

THE PREVENTION OF DEATHS IN POLICE CELLS

by

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LIST OF ABBREVIATIONS

ACHPRC	: African Charter on Human and Peoples' Rights
ECHR	: European Convention on Human Rights
ICCPR	: International Covenant on Civil and Political Rights
ICD	: Independent Complaints Directorate
IPCC	: Independent Police Complaints Commission
IPID	: Independent Police Investigative Directorate
JCHR	: Joint Committee on Human Rights
PACE	: Police and Criminal Evidence
SAPS	: South African Police Service
UDHR	: Universal Declaration of Human Rights
UN	: United Nations
UNISA	: University of South Africa

DECLARATION OF AUTHENTICITY

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I, Lazarus Makgopa, declare that THE PREVENTION OF DEATHS IN POLICE CELLS is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

SIGNATURE

(Lazarus Makgopa)

DATE

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THE PREVENTION OF DEATHS IN POLICE CELLS

Abstract

The research question of this study is to determine what circumstances and conditions contribute to deaths in police cells. The study was undertaken in order to establish the causes of deaths in police cells and the factors which contribute thereto, as well as to determine the best international practices to prevent deaths in police cells. The literature was reviewed in order to establish the extent to which this phenomenon has been researched in South Africa and in other countries and to determine the regulatory framework related thereto. The researcher had collected data from the dockets relating to deaths in police cells which were kept at the IPID provincial offices in Gauteng and Limpopo. The data were collected by using the docket analysis schedule and were categorised into themes during the analysis process. Four causes of deaths in police cells were identified, namely, suicide, natural causes, assault by fellow detainees and injuries which were sustained prior to detention. Suicide is the leading cause of deaths. The second leading causes of deaths in police cells are natural causes and assault by fellow detainees. Deaths as a result of injuries sustained prior to detention came third. The most common ligatures which were used to commit suicide are shoe-laces, belts and strips torn from clothing and bedding items. The preferred ligature points are the burglar proof bars on cell windows. Booted feet and hands were the most common instruments used to inflict fatal injuries on the detainees. It was also found that police officials are generally not complying fully with the standing orders which regulate the management of people who are detained in police cells. The failure of police officials to comply fully with the standing orders on custody in police cells contributed to the deaths of detainees in police cells. Recommendations are made to prevent the deaths of detainees in police cells.

Key terms:

Causes of deaths; custody officers; deaths in police cells; detention facilities; docket analysis; investigation of deaths; ligatures; persons in police cells; police cells; police officials; post mortem, prevention of deaths.

CHAPTER 1 GENERAL BACKGROUND TO THE STUDY

1.1 Introduction

Research seeks to bring about a better understanding of a phenomenon of interest to us and generates more knowledge about a phenomenon being studied. This knowledge is obtained through a process that entails the identification of a problem to be studied, the collection, analysis and interpretation of data as well as the reviewing of literature relating to the phenomenon being studied. This chapter serves as an introduction to the study “The prevention of deaths in police cells”.

This chapter sets out the research problem which is addressed and outlines the aim and objectives of the research. It provides further explanations of the procedures which were followed relating to data collection, data recording, as well as data analysis and interpretation. It also makes provision for the timeframe and geographical demarcation of the study. Lastly, this chapter also addresses the ethical issues of the study as well as the organisation of the dissertation.

1.2 Definitions of key concepts

1.2.1 Detention facility

According to the South African Police Service (2003:2), a detention facility refers to “a police cell, lock-up or a temporary detention facility which is controlled by the police service”.

1.2.2 Police cell

This concept primarily refers to a cell which accommodates the detainees who have not yet made their first appearance in court (Hounmenou, 2010).

1.2.3 Person in police cells

A person in police cells is a person who has been arrested and kept in the custody of the police service and who has not yet been transferred to the Department of Correctional Service or any other institution for detention (South African Police Service, 2003).

1.2.4 Detained person

The United Nations (1988:2) defines a detained person as “any person deprived of personal liberty except as a result of conviction for an offence”.

1.2.5 Death in police cells

This phrase refers to the death of a person which occurs while such person is detained at the detention facility of the police (Norfolk, 1998, Independent Complaints Directorate, 2010).

1.2.6 Docket

A docket is a case file which is kept by the police and which contains all relevant information relating to the investigation of crime (Mistry, Snyman & Van Zyl, 2001, South African Law Commission, 2011).

1.2.7 Docket analysis

Docket analysis means “the analysis of information contained in the police docket” (South African Police Service, 2011:130).

1.3 Research problem

The phenomenon of death in police cells regularly features in the printed and electronic media in South Africa, for example, Hosken (2011:3) reports that a woman “committed suicide” by hanging herself in the cells of Pretoria North police station. In another example, it was reported that four awaiting-trial prisoners allegedly killed another prisoner inside Ritavi police holding cells in the Limpopo Province (Maponya, 2011). A further case was reported by Moodley (2011) in which it was mentioned that the Independent Complaints Directorate (ICD) was investigating the circumstances surrounding the death of a man who allegedly hanged himself in the cells of Douglasdale police station in Randburg, Gauteng Province. The name of the ICD has been changed due to the new Independent Police Investigative Directorate (IPID) Act introduced in 2011. Therefore, pre-2011 references will refer to ICD and post-2011 references to IPID. Another case which made international headlines is the one in which a taxi driver of Mozambican nationality died in the cells of Daveyton police station, Gauteng Province, after the police dragged him at the back of a police vehicle to the police station (Faull, 2013). The deceased was found dead in the police cell two hours after his detention and autopsy results indicated that he died as a result of a lack of oxygen to the brain which was consistent with severe internal bleeding (Faull, 2013).

It is an undisputable fact that people die while in police cells in South Africa, but this phenomenon is not unique to South Africa. Although it is difficult to establish at the moment how high South Africa ranks in this regard in the world, it can be assumed that the incidence of

death in police cells in South Africa is relatively higher than those of other countries such as Australia, Malaysia and England and Wales (McDonald, 1996, Inquest, 2011, Georgatos, 2011). Such comparison is difficult to make due to the manner in which each country compiles its statistics and reports on deaths in custody. This is evident from the statistics discussed below. In the three year period covering the financial years 2007/2008, 2008/2009 and 2009/2010, there were 895 incidences of deaths in police cells in South Africa.

Georgatos (2011) alleges that 2056 people died in prison and police custody in Australia from 1980 to 2008 with 63% or 1295 of these deaths occurring in prisons. This means that 37% or 761 deaths occurred in police cells over a 28 year period. According to McDonald (1996), there were between 60 and 70 deaths in Australian police cells in the period January 1 1980 to May 31 1989. In Malaysia, there were a total of 144 deaths in police custody in the period 2009 to February 2010 (Kaur, 2011). In South Carolina, 25 people died in police custody in the period April 1 2009 to March 31 2010 (Kaminski & Pinchevsky, 2010). However, it should be noted that these figures include deaths as a result of police action and not only deaths in police cells which is the focus of this research study. Although it is impossible to compare the number of deaths in police cells in South Africa with the rest of the world, it is clear that one death in police cells is one too many.

The information relating to deaths in police cells in pre-democracy South Africa is not readily available, probably due to the manner in which access to information was strictly controlled. However, unverifiable reports indicate that 74 detainees died in police cells during apartheid with the first death reportedly having occurred in 1971 and the last death occurring in 1990 (The Times, n.d, Censorbugbear, n.d). There is therefore no way to determine if there is an increase or decrease in the number of deaths in police cells since the end of apartheid. The Independent Complaints Directorate [ICD], which exercises civilian oversight over the conduct of the police in South Africa, is tasked to investigate incidences of deaths in police cells (Masuku, 2004). According to the ICD (2009a), a total of 301 incidences of deaths in police custody have been recorded in the financial year 2007/2008 from 1 April 2007 to 31 March 2008. The ICD (2009b) recorded a total of 300 deaths in police custody in the financial year 2008/2009 between 1 April 2008 and 31 March 2009. In the financial year 2009/2010, the ICD (2010) received 294 complaints relating to deaths in police cells. These figures are shown below in table 1.1 and table 1.2. Table 1.1 shows national figures over 3 years covering the 2007/2008, 2008/2009 and 2009/2010 financial years and table 1.2 depicts the provincial figures for the 2008/2009 and 2009/2010 financial years.

Table 1.1 : National figures on deaths in police cells from 2007 to 2012

Financial year	2007/2008	2008/2009	2009/2010	2011/2012
Total incidences of deaths	301	300	294	232
Drop/Rise in %		0%	-2%	-26%

ICD (2009, 2010, 2012)

The figures in table 1.1 above indicate that the incidences of death in police custody for the financial years 2007/2008 and 2008/2009 remained nearly the same and that there was a substantial decline for the 2011/2012 financial year..However, the incidences of deaths in police custody declined by 2% in the financial year 2009/2010 from 300 to 294. The 2011/2012 ICD Annual Report indicates in general terms that 720 people died in police custody and as a result of police action. A media statement issued by the ICD revealed that the deaths in police custody declined further to 232 which constitute a 26% decrease when compared to the 2009/2010 financial year (Independent Complaints Directorate, 2012, Independent Complaints Directorate Media Statement 01 March 2013). The figures in table 1.2 below show that most complaints of deaths in police custody in the 2008/2009 financial year were recorded in Gauteng Province, with a total of 64 deaths followed by Kwazulu-Natal and Eastern Cape with a total of 57 and 47 respectively (ICD, 2009). Figures in table 1.2 show that 60 incidences of deaths occurred in Kwazulu-Natal, followed by Gauteng with 57 incidences and Eastern Cape with 37 incidences in the financial year 2009/2010 (ICD, 2010).

