A., H.M. Chief Inspector of Prisons, *Prison Inspection and the Protection of Human Rights* (22 October 2003), BIHR Human Rights Lecture, *http://www.bihr.org*
[64] Per Anand J in *Nilabati Behera v State of Orissa* (1993) 2 SCC 746, at 767.
[65] *Reeves v Commissioner of Police of the Metropolis* [2000] 1 AC 360.

240. Too often, blame is placed on the state of mind of detainees who take their own life. Research in the UK have shown that suicides in prisons are not always caused by the individual's vulnerable state of mind or psychological well-being but an equivalent contributing factor is the quality of the prison regimes, the conditions, isolation and the support system[66]. **Therefore, the Panel of Inquiry recommends that the *Pusat Pemulihan Akhlak* Simpang Renggam and the Police adopt a wholistic policy of prevention of suicide and self-harm and a care plan for detainees with suicidal tendencies. The main features of the policy and care plan could include the following[67]:**

a. Commitment to the prevention of suicide and self-harm

A policy on suicide and self-harm prevention must begin with commitment by all, senior and junior staff. It must be instilled that everyone in the *Pusat Pemulihan Akhlak* Simpang Renggam and within the Police force has a role to play in preventing suicide and self-harm. Senior management must take responsibility for the implementation and the efficacy of the policy.

b. Placing responsibility on all Prison staff and Police personnel in caring and identifying suicidal behaviour

It must be realised that the well-being of detainees is the responsibility of all Prison staff and Police personnel and not only those who come in direct contact with the detainees. As such, there must be a change of mindset from relying on the medical officers to identify and care of suicidal detainees to making it a responsibility for all to tend to suicidal detainees and to recognise, at the earliest stage possible, suicidal behaviour.

c. Different strategies for different groups of detainees

The behaviour of young detainees is different from adult detainees and thus requires a different strategy. As Dr. Benjamin Chan pointed out, young persons are more impulsive and certainly more vulnerable. Young detainees often do not understand the consequences of their future and their actions. They are at the formative age of the adulthood, are easily influenced and often need a listening ear. Therefore, officers and warders have to not only be in-charge of the security of the detention centre but also a role model to these young detainees and to help them in times of distress and unhappiness. This role assumes greater importance in the *Pusat Pemulihan Akhlak* Simpang Renggam as most detainees are detained under preventive detention laws and are not given the right to a fair

[66] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pp. 57 - 58.
[67] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pp. 38 - 48.

trial. Understandably, they may be more frustrated, angry and unsatisfied with the system.

d. Training for staff and officers

There seems to be a lack of training and awareness from senior level officers to subordinate officers of the *Pusat Pemulihan Akhlak* Simpang Renggam on suicide and self-harm prevention. Hence, on-going training and support should be given to all officers and staff of the *Pusat Pemulihan Akhlak* Simpang Renggam, to enable them to identify suicide risk behaviours. In addition, training should also include understanding suicidal behaviour, in particular adolescent suicidal behaviour, how to become a counsellor to detainees whereby officers are seen as someone to talk to and turn to in times of distress, identifying suicidal behaviour and how to approach detainees who display such behaviour. Imprisonment is an extreme sanction, more so for a young person. Accordingly, one of the aims of custody should be to ensure that the young person knows that there is at least one person, ideally a personal officer, who is interested in him/her as a person, who cares about his/her health and well-being and who can help the young person to build/maintain relationships back in the community[68].

Such training is also important for the Police. For instance, in New York, every officer of the New York City Department of Correction undergoes 40 hours of learning about mental health, issues for prisoners, including identification of possible symptoms[69].

e. Prisoner Support Scheme

Over the past years, the Prison Service of the UK recognised the importance and effectiveness of prisoner support schemes especially for women and young detainees. The UK Prison Service introduced the Listener scheme whereby prisoners support other prisoners. This Listener scheme proved effective as it was observed that prisoners recognise, understand and appreciate what other prisoners are feeling and are more willing to confide in a fellow prisoner. Under this scheme, prisoners are selected, trained and supported continuously by an external counselling organisation like The Samaritans.

