RECOMMMENDATIONS TO

THE COMMITTEE FOR INSTITUTIONAL REFORM

M A Y 2 0 1 8



THE ATTORNEY-GENERAL & THE ATTORNEY-GENERAL'S CHAMBERS



1.1 Separation of the Powers of the Attorney-General and Public Prosecutor

We call for the roles of the Attorney-General and the Public Prosecutor be separated, and for an independent Director of Public Prosecutions (DPP) or a similar post be created to take up the role and powers of Public Prosecutor instead.

We note that the separation of these roles will require legislative effort and time to accomplish, and as such, until this reform is completed, we must impress that any person selected to hold the office of Attorney-General must be politically independent and be of impeccable character. It is imperative that the person is empowered to carry out his or her prosecuting duties without fear of political bias.

In line with this change, the Attorney-General's Chambers (AGC) should rightfully be renamed to reflect the new demarcation of powers, and we suggest this new office be called the Office of Public Prosecutions (OPP), with the Director taking over as the head of the Office. The Attorney-General as a political appointee will maintain oversight (but not control over) over the Office, and will further be accountable to Parliament for the work of the OPP. In this regard, we refer to the structure of the Crown Prosecution Service in the United Kingdom.

In ensuring the accountability of the Attorney-General, we further suggest that the person appointed to the post be made a member of the Cabinet, given the important and sensitive information that he or she will likely be privy to. As such, provision should be made in line with the example set by the United Kingdom for the person to be accountable to Parliament.

1.2 Formulation of Proper Prosecution Policies

We further call for the OPP (or any similar office) to formulate and publish for public viewing the prosecution policies for public prosecutors to be guided by when deciding whether to prosecute a crime. Prosecutors must be bound by the general principles enshrined within these policies, and further have regard to Malaysia's obligations to international conventions.

Under current prosecution practices, the public does not have specific guidance as to what constitutes an offence, particularly when dealing with offences under the Sedition Act 1948, Peaceful Assembly Act 2012, Communications and Multimedia Act 1998 and other laws commonly used for politically-motivated prosecutions. Thus, it is not surprising that the AGC has been accused of practising double standards and selective prosecution in such cases that seem to only affect dissidents and political opponents while those who support the then government are immune from such prosecutions.

We once again recall the example of the Crown Prosecution Service in the United Kingdom, which utilises the Code for Crown Prosecutors¹ as guidance for public prosecutors

¹ The Code for Crown Prosecutors can be accessed at https://www.cps.gov.uk/sites/default/files/documents/publications/code_2013_accessible_english.pdf.

It is pertinent to note that the Code not only clarifies the general principles to which public prosecutors are bound, but it further defines several tests for public prosecutors before deciding whether to prosecute, namely whether there is enough evidence to proceed, and more importantly, whether proceeding with the case is in the public interest.

This is particularly important in the Malaysian context, given the past behaviour of the AGC during trials and appeals in politically-motivated cases. We note from experience that the AGC often displays a culture of prosecuting to win, witholding crucial evidence during criminal trials to ensure that the accused is found guilty. Such conduct goes blatantly against the public interest and is unjustifiable.

Further, in civil cases, the AGC often challenges cases needlessly, particularly those concerning administrative law and abuse of police powers. This is particularly visible in cases involving judicial review (e.g. statelessness), wrongful deaths caused by police assault or shooting (e.g. A. Kugan and Aminulrasyid) and custodial death inquests (e.g Karuna Nithi), where there are no objective reasons to challenge or persistently appeal but the AGC does so regardless. This has led to injustice, a waste of time and public resources, and unnecessarily burdens the administration of justice.

The formulation of these AGC policies will therefore serve to assist public prosecutors and federal counsel in identifying whether pursuing a case further will be in line with their larger responsibilities, as well as provide an instrument with which to hold them to account. We refer to Appendix B of the Australian Legal Services Directions 2017,² which stipulates that the Australian Legal Service acts 'honestly and fairly in handling claims and litigation brought for and against' the government as guidance with which these policies ought to be drafted.

1.3 Separation of the Legal and Judicial Services

The current structure of the Legal and Judicial Service is untenable and may lead to the perception that lower court judges are unduly influenced by the Attorney-General by means of their appointment. Further, it is common practice for judicial officers (magistrates, Sessions Court judges, registrars, etc.) and legal officers (deputy public prosecutors, legal advisers, etc.) to be transferred between either stream.