Table 1.2: Provincial figures on deaths in police cells from 2008 to 2010

Province	2008/2009	2009/2010	Drop/Rise (actual numbers)
Eastern Cape	47	37	-10
Free State	18	21	-3
Gauteng	64	57	-7
Kwazulu-Natal	57	60	+3
Limpopo	28	24	-4
Mpumalanga	20	32	+12
North West	28	24	-4
Northern Cape	9	8	+1
Western Cape	29	31	-2

ICD, (2009, 2010)

An average of 294 people lost their lives in police cells over a 3 year period from 1 April 2007 to 31 March 2010 (ICD, 2009, ICD, 2010). This is higher than in England and Wales, where 933 people died in custody of the Metropolitan Police and other forces between 1990 to 2011 (Inquest, 2011). Of the 294 deaths mentioned above, 38 of them occurred in the period between April 2003 and March 2004 (Joint Committee on Human Rights, 2004). In England and Wales, the responsibility of investigating deaths in police cells rests with the Independent Police Complaints Commission [IPCC] (Joint Committee on Human Rights, 2004). The figures in South Africa are also higher than those of Australia where between 60 and 70 deaths in police cells occurred each year from 1980 to 1989 (McDonald, 1996).

The deaths of people in police cells are attributed to four main causes namely, injuries sustained in custody, injuries sustained prior to custody, natural causes and suicides (ICD, 2009, Morgan, 1996). Negligence on the part of the police was also identified as a contributory factor to death in police cells, as was intoxication that led to people in the police cells committing

suicide (Ryan, 1996, Bruce, 1997). It has been noted that where the cause of deaths was because of injuries sustained, the majority of the injuries were found to have been self-inflicted with the intention of committing suicide, mostly by hanging themselves in police cells using instruments such as belts, shoe-laces and blankets among others (Dissel & Ngubeni, 1999, ICD, 2009). The fact that persons in police custody have used instruments such as belts and shoe-laces to commit suicide suggests that the members of the police do not comply with the rules and regulations relating to the management of persons in their custody.

The South African Police Service Standing Order (General) (SAPS (SO(G)) 361.11 and section 23 of the Criminal Procedure Act, Act 51 of 1977, mandate members of the police service to search people in their custody and their visitors and seize any objects found in their possession which could be used to cause injury to the person in custody or any other person (SAPS 2003, Bekker et al., 2003). Therefore failure of the police to conduct such searches resulted in such objects being used by prisoners to commit suicide.

1.4 The aim and objectives of the research

The aim of this study is to determine the circumstances and conditions which contribute to deaths in police cells in order to prevent it. The objectives of this study are as follows:

- To determine the ways in which prisoners died whilst in police cells.
- To identify patterns of regulation violations on the part of police officials when deaths occur in police cells.
- To determine international best practices on the prevention of deaths in police cells and
- To make recommendations on the prevention of deaths in police cells.

1.5 The envisaged value of this study

The primary value of this study is to prevent the high number of deaths of people in police cells in South Africa. This study is expected to provide more insight into the root causes of deaths in police cells. The study also sought to identify the other factors which contribute to deaths in police cells. It is the belief of the researcher that the identification of the causes of and contributory factors to the incidence of deaths in police cells would make it possible for the police authorities to implement the correct measures and steps to prevent deaths in police cells. Therefore, this study will make recommendations aimed at preventing deaths in police cells,

taking into consideration the limited resources at the disposal of those responsible for the safekeeping of people in the cells.

The researcher has gathered and analysed data in order to establish the extent to which this topic has been covered and the knowledge already generated by other studies. This study has sought to generate new knowledge how to establish and maintain best practices with the aim of preventing the deaths of detainees in police cells. It is also hoped that the research study will suggest the best possible ways to utilise the available physical and human resources in order to prevent deaths in police cells. The study will also establish the extent to which the Standing Orders (General) of the South African Police Service relating to the handling of persons in police custody are complied with.

1.6 The challenges that were experienced with this study

As is to be expected with any research study, there were challenges experienced in undertaking this study. The challenges that were experienced varied from the feasibility of accessing and analysing dockets in one of the two geographical areas initially chosen for that purpose to the non-availability of the dockets at both research sites as well as long delays relating to the approval of the request to access the statistics from the SAPS.

With regard to the challenge relating to the feasibility of accessing dockets in the demarcated geographical area, the researcher planned to analyse dockets relating to deaths of detainees in police cells at Gauteng and Kwazulu-Natal Provincial offices of the Independent Police Investigative Directorate. Permission to access the dockets was sought from and granted by the National Office of IPID. However, the researcher experienced logistical constraints which prevented him from travelling to Kwazulu-Natal. This particular challenge was overcome through the engagement of the Supervisor of the researcher at the University of South Africa and the IPID National Office. Therefore the researcher applied to the IPID National Office for the replacement of Kwazulu-Natal Provincial Office with Limpopo Provincial Office. This request was granted without delay.

The challenge relating to the non-availability of dockets concerned the fact that the researcher planned to analyse the dockets which were opened by the ICD in the financial year 2009/2010 from 1 April 2009 to 31 March 2010. The dockets that were made available did not add up to the number which was reflected in the annual report of the Directorate. This confusion was caused by the fact that the dockets included in the ICD annual report included those where the detainees died in hospital under police guard rather than in a police cell. To overcome this

challenge, the researcher included dockets which fell outside the intended period of the study after consultation with his supervisor. Regarding the issue of the long delay in receiving the approval from SAPS to access training statistics on human rights, the approval was eventually granted after eight months when the researcher was at an advanced stage of finalising the research study.

1.7 The pragmatic philosophical worldview

After studying the document on the philosophical worldview, the researcher identified the pragmatic philosophical worldview as suitable for his study. Pragmatists seek to find solutions to a specific problem because they are concerned with the consequences of action. Pragmatists are at liberty to apply both quantitative and qualitative research methods in their studies rather than confining themselves to the application of one particular research method (Creswell,2009). However, pragmatists must first establish the need for applying this pluralistic approach. This research study will have a strong emphasis on the modus operandi of deaths in police custody, hence the choice of a pragmatic worldview.

1.8 Research methodology

The researcher decided to follow a descriptive qualitative approach in his research study in line with the pragmatic worldview.

1.8.1 Sample

The two provinces in which most cases of deaths in police custody were recorded for the ICD financial year 2009/2010 were initially chosen for the study. These provinces are Gauteng and Kwazulu-Natal. Kwazulu-Natal Province was later replaced with Limpopo Province due to logistical constraints which were referred to above. The researcher used a saturation sampling technique and completed 52 forms. The number of completed forms is higher than the minimum sampling units required for this purpose. According to Bailey (1994), 30 sampling units constitute the minimum number for a quantitative study. In terms of this sampling technique, all deaths in custody in Gauteng and Limpopo Provinces were included in the study (Black & Champion, 1976). The IPID was requested for permission to access their records relating to the deaths of detainees in police cells that occurred in the respective provinces.

1.8.2 Data collection

The researcher collected data regarding the deaths of detainees in police cells by means of docket analysis. Docket analysis, as a part of document study, is one of the data collection

techniques applied in quantitative research (Bailey, 1994). Docket analysis is therefore useful in helping the researcher to understand the manner in which prisoners died whilst in police custody (Bailey,1994). The researcher compiled a docket analysis schedule for the purpose of conducting the analysis. This schedule appears in Appendix A of this dissertation. This study was initially planned to analyse the dockets involving the deaths of detainees in police cells that occurred in the period 1 April 2009 to 31 March 2010. The intended period to be covered in the study was changed to include the dockets which fell outside the planned period of study. This was necessitated by the availability of fewer dockets due to the manner in which the IPID classify their dockets. The researcher therefore utilised a case docket analysis schedule to analyse said dockets. In order to conduct a docket analysis, the researcher compiled a comprehensive schedule which he filled in whilst examining each docket indicating various aspects like the place, circumstances and cause of death, as well as the outcome of the investigations conducted by the ICD.

1.8.2.1 The description of a docket analysis

Dockets analysis is a process which involves a systematic examination of the contents of a docket. The dockets typically contain basic information relating to the commission, investigation and the prosecution or not of the perpetrators of the crime (South African Law Commission, 2011). Dockets are mainly analysed in order to gain a better understanding of the circumstances surrounding the commission of a crime and to ascertain whether the correct crime investigation principles were followed (Mistry et al., 2001, South African Police Service, 2011). Docket analysis also provides information relating to the profiles of the victim and the offender, the nature of their relationship and whether the use of substances had played a role in the commission of the crime (Mistry et al., 2001). It also sheds light whether the offender was previously convicted for the commission of a crime or not (Mistry et al., 2001). According to the South African Police Service (2011), docket analysis provides useful information which is required for the formulation of informed preventative initiatives.

1.8.2.2 The benefits of docket analysis

There are benefits which can be derived from conducting a docket analysis. One of the benefits of docket analysis is that the information which is contained in the docket can be accessed with relative ease and it is obtained from the primary source (Mistry et al., 2001). The use of information which was obtained from the primary source eliminates or reduces errors which are associated with the use of data which were obtained from the secondary sources (Mistry et al., 2001). According to Mistry et al. (2001), dockets provide useful background information about

the nature of the crime and about the profiles of the victim and the offender. The dockets shed light into the manner in which cases are finalized and they indicate the quality of the investigation which was conducted (Mistry et al., 2001). Furthermore, docket analysis exposes the level of experience of the investigating officers (Mistry et al., 2001). According to Mistry et al., (2001), docket analysis provides information regarding the scene, time and day of the crime, the modus operandi of the perpetrator, including the weapons used and the nature of the injuries sustained as well as whether the perpetrator has previous convictions or not.