f. Physical aspects of cells

The Panel of Inquiry agrees with Dr. Benjamin Chan that physical aspects of cells must be scrutinised to remove suicide hotspots. The practice of using the light along the five-foot way to illuminate the cells is inadequate. Instead, all cells

[68] Principle 5, *Promoting the Health of Young People in Custody*, World Health Organisation, *http://www.euro.who.int*

[69] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pg. 53.

where new detainees are placed should be equipped with dimmer lights, even when detainees are sleeping and cells should be cleared of ligature points[70]. In addition, every cell particularly cells in the isolation block, should be installed with a cell call button or bell where detainees are able to alert warders or officers to the cell for assistance. When the cell call button or bell is pressed, a light and a buzzer at the warder's desk on each floor would be lighted and can be seen by warders on duty and warders patrolling on other floors. This would serve as a good response system not only in cases of suicides but also illnesses and altercations. Warders and officers must respond to the calls promptly and must ensure periodically that the system is in working order.

g. Support and counselling for staff

The Panel of Inquiry appreciates that officers and warders working in the *Pusat Pemulihan Akhlak* Simpang Renggam encounter detainees who are difficult and dangerous. The Panel of Inquiry finds that no support or counselling was given to the warders and officers who were directly involved in the death of S.Hendry. In addition, senior management of the *Pusat Pemulihan Akhlak* Simpang Renggam should ensure that the staff at all levels be treated with respect, informed and consulted on work that involves them and are given the necessary counselling and support after a death in custody occurs. These include providing psychological support for warders and officers when they encounter a death in custody.

h. *Care plan for young detainees who are identified to be at risk of suicide or self-harm[71]:*

- **Separate detention from other young detainees and in a separate block. Separation from other young detainees not displaying suicidal behaviour is imperative as bullying, intimidation may hasten suicidal tendencies;**
- **Save for violent detainees, young detainees who display suicidal behaviour should never be detained alone in a cell. Isolation and seclusion are only suitable in cases of self-mutilation and for violent detainees. In addition, Governors of UK prisons felt that discontinuance of isolation and seclusion would force the prison authorities to deal with suicidal detainees in a more humane way;**
- **Young detainees who are identified to be at risk of suicide or self-harm should be referred to a suicide support worker;**
- **A written guideline should be drawn up stating that inspection on each detainee is carried out at intervals not greater than 15 minutes. However, it must be cautioned that observations of these detainees should not be at fixed**

[70] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pg. 55.
[71] *Suicide is Everyone's Concern, loc.cit*, *supra* n.38, at pg. 56.

intervals as the repetitiveness may create monotony. As such, observations should be carried out according to the needs of the individual detainees, with the 15 minute rule as the yardstick;

- **Daily visits and interviews with trained personnel; and**
- **Provision of necessary assistance and support, for example, phone calls, visits with family members;**

Chapter 8

ISSUES RELATING TO A PROMPT, EFFECTIVE AND INDEPENDENT DEATH INQUIRY

241. The Panel of Inquiry commends the *Pusat Pemulihan Akhlak* Simpang Renggam for conducting an internal inquiry promptly as post-death inquiry is a fundamental part of the protection of human rights[72] and the right to life.

242. Apart from the substantive obligation to protect the life of those in detention, the right to life in article 2 of the ECHR also requires the State to carry out effective investigations where death has occurred[73], including self-inflicted deaths in prisons[74]. In addition, article 13 of the ECHR which embodies the right to an effective remedy necessitates a thorough and effective investigation of suspicious deaths[75]. The right must also be exercised by the authorities on its own motion without being dependant upon a formal complaint[76].

243. The European Court of Human Rights established the following criteria for an effective investigation within the meaning of article 2 of the ECHR[77]:
    a. Independent - Persons carrying out the investigations must be independent from those implicated in the event;
    b. Competent - Capable of leading to a determination;
    c. Expeditious - Promptness and reasonable expedition; and
    d. Public - The next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests. The importance of involvement of family members of the deceased was affirmed in *Güleç v Turkey*[78] and *Ögur v Turkey*[79].