It is also important to note that legal officers transferred into the judiciary will in general be prosecution-minded, and further may feel apprehension when delivering a decision that is unfavourable to the prosecution should they preside over a case with a more senior public prosecutor present.

We therefore recommend that a separate Judicial Service Commission and a Legal Service Commission be formed, with the former dealing with all matters involving judicial officers and the latter with all matters involving legal officers. The heads of these commissions should be entirely different persons, with the chief registrar of the Federal Court heading the former and the Attorney-General heading the latter. The Director of Public Prosecutions ought also to be considered for a seat on the Legal Service Commission along with other senior legal officers, whereas the Judicial Service Commission can be further comprised of several judges as per current practice.

² The Australian Legal Services Direction 2017 and its Appendix B can be found at https://www.legislation.gov.au/Details/F2017L00369.

Nevertheless, we must impress that the Commissions must also include representatives from the Malaysian Bar and civil society as well, to ensure that it is not wholly made up of individuals from the respective services.

1.4 Public Defender Service

With regards to ensuring that accused persons receive fair representation at trial, we urge the Committee to consider the possibility of a national public defender service to represent persons accused of serious crimes who have been granted legal aid. It is noted that there currently exists a limited legal aid fund, the Yayasan Bantuan Guaman Kebangsaan (YBGK), but it no longer receives funding from the government. As such, we highlight the system implemented by the Australian state of New South Wales,³ where public defenders are answerable to the Attorney-General for carrying out their duties.

The New South Wales Public Defender Service operates at the state level in representing individuals, similar to other state/territory-based legal aid services in Australia. Funding is derived from the Australian Department of Justice and the New South Wales state government, and a yearly report is tendered to the Attorney-General of New South Wales and the state Parliament. A similar system could conceivably be implemented in Malaysia, with the respective heads of the Service reporting to the local state government and the Attorney-General of the federal government.

³ The New South Wales Public Defenders Act 1995 can be found at https://legislation.nsw.gov.au/#/view/act/1995/28.

THE ROYAL MALAYSIAN POLICE



2.1 The Inspector-General of Police

We call for the decentralisation of power within the Royal Malaysian Police (PDRM) as a means of reducing the overbroad powers of the Inspector-General (IGP). In this regard, we advocate following the examples set by other countries including the United Kingdom and Australia, with more discretion and power being ceded to state-level police chiefs and forces for the specific purpose of maintaining intra-state law and order. The federal police force should likewise prioritising the policing of federal territories, inter-state and international crime. In addition, state and federal police forces should be made accountable to the state and federal governments respectively. In this way, state police chiefs will have more independence in investigating crimes within their jurisdictions, and not be held hostage to the finality of the IGP's decisions.

This vertical decentralisation will ensure that there are multiple dispersed sources of authority operating at two different levels of government, and not the current concentration of power in the person of the IGP.

2.2 PDRM Reforms and the Special Branch

We further call for the depoliticisation of the PDRM and a refocusing of their scope of responsibilities towards crime prevention, maintaining public order and national security. It is unacceptable that the Special Branch is used to spy on dissidents or political opponents when it should be focused on genuine threats to national security like terrorism. Safeguards must be put in place to ensure that it cannot be utilised as a political tool ever again. The Special Branch should be focused on ensuring incidents such as the assassination of Kim Jong-nam and Palestinian lecturer Fadi al-Batsh by foreign agents do not occur on Malaysian soil.

It is notable that between 2010 and 2012, the police budget allocation increased by over 40% (from RM 4.5 billion in 2010 to RM 6.3 billion in 2012);⁴ by 2015, this had ballooned to an increase of over 80% from 2010 levels (RM 7.98 billion).⁵ Between 2010 to 2012, however, the Criminal Investigation Department (CID), which carries out the day-to-day criminal investigations of the PDRM only received some 8% of the allocated budget.⁶

Similarly, personnel allocation within the PDRM also reflects an overwhelming preponderance towards non-crime related activities (internal security, public order, Special Branch, etc). Much like their allocated funding, the CID is made up of a measly 9% of the police force, leading one to question the actual focus of the PDRM this entire time. It is absolutely critical that the PDRM budget and personnel be reallocated to reflect their focus on crime-fighting.

https://www.malaysiakini.com/news/317294. Accessed 19 May 2018.
6 Ibid.