1.8.2.3 The limitations of docket analysis

As with any other data collection technique, there are drawbacks which are associated with docket analysis, particularly with regard to the quality of the contents of the documents which are attached to the docket (South African Police Service, 2001). The following are some of the limitations which are associated with docket analysis:

The dockets are not always readily available to be analysed due to the fact that they might still be in the hands of investigating officers or they may have been incorrectly registered (South African Police Service, 2011). The handwriting on the statements and on other forms is often illegible or difficult to read (Mistry et al., 2001, South African Law Commission, 2011). The statements are often not completed in full (Mistry et al., 2001, South African Law Commission, 2011). The dockets are often not completed in full (Mistry et al., 2001, South African Police Service, 2011). "The language used is often poor" (Mistry et al., 2001:22). The motive behind the perpetration of the crime cannot be established (Mistry et al., 2001). The full dynamics of the crime and its impact on the life of the victim cannot be ascertained (Mistry et al., 2001, South African Police Service, 2001). There is insufficient information contained in the dockets relating to the injuries sustained (South African Law Commission, 2011).

1.8.3 Data analysis

The researcher personally analysed the data contained in the docket analysis forms. During the analysis process, the data were categorized into the following different themes:

- The quality of the investigation
- The causes of deaths in police cells
- The contributory factors to deaths in police cells and
- The outcomes of investigations conducted into deaths in police cells.

The researcher will present the data numerically and conduct a frequency analysis.

1.9 Ethical issues in research

Researchers should be mindful of ethical considerations when conducting a research study. Ethical research is dependent upon the integrity of the researcher and unethical conduct is highly opposed by the research community (Neuman,1997). Ethical principles relate to but are not limited to the obtaining of informed consent from the participants of the research study, inflicting no harm in collecting data, confidentiality and being fair to the participants when analysing data (Flick,2006, Neuman,1997, Bouma & Ling, 2004). The researcher requested and obtained permission from the ICD to peruse its records and the SAPS to access the training statistics. These gatekeeper permission letters are attached as Addendum A. The researcher also followed the guidelines of UNISA for conducting ethical research which advocate transparency, integrity and accountability in a research study (UNISA, 2012). Researchers have an ethical obligation to protect the confidentiality and anonymity of research respondents. Anonymity and confidentiality are the two techniques used by researchers to preserve the identity of the research respondents (Babbie, 2008, Barbour, 2008). Anonymity refers to the withholding of the identity of the respondent(s), whereas confidentiality relates to the protection of the information against disclosure (Smith, 2010, Ellis, Hartley & Walsh, 2010, Kalof, Dan & Dietz, 2008). Barbour (2008) and Smith (2010) are of the opinion that the anonymity of a person will therefore be guaranteed when neither the researcher nor any other person reading the research findings can link a given response with a particular respondent. Researchers must take the necessary precautions to ensure that the identity of the respondents and the data they provide are kept confidential at all times unless the respondents have given consent for disclosure (Kalof et al., 2008, Smith, 2010, Westmarland, 2011). Protecting the confidentiality of research participants encourages honesty from them (Kalof et al., 2008).

1.9.1 Personal experience of the researcher pertaining to the problem statement

The researcher is a police officer stationed at the National Office of the Human Resource Development Division of the South African Police Service. About ten years ago, while the researcher was about three years in the employ of the South African Police Service, he was stationed at a police station in the North Rand area of Gauteng. One particular morning, the researcher reported for work at the police station and was posted to perform duties as the Community Service Centre Commander (CSCC). The posting as the CSCC puts such posted member in charge of all activities taking place in the Community Service Centre (CSC), including the management of the police cells. On this particular morning one junior member of the shift who had performed duties the previous night and was thus reporting off duty mentioned

that a female detainee had hanged herself inside the cells at night and that his seniors failed to report the death as prescribed. A subsequent cell inspection led to the discovery of the deceased detainee. The detention of the deceased was not recorded in any of the relevant registers, including the custody register. It was further established that a docket was neither opened nor registered. Further enquiries revealed that the husband of the deceased detainee had contacted the police station the previous night and requested that the police officers remove his wife from their shared residence as she was intoxicated and unruly. The husband reportedly asked the police officials who attended to his complaint to let his wife stay in the CSC until she sobered up and that removing her from their residence will allow him time to sleep as he had to report for work in the early hours of the following day. The husband had no wish to open a docket against his wife, as she was reportedly only troublesome when she was intoxicated but peaceful when sober hence the absence of a docket. It is this personal experience of the researcher which prompted him to choose this research topic. The researcher followed the bracketing or epoche process to ensure that his personal experience does not influence the research project. Bracketing is a concept which describes the fact that researchers make every effort to put aside their personal experiences so that they may approach the phenomenon being studied from a fresh perspective (Creswell, 2013). Relevant to bracketing is the concept of transcendence, which means that everything related to the research is dealt with as though it is being perceived for the first time. The researcher embraces LeVasseur's understanding of bracketing as being "suspending our understandings in a reflective move that cultivates curiosity" (in Creswell, 2013:83). Even though the researcher has been a police official for more than a decade, he will not be blinded by his loyalty to his employer to depict the facts in a rosy fashion. The findings of this study have been presented unbiased and truthful.

CHAPTER 2 THE REGULATORY FRAMEWORK FOR THE PREVENTION OF DEATHS IN POLICE CELLS

2.1 Introduction

The management and care of people in police custody take place in an environment which is characterised by strict rules and regulations. These applicable rules and regulations include legislation. The purpose of the regulations is to provide guidance on how to deal with police detainees thereby creating a uniform environment which is conducive to the prevention of deaths in police cells. This chapter contains a discussion of the regulatory instruments which are applicable to the South African environment and the international community.

2.2 The international instruments

The phenomenon of deaths in police custody is a matter of serious concern, not only to South Africa but also to the international community. The international community has, subsequently, established a number of instruments which are aimed at regulating the management and care of people who are detained in the detention facilities of the police. The majority of the instruments was passed under the auspices of the United Nations and entrenched the fundamental human right to life for everyone, regardless of their status.

2.2.1 Regulating the right to life

Article 3 of the Universal Declaration of Human Rights, article 6 of the International Covenant on Civil and Political Rights and article 6 of the Convention on the Rights of the Child stipulate that everyone has the right to life (United Nations, 1948, United Nations, 1966, United Nations, 1989). The guarantee of the right to life is also provided in article 4 of the African Charter on Human and Peoples' Rights and article 2 of the European Convention on Human Rights (Organization of African Unity, 1981, European Court of Human Rights, 2010). Thus article 2 of the European Convention on Human Rights imposes a positive and a negative duty on governments regarding the protection of the right to life (Joint Committee on Human Rights, 2004). According to the Joint Committee on Human Rights (2004), a positive duty involves taking the necessary steps to protect detainees whose lives are at risk and secondly, ensuring that every death in police custody is thoroughly investigated, irrespective of whether the death involves public servants or not (Joint Committee on Human Rights, 2004). A negative obligation, on the other hand, entails taking measure to ensure that the detainee does not lose his/her life

through the intentional or negligent use of excessive force against him/her or through failure to provide sufficiently trained and experienced personnel to ensure safety (Joint Committee on Human Rights, 2004).

2.2.2 Regulating the right to liberty and freedom of the person

Article 9 of the International Covenant on Civil and Political Rights, article 5 of the European Convention on Human Rights and article 6 of the African Charter on Human and Peoples' Rights provide that everyone has the right to liberty and security of the person and that the detention of any person shall be carried out as prescribed by law (United Nations, 1966, European Court of Human Rights, 2010, Organization of African Unity, 1981). In the event that the detention of a person is unavoidable, such a person shall be protected against torture while in police detention. In order to protect the bodily integrity of all persons in custody, article 5 of the Universal Declaration of Human Rights, article 3 of the European Convention on Human Rights and article 5 of the Code of Conduct of Law Enforcement Officials prohibit the torture of any person under detention (United Nations, 1948, European Court of Human Rights, 2010, United Nations, 1979). According to article 2 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, each state to the convention shall put in place effective legislative or other measures to prevent torture within its territories (United Nations, 1984). Furthermore, article 5 of the Code of Conduct of Law Enforcement Officials stipulates that law enforcement officials are prohibited from perpetrating any act of torture or tolerate the perpetration thereof by any person under any circumstances (United Nations, 1979). Article 8 of the Code of Conduct of Law Enforcement Officials therefore imposes a legal obligation upon each law enforcement official to prevent the torture of any person in custody and to report the perpetration thereof to their superiors and other appropriate authorities (United Nations, 1979). There shall be no legal justification for committing any act of torture as stipulated in article 2 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and Article 5 of the Code of Conduct of Law Enforcement Officials (United Nations, 1990, United Nations, 1979). Most importantly, article 14 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment provides that the dependants of a person who died in police custody as a result of torture shall be entitled to receive compensation (United Nations, 1984).

2.2.3 Regulating the provision of medical care

The provision of health care services to people in police custody is guaranteed by several of the international instruments discussed below. According to article 6 of the Code of Conduct of Law Enforcement Officials and principle 24 of the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment provides that proper medical treatment shall be provided free of charge to persons in detention without delay (United Nations, 1979, United Nations, 1988). Paragraph 3.5 of Code C of the Police and Criminal Evidence Act Codes of Practice stipulates that the custody officer or any custody staff delegated by them shall conduct a risk assessment to determine whether the detainee needs or might need medical care and keep a record of the outcome of the assessment (Home Office, 2012). Code C also provides in paragraph 3.16 that it is imperative to have a mentally ill detainee assessed by a registered medical officer without delay (Home Office, 2012). The African Charter on Human and Peoples Rights also provides, in general terms, in article 16 that states that are party to the charter are obliged to provide medical care to their people when the need arises (Organization of African Unity, 1981).