244. The Panel of Inquiry finds that although the PPA Simpang Renggam Internal Inquiry was conducted promptly, it lacked independence as officers of the *Pusat Pemulihan Akhlak* Simpang Renggam conducted the internal inquiry. In addition, the findings of the PPA Simpang Renggam Internal Inquiry were not made public and there was no involvement of the family members of the deceased.

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[72] Owers, A., H.M. Chief Inspector of Prisons, *Prison Inspection and the Protection of Human Rights* (22 October 2003), BIHR Human Rights Lecture, *http://www.bihr.org*
[73] *McCann v the United Kingdom loc. cit., supra* n. 62,
[74] *Keenan v the United Kingdom, loc. cit., supra* n. 60.
[75] See *Aksoy v Turkey* (Case No. 100/1995/606/694), *Aydin v Turkey* (Judgement of 25 September 1997), *Kurt v Turkey* (Judgement of 25 May 1998), *Mc.Cann and Others v the United Kingdom*, *loc. cit., supra* n.62, at para. 147, *Soering v UK* (Judgement of 7 July 1989), at para. 88.
[76] *Kelly v UK* (Judgement of 4 May 2001) at para. 94, *Ilhan v Turkey* (Judgement of 27 June 2000), at para. 63.
[77] *Hugh Jordan v the United Kingdom* (Judgement of 4 May 2001), para. 106 - 109.
[78] Judgement of 27 July 1998, at para. 82.
[79] Application No. 21954/93, para. 92.

245. <u>As such, the Panel of Inquiry recommends that future internal inquiries in deaths in custody conducted by the *Pusat Pemulihan Akhlak* Simpang Renggam:</u>

a. <u>Should be conducted by officers from other detention centres or from the Headquarters, Prisons Department;</u>
b. <u>Should involve the deceased's family members and/or their legal representatives; and</u>
c. <u>Its findings must be made public.</u>

246. At this juncture, whilst an internal inquiry launched by the detention centre where the death occurred may be useful, the Panel of Inquiry would like to underscore the importance of a judicial inquest for a death in custody. To date, no judicial inquest has been carried out on the death of S.Hendry. In the past, SUHAKAM noted that requests for an inquiry into deaths in custody or a second post mortem by family members have more often than not fallen on deaf ears.

247. A post-death inquiry is consistent with principles of transparency and accountability and signifies a commitment to learning from bad outcomes and to improve upon weaknesses[80]. In addition, a public and integrated child death inquiry would also signify society's commitment to the importance of children, improving the lives of children and to ensure effective intervention in child death cases[81]. In Victoria, Australia, child death inquiries are seen as part of the mechanism of public accountability within the child protection system[82]. The Victorian Child Death Review Committee was set up in 1995 to conduct inquiries into all child deaths that occur in the protective services, with a 138 day time line for completion, with annual reports of child deaths tabled in Parliament.

248. In other jurisdictions, child deaths or deaths in prisons automatically set in motion a coroners inquest. In New Zealand, section 17 of the Coroners Act 1988 makes it mandatory for a coroner to conduct an inquest into all deaths that appear to have been a suicide, the death of any child or young person, the death of any person in the custody of the Police or death of any prisoner. In Victoria, Australia, a coroner is required to investigate into all deaths of children and young people[83]. Similarly, section 8 of the Coroners Act 1988 (UK) makes it mandatory for a coroner to hold an

[80] Australasian Child Death Inquiry Workshop (April 1998), *http://www.office-for-children.vic.gov.au*
[81] Court, J., *Value Place on Children,* Australasian Child Death Inquiry Workshop (April 1998), *http://www.office-for-children.vic.gov.au*
[82] Armytage, P., *Value Place on Children,* Australasian Child Death Inquiry Workshop (April 1998), *http://www.office-for-children.vic.gov.au*
[83] Coroners Act 1985 (South Australia).

inquest as soon as practicable, any death that occurred in a prison. Similarly, an inquest is mandatory for all deaths in custody in Australia[84].