⁴ 'Police personnel poorly utilised in crime fighting'. (Malaysiakini, 21 July 2012). https://www.malaysiakini.com/news/204254. Accessed 19 May 2018.

⁵ 'Police do more spying than fighting crime, decries MP'. (Malaysiakini, 27 October 2015). https://www.malaysiakini.com/news/317294_Accessed 19 May 2018

2.3 Release of Standard Operating Procedure & Inspector-General's Standing Orders

We also recommend that in line with international practices,⁷ the PDRM should release to the wider public any Standard Operating Procedure (SOP) documents dealing with their daily conduct, as well as the classified Inspector-General's Standing Orders (IGSOs). This will allow for more accountability of police action particularly during incidents of custodial deaths, fatal police shootings, and other abuses of power.

We wish to further note that we do not support the classification of the IGSOs under the Official Secrets Act, having seen these documents tendered in court previously. Being official guidelines for police personnel, we see no reason why these documents must remain classified; if absolutely necessary, portions dealing with sensitive information can be redacted, with the justification for doing so clearly stated and where it is possible to retrieve this information if needed.

It has been our experience from dealing with previous cases that although these SOPs and IGSOs exist, they are rarely followed by police officers, with some commenting that these documents are often kept under lock and key by a senior police officer due to their classified nature. Unable to refer to them, this often leads to ad-hoc procedures within various police stations or district headquarters that can run contrary to the SOPs and IGSOs. This culture of non-adherence must come to an end for public trust to be restored in the PDRM.

2.4 Remand Process Reforms

In addition to the above, we welcome changes to the remand process as called for by the Malaysian Human Rights Commission (SUHAKAM) in their 2002 report⁸ to ensure that it cannot be abused any further in line with the publishing of SOPs and IGSOs. The current process is such that the police do not necessarily investigate their suspects and build a case prior to arresting and remanding them. While this does not happen in all cases, it is certainly not uncommon.

This is also reflective of the issue of chain remand and abuse of power in continuing to detain a suspect for multiple offences which may be unconnected to the person. We recall the case of S. Balamurugan, who died in police custody after being tortured by a police officer who attempted to force a confession out of him. It is notable that after Balamurugan was ordered to be released by the Magistrate who refused the police remand application upon seeing him clearly unwell and with blood on his mouth, he was taken back to the police station where officers fabricated other charges to keep him in custody. The sheer impunity with which the police decided to fix him up and disregarded a court order

⁷ An example of Scotland Police Policy and Standard Operating Procedures can be found at http://www.npcc.police.uk/documents/FoI%20publication/Disclosure%20Logs/Uniformed%20Operations% 20FOI/2012/093%2012%20%20Att%2001%20of%201%20Management%20Command%20and%20delpyment%2 0of%20Firearms%20Officers.pdf.

⁸ 'Rights of Remand Prisoners'. (SUHAKAM, 2002).

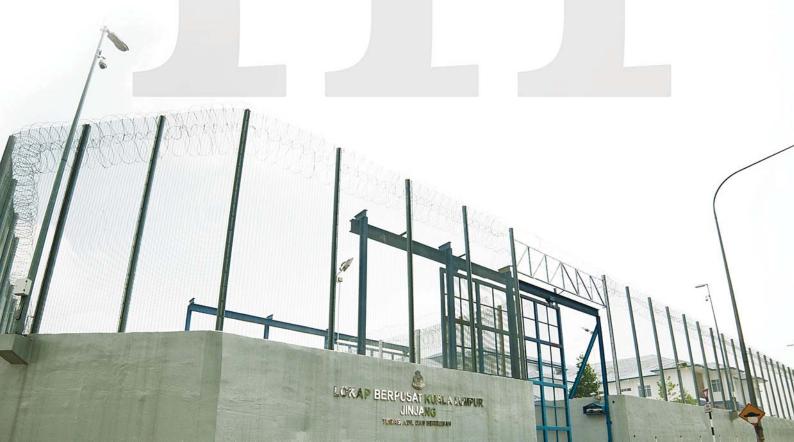
https://drive.google.com/file/d/0B6FQ7SONa3PRUEg5WURGNnVBWTQ/view. Accessed 21 May 2018.
⁹ 'Kenyataan Media Dapatan Siasatan EAIC Ke Atas Kematian S. Balamurugan Semasa Dalam Tahanan Polis'.
(EAIC, 18 January 2018).

http://www.eaic.gov.my/sites/default/files/kenyatan_media_eaic_siasatan_kematian_s._balamurugan.pdf.

is chilling, as is the fact that Balamurugan's case is not an exception but is rather the rule in cases of chain remand.