According to principle 25 of the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, a detained person or their legal representative are entitled to request a second medical examination (United Nations, 1988). Proper records relating to the medical care given to a detained person shall be kept and shall contain the name of the medical practitioner who conducted the examination and the outcome of such an examination as provided for in principle 26 of the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (United Nations, 1988). Subsequent to the provisions contained in the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment referred to above, relating to the provision of medical care and treatment of persons in detention, Code C of the Police and Criminal Evidence Act Codes of Practice which is applicable to police custody issues in England and Wales makes the relevant provisions which are discussed below. The code provides in paragraph 1.1 that detainees must be processed speedily and must be released from detention as soon as their detention is no longer necessary (Home Office, 2012). It is the duty of the custody officer to implement the obligations imposed by the code as soon as possible and they remain wholly responsible for ensuring that the provisions of this code are fully complied with at all times, as provided for in paragraph 1.1A and 1.15 of the code (Home Office, 2012). Furthermore, paragraph 1.2 of the code stipulates that the code of practice must be available at police stations for easy access and consultation by police officers, police personnel, detainees and members of the community

(Home Office, 2012). The code also stipulates in paragraph 9.5 that the custody officer is mandated to summon appropriate medical treatment for a person in detention without delay if such a person appears to physically or mentally ill, in need of medical care or is injured (Home Office, 2012).

The custody officer should consider the need to summon medical attention even when the detainee has not made any request to be medically examined as provided for in paragraph 9.5B of Code C of the Police and Criminal Evidence Act Codes of Practice (Home Office, 2012). When in doubt whether medical care is needed for a detainee who appears to be drunk or behaving abnormally, the custody officer should urgently call medical assistance for the detainee because such behaviour may be masking an illness, injuries sustained, particularly head injuries or may be suffering from the effects of drugs (Home Office, 2012). The custody officer has discretionary powers which he/she may exercise when dealing with detainees who suffer or are suspected to be suffering from an infectious disease or condition. The custody officer may, therefore, isolate such a detainee and their belongings in terms of paragraph 9.7 of Code C of the Police and Criminal Evidence Act Codes of Practice while waiting for advice from the appropriate healthcare practitioner (Home Office, 2012). The custody officer must also consult the relevant healthcare practitioner in circumstances where a detainee is taking prescribed medication before allowing them to administer it (Home Office, 2012). However, the self-administration of certain types of drugs by the detainees can only be done under the supervision of the appropriate healthcare practitioner (Home Office, 2012). In order to ensure that the interests of the detainees are protected, the custody officer shall, in the event where a relevant healthcare professional is called in to examine a detainee, seek and obtain their advice whether there are any risks or problems noted and whether there is a need for the implementation of safeguards (Home Office, 2012).

The custody officer must make sure that any relevant information which might be useful in the treatment of the detainee is provided to the healthcare practitioner (Home Office, 2012). Medical assistance must be summoned in cases where a detainee fails to meet the criteria laid down in Annex H of Code C of the Police and Criminal Evidence Act Codes of Practice (Home Office, 2012). Therefore, medical care must be called to attend to persons in police cells who cannot be roused, cannot respond appropriately to questions such as what their names are or where they live and lastly, when they cannot respond to commands such as being asked to open their eyes (Home Office, 2012). The custody officer and custody staff must also consider the presence of other illnesses, injuries or mental condition (Home Office, 2012). This is important because

drowsiness or the smell of alcohol may be indicative of the presence of diseases such as diabetes, intoxication or head injuries (Home Office, 2012).

2.2.4 Regulating the visits to the cells

There is a need to visit the cells where detainees are locked up to ensure that detainees receive proper care. Principle 29 of the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment provides that police cells shall receive regular visits by experienced persons (United Nations, 1988). The people who visit police cells shall be appointed by and be accountable to a competent authority functioning independently of the authority which is directly responsible for the administration of the police cells (United Nations, 1988). According to paragraph 9.3 of Code C of the Police and Criminal Evidence Act Codes of Practice, cells should be visited at least hourly and sleeping persons in police cells should not be awoken unless they were identified as posing a risk of harm to themselves or those around them during the risk assessment process (Home Office, 2012). However, persons in police cells who are suspected of being under the influence of drugs or intoxicating drinks and those whose level of consciousness is a concern must, under the guidance of the appropriate healthcare practitioner, be visited and awoken at least every half an hour as indicated in paragraph 9.3 (Home Office, 2012). This paragraph also provides that such vulnerable persons in police cells should have their condition assessed and clinical treatment arranged where applicable (Home Office, 2012).

2.2.5 Regulating the searching of detainees

The people who are arrested must be searched prior to being placed in the cells to protect them and those around them from harm. Paragraph 4.1 of Code C of the Police and Criminal Evidence Act Codes of Practice provides that it is the duty of the custody officer to search or delegate the searching of persons in police cells upon their arrival at the police station (Home Office, 2012). The purpose of the search is to ascertain the kind of property which the persons in police cells have in their possession and whether any such property was acquired to perform an unlawful act or to harm themselves or others while in detention (Home Office, 2012). Paragraph 4.2 of Code C of the Police and Criminal Evidence Act Codes of Practice stipulates that the custody officer has the discretion to seize any personal effects and clothing of the detainee which they believe may be used to inflict harm to the detainee or others (Home Office, 2012). The custody officer must, in the event that they seize any articles, provide reasons to the affected detainee regarding the seizure (Home Office, 2012). Annex A of Code C of the Police and Criminal Evidence Act Codes of Practice authorises the conducting of intimate and strip

searching of detainees (Home Office, 2012). According to this paragraph, an intimate search may only be conducted by a registered nurse or registered medical practitioner upon the authority of an officer of the rank of inspector or higher (Home Office, 2012). The purpose of the search shall be to determine whether the detainee has concealed on themselves anything which could be used to cause physical harm either to themselves or those around them (Home Office, 2012).

2.2.6 Regulating the detention of vulnerable people

The detention of vulnerable persons such as children, elderly and mentally ill persons shall only be carried out as a last resort. Article 37 of the Convention on the Rights of the Child as well as Rules 1 and 2 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty stipulate that juveniles should only be detained as a last resort and only for a limited period, taking into account the needs of children and their age (United Nations, 1989, United Nations, 1990). Furthermore, paragraphs 3.16 and 8.8 of Code C of the Police and Criminal Evidence Act Codes of Practice provide respectively that mentally ill persons and juveniles should only be detained at a police station as a last resort (Home Office, 2012). Rule 20 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty prohibits the admission of juveniles in any detention facility without producing a valid commitment order which was issued by the appropriate authority (United Nations, 1990).

Every child in custody shall be separated from adult detainees as provided for in Rule 29 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty and Article 37 of the Convention on the Rights of the Child stipulate (United Nations, 1990, United Nations, 1989). The detention facilities for juveniles should be designed in such a manner that minimises the risk of fire and should have an effective alarm system as well as a safe evacuation plan in order to ensure the safety of detained juveniles as prescribed in Rule 32 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990). Rule 33 of the above-mentioned rules provides that all sleeping quarters of detained juveniles should be supervised during sleeping hours without disturbing them (United Nations, 1990). According to Rules 49, 50 and 51 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990), every detained juvenile is entitled to adequate medical care, to be examined by a physician as soon as they are admitted to a detention facility in order to detect and provide treatment for physical or mental illness and substance abuse. Any medical practitioner who reasonably believes that the continued detention of the juveniles has or will adversely affect their physical or mental health, is obliged in terms of Rule 52 to report such an

opinion to the director of the detention facility and to the appropriate independent authority established for the purpose of the protection of the welfare of the juveniles (United Nations, 1990). Mentally ill juveniles should receive treatment provided by an independent medical institution as stipulated in Rule 53 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990). Medication should only be provided to detained juveniles for the necessary treatment of a medical condition as required by Rule 55 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990). The custody officer shall treat every detainee whom they believe to be mentally ill, a juvenile or blind in a manner laid down in Code C of the Police and Criminal Evidence Act Codes of Practice (Home Office, 2012).

2.2.7 Regulating the implementation of the instruments

Principle 7 of the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment provides that states should pass legislation that prohibits the commission of any act that violates the rights and deviates from the duties entrenched by the principles and conduct investigations in an unbiased manner when complaints regarding alleged violation of the legislation are lodged (United Nations, 1988). Furthermore, Principle 34 of the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment and Rule 57 United Nations Rules for the Protection of Juveniles Deprived of their Liberty state that the death of a person while in custody shall be investigated by a judicial or other appropriate authority upon receipt of a complaint or on its own accord to determine the cause or causes of death (United Nations, 1988). The next of kin of a detained juvenile are entitled to be notified whenever the juvenile becomes ill, injured or dies while in detention and in the event of death of the detained juvenile, the next of kin shall have the right to inspect the death certificate and see the body as determined respectively by Rules 56 and 57 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990). The immediate relative of a detained juvenile who died while in police custody has a further right to access the report of the findings of a judicial enquiry into the cause or causes of death (Home Office, 2012). Rule 57 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty states further that there should be an enquiry into the death of a juvenile who dies within a period of six months after their release from detention where there is a belief that his/her death is linked to his/her detention (Home Office, 2012).

Qualified inspectors who are working independently of the detention facility should conduct regular and unannounced visits to the facility on their own accord in terms of Rule 72 of the

United Nations Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990). The inspection team should comprise of medical practitioners and the purpose of the inspection shall be to determine the extent to which detention facilities comply with the regulations relating to the protection of the physical and mental wellbeing of detainees or relating to any other aspect that impacts on their welfare and submit a report of its findings as provided in Rule 73 and Rule 74 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty(United Nations, 1990).

The detention facilities should use the services of carefully selected and recruited personnel who are suitable to discharge their duties in a manner that results in the proper management of the facility as stated in Rule 82 and Rule 87 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990). The international community has instruments which were passed to regulate the handling of people who are detained in police cells. The instruments, such as the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights, were passed by the United Nations for implementation by the member countries in order to protect every person's right to life among other entrenched human rights. The police detainees are also entitled to receive medical care while in custody as provided for in the Code of Conduct for Law Enforcement Officials and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, among other instruments. There are also other international instruments that regulate the searching of detainees in order to ensure that the safety of detainees and personnel of the detention facility is maintained at all times.