249. The significance and importance of an inquest into deaths in custody, particular child deaths, cannot be ignored. **Therefore, the Panel of Inquiry finds it worthwhile to reiterate SUHAKAM's recommendation to amend the CPC to make it mandatory for Magistrates to hold an inquiry into all deaths in custody unless a person has been charged for an offence in respect of the death[85].**

[84] Section 13 of the Coroners Act 1997 (Australia).
[85] See SUHAKAM Annual Report 2004, at pg. 83.

Chapter 9

SUMMARY OF THE PANEL OF INQUIRY'S FINDINGS

1. S. Hendry's continuous period of 29 days in remand was excessive and too lengthy.

2. There has been a failure to give S.Hendry a medical check-up between 23 August 2005 and 18 November 2005, contravening Rule 10 of the Lock-up Rules 1953 which places an obligation on the Medical Officer to conduct a medical check-up on a detainee.

3. Sending S.Hendry to the *Pusat Pemulihan Akhlak* Simpang Renggam late, where he arrived after working hours was imprudent.

4. There has been a failure on the Police to adhere to Rule 20 of the Lock-up Rules 1953.

5. It was possible that the sounds akin to someone kicking or striking the wall that the detainees heard could have emanated from cell C4B.

6. It was possible that the screams that the detainees heard could have emanated from cells other than C4B.

7. Detainees were merely estimating the time (they heard the noises) and as such their testimonies that they heard the noises between 3.00 a.m. and 5.30 a.m. are unreliable.

8. The time of death of S.Hendry is placed likely between 12.00 midnight and 5.00 a.m.

9. Save for cell C4B, it was likely that the other cells were lighted. It was also likely that the light in cell C4B was faulty and not because of subjective discretion of the warders not to switch on the light in cell C4B. The presence of the lighted fluorescent light along the five-foot way is significant as it indicates that the claim by the warders that they could not be sure if S.Hendry was sleeping or not due to poor lighting cannot be easily accepted. It tends to indicate either total lack of physical monitoring by the relevant warders or negligence.

10. It was highly probable that the fluorescent light along the five-foot way outside cell C4B was functioning and switched on on the night of 18 November 2005 and the early morning of 19 November 2005.

11. There was a failure by the warders to report that the light in cell C4B was not working and to fix the light in cell C4B.

12. There was a failure on the part of the Chief Officer and the Officer-in-Charge to adhere to or carry out diligently the obligations in Rules 261 and 214 of the Emergency Ordinance (Public Order and Prevention of Crime) (Detained Persons) Rules 1970.

13. It was unlikely that the four warders on duty on the night of 18 November 2005 and the early morning of 19 November 2005, made their rounds.

14. The four warders on duty had failed to make the proper entries into the Daily Log Book with regard to the times of their patrolling, including the fact that the light in cell C4B was not working.

15. The evidence of the four warders on duty with regard to what they saw when they looked into cell C4B, cannot be relied upon.

16. The claim by the warders that they could not have seen S.Hendry's body hanging at the right hand corner of the diamond-shaped grill window is unsustainable, more so that the fluorescent light was positioned right beside the particular spot where S.Hendry was found in a hanging position.

17. A view alternative to the above is that despite the extenuating circumstances of the light and the grill, it was likely that the warders took only a cursory glance into cell C4B during their patrolling and thus there has been a failure on their part to carry out their patrolling duties diligently and conscientiously. The warders could have stood at the grill door which would have given them a clearer view of cell C4B and the fluorescent light was sufficiently bright to illuminate cell C4B.

18. The Prison warders failed to adhere to rule 297 of the Emergency (Public Order and Prevention of Crime) (Detained Persons) Rules 1970 which requires warders to count detained persons at least once every half hour and always on receiving charge of a party, on handing over charge and on leaving any building or work.

19. The response of the warders and officers when they found S.Hendry hanging in the cell in the morning of 19 November 2005, was unjustifiable.

20. The warders and officers lacked training in responding to an emergency situation in the isolation block.

21. In general, the *Pusat Pemulihan Akhlak* Simpang Renggam lacked a response system in emergency situations in the isolation block. To rely on detainees to bang their plastic cup on the floor is particularly inadequate in view that the warder's desk is quite a distance away and warders are usually patrolling around the block.