As such, we exhort the Committee to explore the possibility of implementing policy reforms in the PDRM to ensure that suspects are thoroughly investigated prior to arrest, and for the PDRM to only utilise their remand power if they are certain that they cannot carry out investigations if the person is not in custody. There must also be an end to the practice of chain remand.

DEATHS CAUSED BY LAW ENFORCEMENT AND DETENTION AUTHORITIES



According to PDRM statistics, between 2000 to 2014, a total of 255 deaths in police custody were reported, leading to an average of 17 deaths per year in police custody. When added to the number of deaths reported in prisons (1654 deaths reported between 2010 and February 2017) and in immigration detention centres (82 deaths in 2015 and at least 35 deaths in 2016), it is clear there is an endemic problem that is deeply rooted amongst law enforcement and detention authorities that must be investigated thoroughly, beginning with the PDRM.

3.1 Independent Police Complaints and Misconduct Commission

We call for the immediate formation of the long-demanded Independent Police Complaints and Misconduct Commission (IPCMC) in order to investigate police abuse of power and in particular deaths in custody, as recommended by the Royal Commission report for police reform in 2005. While the Enforcement Agency Integrity Commission (EAIC) currently plays a role in investigating these cases, with their limited resources and the 21 agencies (including the PDRM) that they are currently monitoring, they are severely overstretched and unable to carry out their duties effectively. Further, the bulk of their work stems from complaints related to the police force, with 80% (or 440 complaints) of the total complaints lodged in 2017¹³ relating to the PDRM alone. Thus, it is prudent for the IPCMC to be formed to take on police oversight specifically, while the EAIC continues its current role with the other 20 agencies.

It is pertinent that both the IPCMC and EAIC be given all necessary powers in order to carry out their duties. In the case of the IPCMC, it is equally important to authorise peremptory powers to initiate investigations on their own without receiving complaints of police misconduct. Further, IPCMC and EAIC recommendations should be binding upon the respective agencies, with the PDRM to institute the necessary disciplinary action and the AGC to prosecute any officers found responsible for criminal wrongdoing. In addition to the above, it is necessary that all previous SUHAKAM and EAIC recommendations from previous investigations be enforced.

3.2 Procedural Changes When Investigating Deaths & Post-Mortem Reforms

All deaths in custody should be investigated via an inquest in order to have the circumstances of the deaths uncovered. It is notable that according to PDRM statistics, the bulk of deaths while in their custody come from health issues (207 cases). Leven if this is to be believed, it is necessary that investigations be carried out to identify why these health

¹⁰ 'Deaths in Police Custody: A Thematic Study on Lock-Up Conditions And Factors Contributing To The Death'. (SUHAKAM, 2016). https://drive.google.com/file/d/0B6FQ7SONa3PRMIJNUGRvbmRqX3M/view. Accessed 20 May 2018.

[&]quot; 'Over 1,600 deaths in custody since 2010, DPM reveals'. (The Malay Mail Online, 13 March 2017). https://www.malaymail.com/s/1333815/over-1600-deaths-in-custody-since-2010-dpm-reveals. Accessed 20 May 2018.

¹² 'Exclusive: More than 100 die in Malaysian immigration detention camps in two years'. (Reuters, 30 March 2017). https://www.reuters.com/article/us-malaysia-detention-deaths-idUSKBN1710GR. Accessed 20 May 2018.

¹³ 'EAIC: Policemen received the highest number of complaints'. (New Straits Times, 18 April 2018). https://www.nst.com.my/news/nation/2018/04/358803/eaic-policemen-received-highest-number-complaints. Accessed 20 May 2018.

issues could develop in the first place, and whether they were caused by police negligence or mistreatment. The PDRM cannot be entrusted to carry out their own internal investigations into the matter, lest they attempt to exonerate themselves and the deaths are instead covered up.

This same standard should apply to immigration detention centres and prisons when investigating deaths in custody. A staggering number of deaths are reported year in and year out due to 'health issues' is indicative of deeper problems, whether due to cramped and unsanitary conditions, a lack of clean drinking water, food, or healthcare provided, or if this is merely being used as a pretext to cover up wrongdoing and torture. The fact that these issues are not being investigated runs contrary to international practice, where any death in custody would be likely to provoke outrage and serious investigations into the matter.