2.3 South African instruments

Section 11 of the Constitution of the Republic of South Africa stipulates that "everyone has the right to life" and that one of the functions of the police is to protect and secure the inhabitants of the Republic in terms of section 205 (South Africa, 1996). In South Africa, The South African Police Service has put in place regulations which are aimed at ensuring the proper management of people who are detained in police cells. The regulations are in the form of Standing Orders (SO) (General). The Standing Orders (General) that are of specific relevance to the management and care of persons in police cells are the South African Police Service Standing Orders (General) 349, 350, 361 and 362 of the South African Police Service. The South African Police Service Standing Order (General) 349 regulates the provision of medical care and hospitalisation of detainees in police cells (South African Police Service, 2003a). The South African Police Service Standing Order (General) 350 deals with the use of restraining measures

against detainees (South African Police Service, 1999). The South African Police Service Standing Order (General) 361 regulates the handling of persons held in the detention facilities of the police from the moment they arrive at the police station, while South African Police Service Standing Order (General) 362 stipulates how the custody register of the South African Police Service should be completed (South African Police Service, 2003b, South African Police Service, 2003c).

2.3.1 Regulating medical care

The South African Police Service Standing Order (General) 349.1 provides, in general terms, that the police service is responsible for ensuring that the detainees receive medical care whenever a need arises (South African Police Service, 2003a). Furthermore, the Standing Order (General) 349.1 and 349.2, specifically stipulate that it is the duty of the police official who effected the arrest and each police officer who exercises control over the detainee to ensure that such a detainee receives medical treatment whenever the need arises (South African Police Service, 2003a). In order to ensure that the person in police cells receives medical treatment, the South African Police Service Standing Order (General) 349.2 provides that the police officer concerned should use his/her discretion to decide whether urgent medical treatment is necessary where a detainee is seriously ill or injured, the type of transportation which is suitable in the circumstances and take the necessary steps accordingly (South African Police Service, 2003a). In the circumstances where the police officer doubts whether the detainee needs urgent medical treatment, such a police officer is advised in Standing Order (General) 349.2 to make the necessary arrangements for the medical treatment of the detainee (South African Police Service, 2003a).

Any person in police custody who appears to be physically or mentally ill, who has any injuries or who is not responding to sensory stimulation and who, in the opinion of the community service centre commander, needs medical care, must be transported by an ambulance or police vehicle to the nearest provincial hospital as prescribed in South African Police Service Standing Order (General) 349.3 (South African Police Service, 2003a). The South African Police Service Standing Order (General) 349.3 provides further that the instructions issued by the medical practitioner must be complied with immediately (South African Police Service, 2003a). In a situation where medication has been prescribed for a person in police custody, the community service centre commander shall keep the medication in a safe place and ensure that the detainee is afforded the opportunity to receive according to the prescription of the medical practitioner as stated in South African Police Service Standing Order (General) 349.9 (South

African Police Service, 2003a). According to South African Police Service Standing Order (General) 349.6, the community service centre commander has an obligation to allow a person in custody to consult with a medical practitioner of their choice at their expense regardless of whether such a detainee is sick or injured (South African Police Service, 2003a). The South African Police Service Standing Order (General) 349.6 further mandates the community service centre commander to contact such a medical practitioner on behalf of the detainee and they must also inform the medical practitioner concerned that the expenses for their services shall be paid by the detainee (South African Police Service, 2003a). In all other situations, the hospitalisation and medical expenses incurred by the person in police custody shall be settled by the police service as provided for in South African Police Service Standing Order (General) 349.8 (South African Police Service, 2003a). The South African Police Service Standing Order (General) 349.4 and 349.6 provide that all the measures taken to ensure that a person in police cells receives medical care and the result of the medical examination must be recorded in the occurrence book and the record should include the name of the medical practitioner and the place where the examination took place (South African Police Service, 2003a). The South African Police Service Standing Order (General) 349.9 clearly stipulates that a person in custody may only be supplied with medication upon the written authority of the district surgeon or other medical practitioner (South African Police Service, 2003a).

In a situation where the detainee alleges that they have medication which was prescribed for them by a medical practitioner but that the medication is at another place, the community service centre commander must follow the stipulations of South African Police Service Standing Order (General) 349.9 by making the necessary arrangement to have the medication collected (South African Police Service, 2003a). The community service centre commander must, in terms of South African Police Service Standing Order (General) 349.9, always contact the service provider to confirm whether the medication was indeed prescribed by a medical practitioner for the specific detainee and enquire on how to administer the medication (South African Police Service, 2003a). Furthermore, this standing order stipulates that the community service centre commander must record the information which was provided by the service provider in the occurrence book (South African Police Service, 2003a). Every time medication is administered to a person in custody, the medication form must be completed and an entry must be made in the occurrence book in terms of South African Police Service Standing Order 349.9 (South African Police Service, 2003a). The South African Police Service Standing Order (General) 349.10 provides that if a person in custody is admitted to a hospital, the community service centre commander must bring this fact to the attention of the relevant investigation

officer so that the investigation officer concerned could consider the release of such detainee (South African Police Service, 2003a). In the event that the person in custody does not qualify for release from custody, the station commander must give instructions in writing to the person in charge of the hospital concerned that the person in custody must be discharged from the hospital if he/she has sufficiently recovered as stated in South African Police Service Standing Order (General) 349.10 (South African Police Service, 2003a). In such case, this standing order provides further that the station commander must give a further instruction that they must be informed of the date and time of the intended discharge of the detainee from the hospital so that proper arrangements can be made for the transportation of the detainee to a police detention facility (South African Police Service, 2003a). According to South African Police Service Standing Order (General) 349.11, members of the service must, whenever circumstances permit, not detain a person who is suffering from an infectious disease such as tuberculosis together with other detainees in the same cell to prevent the spread of the disease (South African Police Service, 2003a). This standing order also encourages members of the South African Police Service to consider the release, on a warning, of a person in custody who is suffering from tuberculosis or any other infectious disease if such a person was detained for allegedly committing a petty crime (South African Police Service, 2003a).

2.3.2 Regulating detainees' illnesses and deaths

Whenever a person dies or becomes seriously ill while in police custody, his/her next of kin, if known, must be promptly informed as provided for in South African Police Service Standing Order (General) 349.12 (South African Police Service, 2003a). The South African Police Service Standing Order (General) 349.13 provides that in the event that a foreigner dies while in police custody, the office of the Ambassador or Consul-General of the country of origin of the deceased detainee must be telephonically informed of the death as soon as it is reasonably possible (South African Police Service, 2003a). The station commander has a legal duty, in terms of South African Police Service Standing Order (General) 349.14, to ensure that the Independent Police Investigative Directorate is notified of every death of a person in police custody at their respective stations (South African Police Service, 2003a). The South African Police Service Standing Order (General) 361 which regulates the handling of persons in police custody from their arrival at the police station provides in paragraph 361.3 that the arrest and arrival of a person at the police station must be recorded in the occurrence book (South African Police Service, 2003b). This standing order provides further that the entry in the occurrence book must contain the name of the arresting officer, the name of the arrested person, the reason for the arrest together with the case number and whether the arrested person has any

visible injuries, is sick or intoxicated (South African Police Service, 2003b). In addition to the provisions of Standing Order (General) 361.3, the Standing Order (General) 362.3 states that the particulars of the person in police custody must be entered into the custody register (South African Police Service, 2003c). These particulars should include, among others, personal particulars of the person in police custody as well as the date, time and cause of the arrest (South African Police Service, 2003c).

2.3.3 Regulating the searching of detainees and visitors

Persons in police custody must be searched in accordance with the provisions of Standing Order (General) 361.11 and section 23 of the Criminal Procedure Act 51 of 1977, respectively, in order to determine what possessions they have in their possession and to seize the possessions including clothing items which may be used to harm anybody or which may be used to prove the commission of a crime (South African Police Service, 2003b, Bekker, Geldenhuys, Joubert, Swanepoel, Terblance & van der Merwe, 2003). In cases where clothing items are removed from the person in custody, such person shall be provided with replacement clothing in terms of Standing Order (General) 361.11 (South African Police Service, 2003b). The duty to conduct such a search is imposed on the community service centre commander who may delegate such a responsibility in accordance with the prescripts of Standing Order (General) 361.11 (South African Police Service, 2003b). This standing order also provides that a detainee must be searched whenever he/she is re-admitted to a detention facility (South African Police Service, 2003b). The people who visit persons in the custody of the police must be requested, in terms of Standing Order (General) 361.12, to consent to have their bodies or possessions searched as a prerequisite for being allowed to visit any detainee (South African Police Service, 2003b). The Standing Order (General) 361.13 provides that convicted persons should be detained separately from those awaiting trial and that children should only be detained as a last measure and separately from adults (South African Police Service, 2003b). This standing order stipulates that mentally disturbed persons and those who are blind should also be detained separately (South African Police Service, 2003b). A mentally disturbed person who is in custody must, whenever it is necessary, be handcuffed and placed under observation to prevent him/her from causing harm to himself/herself or to others in terms of Standing Order (General) 350.10 (South African Police Service, 1999). This standing order also stipulates that where it is reasonably possible, the member concerned must immediately seek the assistance of a medical practitioner in prescribing a sedative necessary to bring the detainee under control (South African Police Service, 1999). Furthermore, people who are detained for the alleged

commission of violent crimes must be held in separate cells away from other detainees in accordance with Standing Order (General) 361.13 (South African Police Service, 2003b).