22. The fact that S.Hendry could have been told of possible renewals of his detention order is a relevant factor in determining the cause of his death.

23. Based on the the post mortem examination report, the absence of physical and internal injuries, that the detainees did not hear anyone going into cell C4B and the impulsive nature of young persons, a case of homicide by suicide is most probable.

24. The explanation proffered by Dr. Shahidan with regard to the tiny black spots around S.Hendry's body was satisfactory and acceptable.

25. Not allowing Mr. Sreedhran from seeing his son's body on 19 November 2005 was unjustifiable.

26. Notification of the date and time of the post mortem examination and scant information of the findings of the post mortem examination was insufficient information for the deceased's next-of-kin, especially in a case of death in custody.

27. *The Pusat Pemulihan Akhlak* Simpang Renggam lacked a system of assessment to determine whether a young detainee is likely to self-harm at the reception and registration stage. Assessment, if any, is done on an ad hoc basis by untrained officers.

28. S.Hendry should not have been placed alone in cell C4B but should have been placed in the same cell as the other young detainee who was brought in on the same day.

29. The 14-day period for quarantine for detainees detained under the POPOC was too lengthy as the objectives of the 14-day quarantine rule, such as urine tests and procedures employed to ensure contraband articles are not brought into the detention centres, could be achieved in a much shorter period of time.

30. The rehabilitation programme drawn up for young detainees do provide the basal education, work training and rehabilitation aspects. However, certain areas need to be added to elevate it to a healthy custodial environment for young detainees and to ensure conformity with article 10(3) of the International Covenant on Civil and Political Rights (ICCPR) which requires that the essential aim of treatment of prisoners

should be their " reformation and social rehabilitation".

31. The *Pusat Pemulihan Akhlak* Simpang Renggam does not have a policy on prevention of suicides and self-harm. Officers merely use their intuition to identify detainees who are likely to commit suicide, at the reception stage and also during the entire duration of detention of the detainee.

32. There is a lack of experienced staff dealing with young detainees who display suicidal behaviour.

33. Although the PPA Simpang Renggam Internal Inquiry was conducted promptly, it lacked independence as officers of the *Pusat Pemulihan Akhlak* Simpang Renggam conducted the internal inquiry. In addition, the findings of the PPA Simpang Renggam Internal Inquiry were not made public and there was no involvement of the family members of the deceased.

SUMMARY OF THE PANEL OF INQUIRY'S RECOMMENDATIONS

1. Introduce a legal provision setting a custody time limit to avoid an accused person languishing in jail for an excessively long period.

2. Comply strictly with section 117 of the CPC that a remand order can only be granted if "investigation cannot be completed within 24 hours" *and (emphasis added)* there are "grounds for believing that the accusation or information is well founded.

3. That the Police be advised of the circular of the then Chief Justice, Tun Mohamed Dzaiddin bin Haji Abdullah, issued in 2003 advising Magistrates that the onus is upon the Police to satisfy the Magistrate that more time is needed to complete investigations, bearing in mind the obligation to submit a diary of proceedings in investigations under section 119 of the CPC and if remand is necessary, short remand periods are to be given.

4. Amend section 117 of the CPC to provide that the Magistrate who makes a remand order, must be satisfied, that upon material produced by the Police, there is sufficient justification linking the detainee to the offence being investigated.

5. That the Chief Justice issue a circular requiring Magistrates to take into consideration the entire period of remand and inclusive of different remand orders, the remand period should be no more than necessary in each distinct cases. Distinct cases having the nexus of 'in the same transaction' ought to be treated as a single distinct case for purposes of remand.

6. Amend Rule 10 of the Lock-up Rules 1953 to provide that detainees should be given a medical check-up within three days from the day of remand or detention.

7. To send all detainees to the *Pusat Pemulihan Akhlak* Simpang Renggam earlier and in all cases, to arrive at the *Pusat Pemulihan Akhlak* Simpang Renggam before 5.00 p.m.

8. Until the sensor system is put in place, warders record the times of patrolling upon receiving and handing over charge and the number of detainees in the Daily Log Book.