It is also critically important that the post-mortem system be reformed to ensure that pathologists are fully independent and trained to identify signs of non-natural deaths. It has been our experience from dealing with previous death in police custody cases that post-mortem reports are generally unreliable, and pathologists seek to exonerate the police of wrongdoing – as was particularly clear in cases such as A. Kugan, Karuna Nithi, C. Sugumar, and S. Balamurugan to name a few.

We further note that pathologists are often misled by the police or fail to consider the suspicious circumstances of many deaths, leading to grave errors of judgement, or worse yet, active connivance to suppress PDRM misconduct. In addition, where outcomes do indeed find evidence of foul play, the Ministry of Health has previously convened panel of experts who attempt to downplay the post-mortem report or the Coroner's verdict by means of submitting their own version of it (as evidenced in A. Kugan and Karuna Nithi).

The current practice of family members of the deceased, lawyers, members of Parliament and civil society congregating at the morgue to ensure the post-mortem is carried out correctly and further requesting a second post-mortem if dissatisfied, speaks volumes about the lack of credibility of the post-mortem system and how it has been severely compromised.

We recommend subjecting post-mortem reports to an auditing process as called for by the Shipman Inquiry in the United Kingdom.¹⁵ A second tier of certification by a panel of independent pathologists from different hospitals should be established when post-mortem reports are compiled; this panel may also be responsible for performing retrospective checks on previous post-mortem reports, particularly given the suspicious conclusions of some in previous years.

3.3 Reforms to the Present Inquest System

Section 334 of the Criminal Procedure Code (CPC) states that in the event of a death in state custody, an inquiry must be opened into the matter, with the present system being

http://webarchive.nationalarchives.gov.uk/20090808155110/http://www.the-shipman-inquiry.org.uk/reports.asp.

that of an inquest. This seemingly-robust legislation, however, has never been applied properly - it is notable that in the period between 2000-2004, inquests were only held into 6 of 80 deaths in police custody, ¹⁶ and more worryingly, in 22 other cases, the inquest was deemed unnecessary by either the Magistrate or DPP. This selective opening of inquests in direct contravention of the law, coupled with poor investigation and prosecution practices by both the police and the AGC allowed for many offenders to escape justice, leading to widespread dissatisfaction with the inquest system. Subsequently, following an announcement by then-Minister Nancy Shukri and a Practice Direction from the Chief Justice in April 2014, ¹⁷ the current Coroner's Court was established to deal with deaths in custody (and other cases of suspicious death).

In reality, however, the new Coroner's Court is merely a reskinned version of the previous inquest system, with the only real change being that cases are now heard by selected Sessions Court judges as opposed to magistrates. The previous Practice Direction on inquest guidelines was reproduced verbatim as guidance for the Coroner's Court, reinforcing the fact that nothing has changed. It is not the coroner who carries out the investigation but the police themselves (leading to a serious conflict of interests), and the DPP who conducts the proceedings during the inquest. As we have noted above, both parties are largely complicit in a culture of cover-up, with the AGC more likely to act akin to a defence lawyer for the police (or other detention authorities in the inquest) as opposed to genuinely facilitating the inquest in the public interest.

As such, it is necessary to break the monopoly of the police investigating themselves and empower the coroner to carry out his or her responsibilities as opposed to merely acting like a judge and relying wholly on the police and DPP in the investigations and direction of the inquest (who to call and what evidence to tender). To resolve this, we suggest that a comprehensive Coroner's Act be enacted, taking into account best practices from the UK as guidance.

3.4 Coroners' Act

In light of the above and the continued inaction of authorities over unfavourable inquest decisions, reform to the coroner system is necessary to set out the coroners' responsibilities and powers and ensure that their verdicts are taken seriously. In this regard, we highlight the UK's Coroners and Justice Act (CJA) 2009¹⁸ as an example of legislation to guide the enactment of a Coroners' Act here.

Much like section 334 of the CPC, the CJA 2009 mandates that coroners who are made aware of the body of a deceased person within their jurisdiction must open an investigation

¹⁶ 'Report of the Royal Commission to Enhance the Operation and Management of the Royal Malaysia Police'. (Royal Commission, 2005). https://www.refsa.org/announcement/2005-report-of-the-royal-commission-to-enhance-the-operation-and-management-of-the-royal-malaysia-police/. Accessed 6 June 2018.