2.3.4 Regulating frequency of routine cell visits

The Standing Order (General) 361.13 regulates the visiting of cells by police officials and provides that ordinary detainees must be visited at least every hour, those under restraint and those rendered unconscious by alcohol or any other cause must be visited at least every half-hour until their situation improves (South African Police Service, 2003b). According to Standing Order (General) 361.13, the cells must, at all times, be visited by at least two members of the police service and under no circumstances shall a member enter the cells where persons in police cells are locked up while such member is armed (South African Police Service, 2003b). This prohibition is aimed at preventing police officials who visit the cells from being disarmed by persons in police cells and thus reducing the risk of escape or violence (South African Police Service, 2003b). Smoking in the detention facilities is prohibited for safety reasons in terms of the Standing Order (General) 361 (South African Police Service, 2003b).

2.3.5 The Independent Police Investigative Directorate

The Independent Police Investigative Directorate has been established in terms of section 3 read with section 4 of the Independent Police Investigative Directorate Act 1 of 2011 to function independently from the South African Police Service to ensure an effective independent oversight of the South African Police Service and Municipal Police Services (Parliament of the Republic of South Africa, 2011). The Independent Police Investigative Directorate is authorised and obliged in terms of section 28 of the Independent Police Investigative Directorate Act to investigate, among others, any deaths in police custody (Parliament of the Republic of South Africa, 2011). Regulation 4 of the Independent Police Investigative Directorate also provides that the investigation must be carried out as prescribed by the Independent Police Investigative Directorate Regulations and must be concluded as soon as it is reasonably possible but not later than ninety days (Parliament of the Republic of South Africa, 2011). In order to fulfil this mandate, section 29 of the Independent Police Investigative Directorate imposes a legal duty on station commanders or any member of the South African Police Service or Municipal Police Service to immediately report any such matter referred to in section 28 of the Independent Police Investigative Directorate Act and to co-operate fully (Parliament of the Republic of South

Africa, 2011). Furthermore, section 30 of the Independent Police Investigative Directorate Act provides that the National Commissioner or Provincial Commissioner of the South African Police Service must undertake disciplinary proceedings against a member within 30 days of receiving the recommendations of the Independent Police Investigative Directorate to that effect (Parliament of the Republic of South Africa, 2011). This section also stipulates that the respective Commissioners must also provide a written report to the Minister of Police, the Executive Director of the Independent Police Investigative Directorate and the Secretary for the Police Service (Parliament of the Republic of South Africa, 2011). Section 33 of the Act mentioned above provides that it is an offence to interfere with, hinder or obstruct the Executive Director or a member of the Independent Police Investigative Directorate in the performance of their functions (Parliament of the Republic of South Africa, 2011). The preservation of life is also guaranteed by the Constitution of the Republic of South Africa. The searching of detainees is also legislated in terms of the provisions of the Criminal Procedure Act in order to protect their bodily integrity. The Independent Police Investigative Directorate was established to function as an independent oversight body over the activities of the police service or metropolitan police services and to investigate any such matters that are referred to in the Independent Police Investigative Directorate Act. From the discussion of literature review above, it appears that the Republic of South Africa complies with the international instruments designed to manage persons in police cells.

2.4 The alignment of the South African Police Service regulations to the international instruments

The South African Police Service performs its duties within a human rights environment which is mandated by the Constitution of the Republic of South Africa in line with the instruments which are applicable to the international community. The regulations of the South African Police Service which are relevant to the prevention of deaths in police cells are also generally aligned to the international instruments. The South African Police Service regulations deal with measures relating to the detention of persons, the protection of life, the provision of medical care and the searching of detainees among other measures which are designed to prevent the deaths of people in police cells. All these preventative measures are also addressed by the relevant international instruments. For example, section 11 of the Constitution of the Republic of South Africa entrenches the right of every person to life (Parliament of the Republic of South Africa, 1996). The constitutional guarantee to life is in line with similar provisions contained in international instruments such as article 3 of the Universal Declaration of Human Rights, article 6 of the Covenant on Civil and Political Rights, article 6 of the Convention on the Rights of the

Child, article 4 of the African Charter on Human and Peoples' Rights and article 2 of the European Convention on Human Rights (United Nations, 1948, United Nations, 1966, United Nations, 1989, Organization of African Unity, 1981, European Court of Human Rights, 2010). However, the South African Police Service regulations appear to be lacking on the issue of the kind of personnel that is employed to manage the detention facilities in comparison to the international practice. In England and Wales, for example, the detention and care of police detainees is regarded as a specialised field which requires the services of specially trained personnel (Home Office, 2012). Contrary to the practice within the South African Police Service, custody officers are wholly responsible for the wellbeing of detainees in England and Wales (Home Office, 2012).

Another area where the South African Police Service regulations appear to be falling behind the international practice relates to the issue of the conducting of regular and unannounced visits to the police cells by experienced and independent members of the community. The visits of the community members to the police cells serve to assess the conditions under which people are detained as provided for in terms of Principle 29 of the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (United Nations, 1988). The other potential benefits of these schemes lie in the promotion of transparency, accountability and consultation whereby the detention facilities may be scrutinised by the members of the community (Van der Spuy, n.d). The representatives from the community and the police are also afforded the opportunity to engage one another on matters relating to the treatment of detainees (Van der Spuy, n.d). The monitoring of detention facilities may be carried out by various agencies, be it national or international, formal or informal agencies with or without a legal mandate. South Africa has piloted the community visitors' system in 1993 and also passed a policy in 1994 in order to introduce and regulate the visits to police cells by members of the community under the leadership of the Community Policing Forums (Dissel & Ngubeni, 2000, Van der Spuy, n.d). According to Van der Spuy (n.d), the South African lay visiting schemes, which was exported from Britain, was extended to operate nationally. However, it appears that the lay visitors' scheme is not operational in South Africa (Dissel & Ngubeni, 2000). The implementation of functional lay visiting schemes could not be sustained due to a combination of factors. These factors included constraints relating to infrastructure, changes in political climate regarding detainees in police custody and the perceptions that informal civilian oversight was replaced by the introduction of formal external oversight agencies such as the IPID (Van der Spuy, n.d). However, Non-Governmental Organisations which deal with human rights issues continued to conduct pilot oversight projects in parts of Kwazulu-Natal where reports about the

abuse of detainees were documented and subsequently submitted to the management of the police who failed to react to the reports (Van der Spuy, n.d). Prior to 1994, the visits to police detention facilities were conducted by officials from the International Red Cross and magistrates (Dissel & Ngubeni, 2000). The community visitor system plays a preventative role because the visits are carried out without prior warning to the people who are in charge of the detention facilities (Dissel & Ngubeni, 2000).

The regulatory framework of the South African Police Service relating to the prevention of deaths in police cells generally compares favourably with the instruments applicable to the international community. However, the regulations appear to lack behind the international instruments as far as the employment and utilisation of custody officers to manage the cells and the implementation of the independent community visitors' system are concerned.

2.5 Summary

The prevention of deaths in police cells is dependent on the existence of the relevant regulation and proper implementation thereof. In South Africa, the police service has regulations which are meant to assist in the prevention of the deaths of people who are detained in police cells. The international community also has instruments which are intended to prevent such deaths. All these instruments could be valuable as preventative measures only when they are properly interpreted and implemented by the people who are responsible for the management of the custody facilities.

CHAPTER 3: THE REVIEW OF THE LITERATURE

3.1. Introduction

A review of literature on the phenomenon of deaths in police cells was undertaken. The purpose of conducting a literature review is to establish the extent to which this topic has been researched. A review of literature led to the identification of the causes of deaths in police custody in South Africa and in other countries. The factors that contributed to the existence of the phenomenon being studied were also identified through the process of literature review. The different measures which were implemented by the South African Police Service to prevent or reduce the incidences of deaths in police cells are also discussed hereunder. The international best practices which were established to deal with the phenomenon of death in police cells were identified through a review of literature.

3.2. The causes of deaths in police cells

There are different methods of bringing people, who are suspected of committing offences, to court. The arrest and subsequent detention of such people is one such method in terms of section 38 of the Criminal Procedure Act 51 of 1977 (Bekker, Geldenhuys, Joubert, Swanepoel & Terblanche, 2003). The police have a legal obligation to respect and protect the lives of all the members of the community including the lives of the people detained in police cells (Parliament of the Republic of South Africa, 1996). It is important to understand the circumstances under which people died while in police custody. The identification of the causes of deaths in police cells is a pre-requisite for the prevention of such deaths. The different causes of deaths in police cells are discussed below. Suicide is one of the leading causes of death in police cells. A study conducted by Dissel and Ngubeni (1999) into deaths in police custody revealed that suicide was the cause of death in 59 out of 204 incidences of deaths in police custody which occurred in the period between January to December 1998. The Independent Complaints Directorate (2009a) found that suicide was the cause of death in 13 out of 22 incidences analysed in its study in 1998. In England and Wales, a total of 73 detainees out of 76 committed suicide by hanging themselves while in detention in the period between January 1990 to December 1996 (Leigh, Johnson & Ingram, 1998). In New Zealand, a total of ten people out of 27 hanged themselves while detained in police cells in the ten years period of the study between 2000 and 2010 (Independent Police Conduct Authority as cited in Fairex NZ News, 2012). Leigh et al. (1998,13) refer to these incidences as “in-custody deliberate self-harm”. The Independent Police

Complaints Commission (2011) in the United Kingdom maintained that suicide was one of the three leading causes of deaths in police custody. There were 44 incidences of suicide in the 11 year period of study between 1998 and 2009, which resulted from hangings, poisoning, self-harm incidents and overdoses (Independent Police Complaints Commission, 2011). The fact that suicide is the leading cause of death in police custody in South Africa is not unique, as it is in line with a similar trend in New Zealand, as well as England and Wales.