9. To supply warders with torch lights during the night patrols, until dimmers are fixed in the cells.

10. Implement progressively a sensor system for warders, with motion detectors placed around the isolation block. The system would be able to record the number of times the warder patrolled the block and the time and the exact location of the guard. If a warder is lying down or if there is no movement for 20 minutes, an alarm will sound.

11. Hire more warders to be deployed to the isolation block.

12. Implement strictly Rule 297 of the Emergency Ordinance (Public Order and Prevention of Crime) (Detained Persons) Rules 1970, which requires warders to count detained persons at least once every half hour and always on receiving charge of a party, on handing over charge and on leaving any building or work.

13. Provide training to all staff of the *Pusat Pemulihan Akhlak* Simpang Renggam on how to respond in emergency situations, suicides and attempted suicides.

14. Draw up clear procedures which will enable the warders to open the cells as quickly as possible and not to wait for an officer to open the cell. In a situation of attempted suicide, time is of the essence.

15. Allow family members of every death in custody to see the body of the deceased immediately, with a condition that family members are only allowed to see but not touch the body.

16. Inform the next-of-kin in cases of deaths in custody the essential information, including date, time and place of the post mortem examination, the right to be represented by a legally qualified medical practitioner or a legal practitioner or a medical practitioner during the post mortem examination, right of family members to have a second post mortem examination and a thorough explanation, in layman's language of the findings of the post mortem examination.

17. Carry out an initial risk assessment during the reception and registration stage for all detainees, particularly young detainees. Initial risk assessment could take the form of a risk assessment checklist.

18. Provide new young detainees with the usual toiletries, reading material, a radio and information on how they can obtain help and advice anytime.

19. Provide training for all staff, particularly those involved at the reception and registration stage on how to identify high risk and suicidal behaviour.

20. Ensure that the Police convey any suicidal risks, to the *Pusat Pemulihan Akhlak* Simpang Renggam when escorting the detainee.

21. Avoid placing young detainees alone in cells during the quarantine period. Young detainees should always be in shared accommodation with other young detainees save for if the young detainee is violent.

22. Shorten the 14-day quarantine rule for new young detainees detained under the POPOC.

23. Place all new young detainees under close observation by trained personnel during the quarantine period. Inspection of detainees should be carried out at intervals of no greater than 30 minutes.

24. Assess new young detainees individually for suicide risks. Assessment should be carried out by trained personnel and performed during the quarantine period. New young detainees should also be given essential information on how they will be treated and how to obtain help,

25. Include in the orientation phase, a special programme for young detainees on how to adjust to life in the detention centre.

26. Empower the staff with skills to encourage detainees to take up the opportunities available to them and to provide staff with a healthy culture.

27. Select, resource and train staff so that young people in their care can take full advantage of opportunities in custody.

28. Create incentives to encourage young detainees who, at time of admission may be apathetic and lacking in motivation, to participate in and gain from the developmental opportunities available.

29. Adopt a wholistic policy of prevention of suicide and self-harm, which includes:
    i. A commitment to the prevention of suicide and self-harm;
    ii. Instilling amongst all Prison staff and Police personnel that everyone, not only medical officers, has the responsibility to care for the detainees and to identify suicidal behaviour;
    iii. Drawing up different strategies for different groups of detainees;
    iv. Training for all staff and officers on suicide and self-harm prevention;
    v. Implementing a scheme similar to the Listener scheme in the UK;
    vi. Scrutinising cells to remove suicide hotspots;

vii. Providing support and counselling for staff; and

viii. Drawing up a care plan for detainees with suicidal tendencies.

30. Ensure that future internal inquiries in deaths in custody conducted by the *Pusat Pemulihan Akhlak* Simpang Renggam should be conducted by officers from other detention centres or from the Headquarters, Prisons Department, should involve the deceased's family members and/or their legal representatives and its findings must be made public.

31. Amend the CPC to make it mandatory for Magistrates to hold an inquiry into all deaths in custody unless a person has been charged for an offence in respect of the death.