¹⁷ 'Arahan Amalan Bil 2 Tahun 2014 Pengendalian Siasatan Kematian (Death Inquiry) Selaras dengan Penubuhan Mahkamah Khas Koroner'. (Office of the Chief Registrar Federal Court of Malaysia, 8 April 2014). http://www.malaysianbar.org.my/index.php?option=com_docman&task=doc_details&gid=4500&Itemid=332. Accessed 4 June 2018.

¹⁸ The Coroners and Justice Act 2009 can be found at https://www.legislation.gov.uk/ukpga/2009/25/contents

into the death if "the deceased died a violent and unnatural death...the cause of the death is unknown, or...the deceased died while in custody or otherwise in state detention." In this scenario, the UK's Crown Prosecution Service website further notes that "...there is one circumstance where the coroner will have automatic jurisdiction (power to exercise their function): where a death caused by natural causes occurs in a prison or other place of 'custody'. These cases will automatically be referred to the coroner for an inquest and will be held with a jury present."

Although it falls to the coroner in the UK to conduct the inquest (and order a post-mortem examination), it is the duty of the Independent Office for Police Conduct (formerly the Independent Police Complaints Commission) to conduct investigations into the death in police custody, and the Prisons and Probation Ombudsman if the death occurs in prison, and upon conclusion, submit their reports and information to the coroner for the inquest to proceed. Likewise, we propose that the IPCMC (for police custodial deaths) and the Enforcement Agency Integrity Commission (for deaths in immigration detention centres and prisons) be given the same investigative roles and authority within the Malaysian context to assist the coroner.

As further guidance for coroners conducting their investigations, the UK enacted the Coroners (Investigations) Regulations 2013. Amongst other things, regulation 16(2) dealing with post-mortem reports notes that "unless authorised in writing by the coroner, the suitable practitioner who made the post-mortem examination may not supply any other person with the post-mortem examination report or any copy of that report." This ensures that the coroner deals directly with the pathologist, minimising the possibility of police interference in the post-mortem report.

Additionally, Part 7 of the 2013 regulations details further the coroner's powers post-investigation to publish a report on action to prevent other deaths and send a copy of the report to the Chief Coroner and other interested/relevant parties. Further, the recipient of the report from the coroner is obliged to respond within 56 days from the date on which the report is sent, detailing any actions taken or proposed as a result of the report as well as a timetable detailing the implementation of these actions, or a justification as to why no action is proposed. This response in turn must be sent to the Chief Coroner, as well as any other interested/relevant parties that the coroner deems fit.

We also wish to reiterate that an inquest is a fact-finding exercise and should not be adversarial; in Malaysia, however, it has become as such due to the actions of the police and the AGC. Often, lawyers for the family of the deceased are forced to cross-examine witnesses (which often includes pathologists) in order to extract the truth. It is necessary to return to this original purpose, and we highlight the inquest practice in the UK, where the coroner is the one questioning witnesses during a proceeding (followed by family members of the deceased and any members of the public).

In the interests of facilitating the inquest proceedings, special powers ought to be provided to the relevant officers of the IPCMC and EAIC to assist the coroner, who throughout the course of their investigations into the death will have become familiar with

¹⁹ The Coroners (Investigations) Regulations 2013 can be found at http://www.legislation.gov.uk/uksi/2013/1629/regulation/16/made.

the case. Further, given their independent stance, they will be far less likely to have a conflict of interests in assisting the inquest.

3.5 Internal Culture of Cover-Up within PDRM & AGC

We also note that reforms will be required with regards to the culture of cover-up entrenched within the PDRM. As has been noted previously in the Royal Commission of Inquiry into the Death of Teoh Beng Hock, there exists a 'blue wall of silence' amongst the police, who are often loath to break ties of brotherhood in criminal investigations against one of their own, and as a result frustrate the administration of justice. In the few cases where abuses are too serious to cover-up, only lower-ranked scapegoats are often charged whilst the higher-ups get away scot-free, as evidenced for example in the death of A. Kugan where only a constable was changed when more than a dozen police officers were involved in his interrogation. As a result, most offenders go unpunished.

Even in high-profile cases resulting in deaths, the outcome is often an outrage of justice. We note the criminal case concerning the death of N. Dharmendran, in which poor standards of investigation and/or prosecution or a combination of both resulted in the acquittal of four policemen of murder. They were also not found guilty of lesser charges.