The deaths of people in police cells were also attributed to natural causes resulting from the deceased's medical conditions. A study of deaths in police custody revealed that natural causes were the cause of the deaths of 4 detainees out of a total of 29 cases in South Africa (Bruce, 2000). According to the records of the Independent Complaints Directorate (Dissel & Ngubeni, 1999), 52 detainees died as a result of natural causes in 1998. However, this figure increased to 93 in the period between April 2009 to March 2010 (Independent Complaints Directorate, 2010). The deceased falling in this category had experienced medical problems relating to the heart, brain, liver, pneumonia and multiple failure of the organs (Independent Police Complaints Commission, 2011). Leigh et al. (1998) added epilepsy, head injuries and lung disease to the list of medical conditions that led to the deaths of the detainees. Heart problems and head injuries were the most common medical conditions that caused the deaths of detainees (Leigh et al. 1998). The Independent Police Conduct Authority (Fairex NZ News, 2012) found that there were seven incidences of deaths in police custody in New Zealand in the period between 2000 and 2010. In Australia, a total of 36 detainees died in police cells due to natural causes in the 15 year period between 1990 and 2004 (Joudo, 2006). In Kenya, as in other countries, there were incidences of deaths in police custody, but it is difficult to ascertain the prevalence of such incidences owing to the fact that the police often failed to keep proper custody records (Independent Medical-Legal Unit as cited in United State Department of State, 2011). From this, it appears as if the deaths of detainees are not necessarily linked to their detention.

Another major cause of death is individuals who died in police custody as a result of injuries which were inflicted upon them before their arrest and subsequent incarceration. Bruce (2000) maintains that there have been instances where custody deaths were caused by other people prior to the detainees being taken into police cells. The typical examples of the causes of deaths falling into this category are incidences where people who are suspected of having committed offences were gravely injured by members of the community before being handed over to the police (Bruce, 2000). The community members may have either acted lawfully, such as when causing injuries to detainees in private defense or unlawfully such as in apparent vigilant actions (Bruce, 2000). According to a study conducted by Dissel and Ngubeni, (1999), 48 detainees out

of 204 died as a result of injuries which they sustained before their detention in the period between January to December 1998. The Independent Complaints Directorate (2009a) found that 85 detainees out of 309 and 46 out of 279 died in police custody due to injuries sustained prior to custody during the financial years 2005/2006 and 2006/2007 respectively. A study conducted by the Independent Police Complaints Commission (2011) revealed that 36 detainees died while in police custody in the United Kingdom in the period 1998 to 2009 as a result of injuries they sustained prior to their detention. Although injuries sustained prior to detention were identified as the cause of some of the deaths in police custody in South Africa as well as in England and Wales, such injuries were not ascribed to incidences of vigilantism (Independent Police Complaints Commission, 2011). It appears as though injuries sustained by detainees prior to detention fall under the main causes of deaths in police custody.

People died in police custody due to the injuries inflicted upon them while in police custody. There were a total of 28 detainees out of 309 and 31 out of 279 who died in police custody because of the injuries they sustained while in custody during the respective 2005/2006 and 2006/2007 financial years (Independent Complaints Directorate, 2009a). This figure increased to 97 deaths out of 294 in the financial year 2009/2010 (Independent Complaints Directorate, 2010). According to Dissel and Ngubeni (1999), injuries sustained in police custody was identified as the cause of deaths in 25 cases out of 204 in 1998. Of concern is the fact that the fatal injuries could have been inflicted upon the deceased by members of the police, third parties, self-inflicted or accidental (Dissel & Ngubeni, 1999). Bruce (2000) also confirms that detainees died in police custody as a result of the actions of other persons. The Independent Police Complaints Commission (2011) found that injuries which were sustained in police detention led to the death of 6 detainees out of a total of 333 in the United Kingdom in the period 1998 to 2009. It appears from the different sources consulted that there is a general agreement that injuries sustained by detainees while in police custody caused many such deaths. People in police cells also died from unknown causes. It was not always possible for investigators to identify the actual cause of deaths at all times. For example, the Independent Complaints Directorate (2009a) reported that there were three incidences of deaths out of 22 resulting from unknown causes. According to the Independent Police Complaints Commission (2011:16), less than 5 percent of deaths in police custody were ascribed to what is termed "other" causes. In his study, Bruce (2000) found that two deaths in police custody out of 100 were caused by other causes which he did not identify. Therefore, this means that there are other causes of deaths in police custody which still need to be identified other than the main four causes discussed above.

The main causes of deaths of people in police cells are suicide, natural causes, injuries sustained before their detention, injuries sustained while in police cells and deaths due to unknown causes. Amongst these causes, suicide and illness were found to be the leading causes.

3.3 The contributory factors to deaths in police cells

There is a wide array of factors which contribute to the incidences of deaths in police cells. The consumption or use of substances such as alcohol and drugs is a contributing factor to the incidences of deaths in police cells. A study undertaken by Bruce (2000) found that two detainees out of 100 died in South African police cells as a result of complications that were associated with substance abuse. The abuse of substances with a narcotic effect was identified as having contributed to the deaths of 333 detainees in the United Kingdom in the period 1998/1999 and 2008/2009 (Independent Police Complaints Commission, 2011). In their study, Leigh et al. (1998) also conclude that substance abuse had contributed to the deaths of 69 people in police cells in the United Kingdom. The deceased had either consumed alcohol or used drugs or took a combination of both drugs and alcohol (Leigh et al., 1998). The fact that substance abuse by detainees contributed to their deaths in police cells in South Africa is in line with similar trends elsewhere.

Deaths in police cells occurred as a consequence of possible police negligence on the side of the police. The South African Police Service Standing Order 361.11 provides, unambiguously, that police officials must remove from persons in police cells, any items, including clothing items that may pose a risk of harm to detainees themselves or any other persons (Standing Order 361.11). However, Dissel and Ngubeni (1999), found that 30 detainees out of 204 might have lost their lives in South Africa due to possible negligence of the police. The inference of possible police negligence was probably drawn from the fact that the deceased used articles such as shoelaces, belts and firearms among others, to commit suicide while in police cells (Independent Complaints Directorate, 2009a, Dissel & Ngubeni, 1999). According to Leigh et al. (1998), persons in police cells in the United Kingdom hanged themselves using similar items mentioned above, which were in their possession in contravention of the stipulations of the PACE Codes of Practice. In the United Kingdom, the Independent Police Complaints Commission (2011) found that police officers omitted to remove the personal belongings of 47 of the detainees. Police officers also placed 9 mentally ill detainees in police custody instead of placing them in a hospital, thereby contravening the prescripts of the relevant regulations (Independent Police Complaints Commission, 2011). The Independent Complaints Directorate

(2009a) is of the view that the high incidence of suicide in police cells is indicative of the failure of some police officials to conduct hourly cell inspections as mandated by regulations such as the Standing Order 361.11. From this, it can be deduced that the police officials were negligent in implementing set regulations relating to the care of people in their custody.

Placing mentally ill people in police cells may contribute to their deaths or the deaths of those detained with them. According to Docking et al. (Independent Police Complaints Commission, 2011) various people have questioned the practice of placing the mentally ill people in police cells instead of suitable places of safety as this may worsen their mental condition. According to Independent Police Complaints Commission (2011) 17 people died in police cells in the United Kingdom after being detained under the provisions of section 36 of the Mental Health Act. This section sanctions the arrest of people in need of immediate care and control, as well as their subsequent detention for the purpose of ensuring their safety (Independent Police Complaints Commission, 2011). However, it must be noted that some of these people were detained after normal working hours, thereby suggesting the non-availability of alternatives to detention (Independent Police Complaints Commission, 2011). A study conducted by the Police Complaints Authority (Joint Committee on Human Rights, 2004) found a correlation between mental illness and deaths in police cells. This study revealed that over half of the deceased covered in the study had mental health problems (Joint Committee on Human Rights, 2004). According to the Joint Committee on Human Rights (2004), the Mental Health Act Commission in the United Kingdom found that 233 people detained under the Act died as a result of unnatural causes in the period between 1997 and 2000. It appears as though placing mentally ill people in police cells exposes them to the risk of deaths.

Apart from the causes of deaths discussed above, there are also a number of factors that contributed to the deaths of detainees in police cells. Substance abuse, police negligence and mental illness were found to have contributed to the deaths of people detained in police cells in South Africa and the United Kingdom.

3.4 The prevention of deaths in police cells

The phenomenon of death in police cells cannot be completely eradicated. However, every effort should be made to prevent, or at least reduce the deaths in police cells. A multi-disciplinary approach to achieve this goal is discussed below. The prevention of deaths in police cells is dependent on the proper training of the personnel who are involved in the management and care of detainees. The prevention of such deaths is consistent with the constitutional guarantee of the right to life (Bruce, 2000). The training of police officials on human rights is, therefore, imperative to enable them to perform their duties within the limits of the law (Dissel & Ngbeni, 1999, Sallybanks as cited in Joudo, 2006). Sallybank (Joudo, 2006) found that police officers in Australia undergo training on safe custody as one of the strategies which is aimed at ensuring the safety of police officers and detainees. According to Dissel and Ngubeni (1999), only a few police officials in South Africa had undergone any training on human rights, as well as on the management and care of people in police cells. The statistics which were obtained from the SAPS Division Human Resource Development indicate that 4069 police personnel had undergone human rights training, in addition to the broad-based human rights training covered during basic training, from the financial year 1999/2000 up to the first quarter of 2013/2014. The South African Police Service employs 156,041 police officials as on January 2013 (South African Police Service Division Human Resource Development, 2013). One hundred and eighty-five, namely 4.5%, of the 4069 people trained on human rights are civilian personnel who are employed under the Public Service Act (South African Police Service Division Human Resource Development, 2013).