The opinion herein is the unanimous opinion of the following members of the Commission that formed the Panel of Inquiry:

SIGNED

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DATO' HAJI HAMDAN ADNAN
COMMISSIONER, SUHAKAM

SIGNED

……

DATO' SIVA SUBRAMANIAM
COMMISSIONER, SUHAKAM

SIGNED

……

DATO' MUHAMMAD SHAFEE ABDULLAH
COMMISSIONER, SUHAKAM

DATED THE 21ST DAY OF APRIL 2006

APPENDIX 1

WITNESS LIST

17 FEBRUARY 2006 (FRIDAY)

IDENTIFIER	NAME	I.C. NO./ POLICE NO.	DOCUMENTS
IW 1	Inspector Alimuddin Bin Usman	No. Polis: I/15116 D.O.B.: 04/09/1977	P1 P2 P3 P4 P5 P6 P7
IW 2	Mr. Sreedhran a/l Henry	570128-08-5061	P8
IW 3	ASP Wong Yuen Chuan	No. Polis: G/14951	P9
IW 4	ASP Azizan bin Haji Mohd. Isa	No. Polis: G/9363	-
IW 5	Inspector Mohd. Yusrizal bin Mohd Ghazali	No. Polis: I/16040	-
IW 6	Tuan Harmi Thamri B. Mohamad @ Shaharudin	740602-10-5015	-
IW 7	Chief Inspector Ahmad Izuddin bin Mohd. Juhari	No. Polis: I/13435	P10 P11
IW 8	Encik Aritharan a/l Raman	851201-14-5739	P12
IW 9	Inspector Azamudin bin Azim	640123-01-5639	P13
IW 10	Encik Ramesh a/l Subramaniam	811010-01-6399	P14
IW11	Encik Nordin bin Yunus	690225-06-5077	P15
IW12	Encik Abdul Rahim bin Kahar	630827-01-5339	P16

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IW13	Encik Abu Bakar bin Ishak	640612-08-6139	P17
IW14	Encik Lasiman bin Jahim	650308-01-5319	P18 P19
IW15	Encik Kasilingam Nadar a/l Kanipan	760421-14-5219	P20
IW16	Encik Anil Rajagopal a/l Muniandy	810506-14-5843	P21
IW17	Encik Faisal bin Mohd. Husin	Passport N716084	P22
IW18	Encik Zohari bin Hasan	600318-11-5457	P23

APPENDIX 1

18 FEBRUARY 2006 (SATURDAY)

IDENTIFIER	NAME	I.C. NO./ POLICE NO.	DOCUMENTS
IW 19	Tuan Mohd. Zawawi bin Abdul Rahim	620916-03-5367	P24 P25
IW20	Encik Jeffridin bin Yusoff	763003-03-5145	P26
IW21	Encik Mohamad bin Yusoff	701110-03-5039	P27
IW22	Mr. Pang Neng Hua	770521-13-5543	-
IW23	Encik Norazwan bin Mamat	790804-03-5305	P28
IW24	Corporal Md. Aini bin Hassan	570313-08-5653	P29
IW25	Inspector Mohd. Zulkifli bin Che Soh	740624-03-5943	P30
IW26	Dr. Shahidan bin Md Noor	590405-08-5341	P31 P32
IW27	Dr. Benjamin Chan Teck Ming	580901-10-6149	-

APPENDIX 2

LIST OF EXHIBITS

EXHIBIT NO.	DESCRIPTION	NAME OF WITNESS	DATE ENTERED
P-1	Polis Report SPG RENGAM/002773/05 dated 19/11/2005	Alimuddin bin Usman	17/02/06
P-2	*Rajah Kasar Tempat Kejadian* LMM. No: 57/05 (D19)	Alimuddin bin Usman	17/02/06
P-2K	*Kunci bagi* P-2	Alimuddin bin Usman	17/02/06
P-3	*Rajah Kasar Keseluruhan Tempat Kejadian* LMM No. 57/05 (D21)	Alimuddin bin Usman	17/02/06
P-3K	*Kunci bagi* P-3	Alimuddin bin Usman	17/02/06
P-4(a)-(h)	Photographs of S.Hendry taken at the cell	Alimuddin bin Usman	17/02/06
P-4(an) – (hn)	Negatives of photographs of S.Hendry taken at the cell (*Pusat Pemulihan Akhlak* Simpang Renggam)	Alimuddin bin Usman	17/02/06
P-5(a)-(e)	Photographs of S.Hendry taken before the post mortem	Alimuddin bin Usman	17/02/06
P-5(an)-(en)	Negatives of photographs of S.Hendry taken before the post mortem	Alimuddin bin Usman	17/02/06
P-6 (a)	Blanket shown - knotted part of blanket	Alimuddin bin Usman	17/02/06
P-6(b)	Blanket shown - loose part of blanket	Alimuddin bin Usman	17/02/06
P-7	Black bucket (22cm in height)	Alimuddin bin Usman	17/02/06