We further call for action to be taken on all previous inquest decisions. We note that in cases such as Karuna Nithi, C. Sugumar, and a few others, Coroner findings that the policemen are culpable for the deaths of these individuals have been ignored, and the AGC nor the PDRM have ever attempted to charge or identify those responsible. Below are four cases in which inquest decisions warranting further action have been ignored:

Karuna Nithi was a 42-year-old Indian male who died on 1 June 2013 while being remanded at IPD Tampin, Negeri Sembilan. Throughout his time in the lockup (he was remanded for three days), he was beaten by other inmates and police officers and displayed mentally abnormal behaviour. Despite having 49 injuries including a broken jaw, the post-mortem attributed his cause of death to 'fatty change of the liver'. However, the post-mortem report was subsequently discredited during the inquest, and in June 2015, Coroner Jagjit Singh found the police and other inmates both directly and indirectly responsible for his death. In the years since, the AGC reopened the inquest under the pretext of new evidence (the coroner's verdict ultimately remained unchanged), applied to the High Court for a revision (but was dismissed), and are now appealing to the Court of Appeal. No action has ever been taken on the part of the police or the AGC to identify and prosecute those responsible despite the coroner's findings.²⁰

Chelladury Sugumar was a 39-year-old Indian male who died on 23 January 2013 after being apprehended violently by police after running amok in Hulu Langat, Selangor (the deceased was mentally unsound). After being chased by the public and police officers for over two kilometres, Sugumar was forced to the ground by a

²⁰ 'High Court upholds coroner's findings on custodial death of Karuna Nithi' (FMT, 9 October 2017). http://www.freemalaysiatoday.com/category/nation/2017/10/09/high-court-upholds-coroners-findings-on-custodial-death-of-karuna-nithi/. Accessed 6 June 2018.

policeman, handcuffed twice as a policeman sat on his back, and another policeman stepped on his neck until he stopped struggling. Sometime during this apprehension, he died, and his nearly-naked body was left by the side of the road for over four hours by the police. In addition, curry powder was found smeared on his face. No attempt was ever made to resuscitate him or to send him to the hospital. Despite the circumstances surrounding his death, the pathologist concluded he had died of 'coronary artery disease'. In March 2015, Coroner Rozi Bainon found that the police were responsible for the death given the unnatural way he had died.²¹ Nevertheless, no action has ever been taken by the police or the AGC to identify and prosecute those responsible despite the coroner's findings.

Sasikumar Selvam was a 22-year-old Indian male prisoner in Kluang Prison, Johor who was found dead hanging from an air vent grill on 22 May 2015. His death took place under suspicious circumstances, given that he had provided evidence of a drug racket within the prison to the prison authorities. A statement from the Prisons Department²² declared that there was no foul play involved in his death. However, in November 2017, Coroner Kamarudin Kamsun presiding over the inquest into Sasikumar's death ruled that it was a homicide,²³ and that the pathologist's post-mortem findings were suspect and not backed up by evidence. Since then, no action has ever been taken by the police or the AGC to identify and prosecute those responsible despite the coroner's findings.

Chandran Perumal was a 47-year-old Indian male who died in IPD Dang Wangi lockup on 10 September 2012 (he had been remanded for four days). During the inquest, it was discovered that during the remand application, the magistrate's order to an inspector to attend to Chandran's medical needs was ignored. At the time, he was suffering from hypertensive heart disease which was exacerbated by the police not providing him with the appropriate care or taking him to the hospital for treatment. Further, when the deceased's widow informed police officers at the lockup that her husband required medicine for his condition, she was bizarrely told that the police have medicines of their own. In January 2015, Coroner Ahmad Bache found the police responsible for the death by failing to provide him with medical assistance.²⁴ No action has ever been taken on the part of the police or the AGC to identify and prosecute those responsible despite the coroner's findings.

Worse still, in various inquests, the conduct of the deputy public prosecutors has run contrary to their mandate as the guardian of public interest, often acting akin to defence lawyers for the PDRM or pathologists when the conclusion of the post-mortem report is seriously challenged. This is made clear in their conduct in

²⁰ 'High Court upholds coroner's findings on custodial death of Karuna Nithi' (FMT, 9 October 2017). http://www.freemalaysiatoday.com/category/nation/2017/10/09/high-court-upholds-coroners-findings-on-custodial-death-of-karuna-nithi/. Accessed 6 June 2018.

²¹ 'Coroner rules police responsible for security guard Sugumar's death'. (The Star, 6 March 2015). https://www.thestar.com.my/news/nation/2015/03/06/coronors-court-sugumar/. Accessed 6 June 2018.

^{22 &#}x27;No foul play in Sasikumar's death - Prisons Department'. (The Malaysian Times, 2 June 2015). http://www.themalaysiantimes.com.my/no-foul-play-in-sasikumars-death-prisons-department/. Accessed 31 May 2018.

the Karuna Nithi inquest, which found the PDRM responsible for the death and the post-mortem report unreliable.

The Karuna Nithi inquest was reopened at the behest of the deputy public prosecutor on the pretext of 'new evidence' being submitted in the form of the Ministry of Health panel of experts' report, but the Coroner disagreed and upheld his original verdict. Being dissatisfied with the outcome, the deputy public prosecutor appealed the inquest verdict to the High Court where it was dismissed, and being dissatisfied once again, has appealed further to the Court of Appeal. The conduct of the deputy public prosecutors in the handling of the inquest and appeals make clear that the AGC is more interested in exonerating the police and the pathologist as opposed to finding out the true cause and circumstances surrounding the death of the deceased.

This deep-rooted culture of cover-up is seriously troubling. The deputy public prosecutors should be seeking to identify and charge those responsible for the deaths, not protect them. We call urgently for such conduct to be reversed, and for the AGC to carry out their duties independently, fairly and professionally.

3.6 Reforms in All Places of Detention: Lock-Ups, Prisons and Immigration Detention Centres

There is a need to see overall improvements in the conditions of all places of detention. It is imperative that places of detention are no longer seen and used as a punitive tool where living conditions of detainees are deliberately made harsh and difficult as they are already being punished by the incarceration. By improving these conditions, we will see a significant drop in the number of deaths caused by health issues (which are attributed to overcrowding and lack of access to clean drinking water, nutrition and healthcare).

Other issues that merit attention include the lack of working CCTVs in detention centres, or even the existence of 'dummy' CCTVs. This failing leaves detainees dangerously open to physical abuse and torture, whether by other detainees or the detaining authorities. We also highlight allegations of detainees forced to drink toilet water in immigration detention centres²⁵ as extremely worrying and in dire need of immediate remedial action. Further, we note that despite the budget allocation by the Ministry of Home Affairs for detainees' food, what is often received at the end of the day, is normally of poor quality, leading one to question how these funds are being utilised.

As such, we fully support SUHAKAM's 2017 report on prison reform²⁶ and generalise the recommendations within to be applied to all places of detention. These reforms include making the Ministry of Health responsible for ensuring adequate healthcare is available for all detainees and immunised from infectious diseases if necessary. Likewise, the Ministry of Home Affairs must allocate funds and resources accordingly to ensure the nutritional needs of detainees are met; that the overall detention conditions are improved: better toilets and bathing facilities, sanitation, clean drinking water, ventilation, bedding etc.

²⁵ 'Refugees describe death and despair in Malaysian detention centres'. (The Guardian, 16 May 2017). https://www.theguardian.com/world/2017/may/16/dozens-of-

refugees-have-died-in-malaysian-detention-centres-un-reveals. Accessed 22 May 2018.

²⁶ 'The Right to Health in Prison'. (SUHAKAM, 2017).

https://drive.google.com/file/d/0B6FQ7SONa3PRZXNaejlsZktQWTg/view. Accessed 22 May 2018.

Overcrowding in detention centres must be urgently addressed. The Immigration Department must ensure that detainees are processed as quickly as possible to prevent them being held for extensive periods of time.

Lastly, the laws and regulations governing places of detention including the Lock-Up Rules 1958, Prison Act 1995, Immigration Regulations (Administration and Management of Depots) 2003 etc. are outdated and must be amended to reflect international standards of detention, and we encourage the Committee to be guided by European standards in this regard.





Unit A-1-1, Block A, 8 Avenue Jalan Sungai Jernih 8/1 Seksyen 8, 46050 Petaling Jaya Selangor, Malaysia

Tel: +603-7960 4537, +603-7960 5688 Fax: +603-7960 6688 Email: admin@lawyersforliberty.org

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rights, the value of individual human dignity, and equal treatment and fairness as the foundation of a democratic and just society.