APPENDIX 2

P-8	Statement of Sreedharan a/l Henry	Sreedharan a/l Henry	17/02/06
P-9 (a)	Semenyih Rpt: 2116/2004	Wong Yuen Chuan	17/02/06
P-9 (b)	Handwritten notes made by Tuan Harmi	Wong Yuen Chuan	17/02/06
P-9 (c)	Semenyih/002797/05	Wong Yuen Chuan	17/02/06
P-10 (a)	*Perintah tahanan*	Ahmad Izuddin bin Mohd. Juhari	17/02/06
P-10 (b)	*Alasan-alasan perintah tahanan*	Ahmad Izuddin bin Mohd. Juhari	17/02/06
P-11	Photographs of victim	Ahmad Izuddin bin Mohd. Juhari	17/02/06
P-12	Statement of Aritharan a/l Raman	Aritharan a/l Raman	17/02/06
P-13	Statement of Azamudin bin Azim	Azamudin bin Azim	17/02/06
P-13A	List of detainees received by *Pusat Pemulihan Akhlak* Simpang Renggam on 18 November 2005	Azamudin bin Azim	17/02/06
P-14	Statement of Ramesh a/l Subramaniam	Ramesh a/l Subramaniam	17/02/06
P-15	Statement of Nordin bin Yunus	Nordin bin Yunus	17/02/06
P-16	Statement of Abdul Rahim bin Kahar	Abdul Rahim bin Kahar	17/02/06
P-17	Statement of Abu Bakar bin Ishak	Abu Bakar bin Ishak	17/02/06
P-18	Statement of Lasiman bin Jahim	Lasiman bin Jahim	17/02/06

P-19	*Buku Pengharian – Pusat Pemulihan Akhlak* Simpang Renggam	-	17/02/06
P-20	Statement of Kasilingam Nadar a/l Kanipan	Kasilingam Nadar a/l Kanipan	17/02/06
P-21	Statement of Anil Rajagopal a/l Muniandy	Anil Rajagopal a/l Muniandy	17/02/06
P-22	Statement of Faisal bin Mohd. Husin	Faisal bin Mohd. Husin	17/02/06
P-23	Statement of Zohari bin Hasan	Zohari bin Hasan	17/02/06
P-24	*Pusat Pemulihan Akhlak* Simpang Renggam Internal Inquiry Report	Mohd, Zawawi bin Abdul Rahim	18/02/06
P-25	Rehabilitation Programme for Young Detainees of the *Pusat Pemulihan Akhlak* Simpang Renggam	Mohd. Zawawi bin Abdul Rahim	18/02/06
P-26	Statement by Jeffridin bin Yusoff	Jeffridin bin Yusoff	18/02/06
P-27	Statement by Mohamad bin Yusoff	Mohamad bin Yusoff	18/02/06
P-28	Statement by Noraswan bin Mamat (Nor Azwan)	Noraswan bin Mamat	18/02/06
P-29	Statement by Md. Aini bin Hassan	Md. Aini bin Hassan	18/02/06
P-30	Statement by Mohd. Zulkifli Che Soh	Mohd. Zulkifli Che Soh	18/02/06
P-31	Post Mortem Report	Shahidan bin Md Noor	18/02/06
P-32	Chemist Blood Analysis Report (To date the Panel of Inquiry has yet to receive the said report)	Shahidan bin Md Noor	18/02/06
	END OF EXHIBITS		