As a preventative measure and in order to ensure compliance in the United Kingdom with the provisions of the Human Rights Act, the Joint Committee on Human Rights (2004) made a recommendation relating to the training of police officials who deal with detainees. The Joint Committee on Human Rights (2004) recommended that police forces in the United Kingdom should make it a prerequisite for every police official who deals with the detention and care of detainees to first undergo and successfully complete a training programme which is designed for custody officers. Dissel and Ngubeni (1999) are also of the opinion that police officials who deal with the detention and management of people in police cells should be trained how to identify and manage detainees who are at risk of harming themselves due to their mental illness or suicidal inclination. The envisaged training should also focus on various aspects relating to the general safety and security of detainees among other areas of interest (Dissel & Ngubeni, 1999). The objective of this training should therefore be the general development of personnel and should cover aspects such as training in first aid, medical care and the

recognition of signs of drug overdose among others (Independent Police Complaints Commission, 2011). From this an inference can be drawn that training is a pre-requisite for preventing deaths in police cells. Despite the recommendation on the focused training by Dissel and Ngubeni, only a few police officers at station level had apparently undergone such training which is presented at the provincial decentralised training centres (South African Police Service Division Human Resource Development, 2013).

The deaths in police cells could be prevented or reduced through the implementation of proper risk assessments of detainees before being taken to the cells. The effective risk assessment serves to identify problems that have the potential to cause injuries or deaths amongst the detainees at an early stage (Hounmenou, 2010). Risk assessment involves the questioning of individual detainees on their health and mental wellbeing upon their reception in police custody. The purpose of the questioning should be aimed at establishing whether the detainees are prone to harm themselves or pose any threat of causing harm to others (Joint Committee on Human Rights, 2004, Independent Police Complaints Commission, 2011). According to the Joint Committee on Human Rights (2004), risk assessment in the United Kingdom is actually the responsibility of custody officials and informs the referral of identified risk cases to police surgeons. In Australia, the police implemented strategies such as making records of risk factors and medical conditions of detainees in order to increase safety in police cells (Joudo, 2006). The primary aim of conducting risk assessments is, therefore, to determine the risks which vulnerable detainees are exposed to and to minimise them (Joint Committee on Human Rights, 2004). According to Dissel and Ngubeni (1999), police officers in South Africa should engage themselves in the process of screening detainees who are at risk and to pay special attention to complaints or statements indicative of the risk factor. The custody officers should be alert to warning signs at the detention point (Leigh et al., 1998). The warning signs could be cases involving substance abuse and head injuries which may be misjudged for drunkenness (Leigh et al., 1998, Independent Police Complaints Commission, 2011). Furthermore, the ability of the police officials to identify early warning signs and take prompt appropriate action may help prevent some of the deaths resulting from suicide, substance abuse, injuries and other medical conditions while in police cells (Bruce, 2000). It seems as though risk assessment, if implemented correctly, could be beneficial in preventing deaths in police cells.

The proper searching of persons in police cells and the subsequent removal of dangerous articles and clothing items deemed to be detrimental to the safety and security of persons in police cells and those around them could significantly contribute to the prevention of deaths in police cells. Bruce (2000) is of the view that the strict enforcement of the rules dealing with the

securing and searching of persons in police cells and their visitors is potentially beneficial in preventing deliberate self-harm. The removal of dangerous items from persons in police cells shall be in compliance with the dictates of the PACE Codes of Practice which are applicable to the United Kingdom and of the South African Police Service Standing Orders (General) (Leigh et al., 1998, Independent Police Complaints Commission, 2011, South African Police Service Standing Order (General) 361). The Independent Complaints Directorate (2009a) recommended that a separate room should be established at every police station for the purpose of searching arrestees therein prior to their detention. The establishment and use of such rooms will serve the following dual purpose:

- It will prevent the smuggling of weapons and other unauthorised articles into the police cells and
- It will also allow for the decent and orderly searching of detainees which is a legal obligation imposed upon the police (Independent Complaints Directorate, 2009a).

The searching needs to be extended to anyone who visits any person in the custody of the police (Independent Complaints Directorate, 2009a). According to the Independent Complaints Directorate (2009a), police officers do conduct searches on persons in police cells during the arrests and prior to placing them inside the cells in order to establish if such persons in police cells possess any articles that pose danger to themselves or any other person. From this, it can be deduced that the searching of detainees plays an important role in ensuring safety and security in police cells.

The conducting of regular cell inspections will help improve the safety and security of persons in police cells, thereby making a contribution to the prevention of deaths in police cells. The police regulations which deal with cell inspections stipulate how the cells should be inspected. The South African Police Service Standing Orders (General) and the PACE Codes of Practice in the United Kingdom provide that police officials who are in charge of police cells should visit ordinary detainees at least every hour and that detainees who are classified as being at risk should be visited at least every half hour (South African Police Service Standing Order (General) 361.13, Leigh et al., 1998, Independent Police Complaints Commission, 2011). Certain categories of persons in police cells such as those who were rendered insensitive by the consumption of alcohol should be aroused during cell inspections in order that their level of consciousness may be assessed (Independent Police Complaints Commission, 2011). The station commanders carry the overall responsibility of ensuring that the cells are visited randomly to avoid the chances of these visits being predictable, thereby defeating the object of

their existence (Dissel & Ngubeni, 1999). The Independent Police Complaints Commission (2011) further maintains that the mentally ill, high risk and unconscious persons in police cells must be constantly supervised. Persons in police cells who lost their lives while in police cells could have been saved, had the regulations on cell inspections been complied with, as evidenced from a study conducted by the Independent Police Complaints Commission (2011). The Independent Police Complaints Commission (2011) found that out of the 205 persons in police cells who should have received constant supervision, only 13 of them were actually constantly supervised. There was also evidence of non-compliance with the police regulations in the case of persons in police cells who were scheduled to receive checks every half hour (Independent Police Complaints Commission, 2011). It appears as though proper cell inspections have a major role to play in preventing this phenomenon.

The immediate provision of medical care to persons in police cells who are experiencing difficulties could greatly contribute to the prevention of deaths in police cells. The provision of medical care to persons in police cells may be helpful in preventing deaths which may arise from natural causes, injuries sustained in custody or prior to custody or from substance abuse (Bruce, 2000 , Dissel & Ngubeni, 1999). Members of the police should, therefore, be encouraged to ensure that persons in police cells who are injured or sick receive prompt medical attention (Bruce, 2000).The Independent Police Complaints Commission (2011) argued that Forensic Physicians who provide medical care to persons in police cells in the United Kingdom should be made aware of their legislated duty of care towards persons in police cells. According to the Joint Committee on Human Rights (2004), the Police and Criminal Evidence Codes of Practice which are applicable to the United Kingdom require that custody officers must ensure that persons in police cells receive appropriate medical care whenever it is needed. The custody officers are also expected to summon medical practitioners urgently when a person in police cells cannot be aroused, fail to respond to questions or fail to respond to simple instructions appropriately (Joint Committee on Human Rights, 2004, South African Police Service Standing Order 349). From this, it can be interpreted that the provision of medical care to persons in police cells could help reduce deaths in police cells.

The improvement in the physical conditions of cells could help to prevent the deaths of persons in police cells. A study conducted by Dando in the United Kingdom found that safer cells are likely to prevent suicide if implemented in a proper way (Joint Committee on Human Rights, 2004). The elimination of all ligature points in the cells was found to reduce the incidences of suicides by hanging (Joint Committee on Human Rights, 2004, Joudo, 2006). According to Joudo (2006), the removal of ligature points had indeed led to a decline in the number of

suicides by hanging in Australia in the period between 1990 and 2004. However, it must be noted that the mere removal of ligature points may not deter a determined person in police cells from committing suicide (Leigh et al., 1998). The proper ventilation of the cells will also eliminate the need for windows which could be used as ligature points (Joint Committee on Human Rights, 2004). The conditions of the police cells should be such that they do not cause despair in the mind of persons in police cells and are compliant with the constitutional guarantee of human dignity (Dissel & Ngubeni, 1999). This means that poor cell conditions have contributed to deaths in police cells.

The installation of closed circuit television cameras in the cells for the purpose of monitoring the activities therein could potentially lead to prompt reaction when the need arises, thereby saving lives. The major advantage of closed circuit television cameras is their ability to alert police officials to situations where persons in police cells are deliberately harming themselves or are unconscious as a result of a medical condition (Leigh et al. 1998). The Independent Police Complaints Commission (2011) has recommended the installation of closed circuit television cameras in custody suites as a preventative measure, particularly in cells where persons in police cells who are classified as risky are detained. According to Joint Committee on Human Rights (2004), many police forces in the United Kingdom have started installing closed circuit television cameras in the cells as a measure of ensuring safety. However, the high costs associated with the installation thereof limit such installation to a few cells (Joint Commission on Human Rights, 2004). According to the Independent Police Complaints Commission (2011) and Hounmenou (2010), vulnerable persons in police cells are, in most instances, afforded additional protection in the form of monitoring through closed circuit television. However, Leigh et al. (1998) question the value of closed circuit television in the prevention of deaths in police cells as they point out that detainees died in police cells in which closed circuit television cameras were installed. Furthermore, the availability of closed circuit television in the cells does not replace the need for police officers to visit the cells physically (Leigh et al., 1998, Hounmenou, 2010). It appears as though closed circuit television could help in the monitoring of police cells.

A thorough investigation of custody deaths by independent institutions and the subsequent prosecution of those implicated should create a culture of respect for the safety and security of persons in police cells amongst police officers. Dissel and Ngubeni (1999) are of the view that the primary aims of the Independent Complaints Directorate investigations should not only be to determine criminal liability, but also be extended to establishing how similar incidences could be prevented in the future. The need for police officials to explain the reasonableness of their

actions to an independent body when deaths occur in police cells would encourage proper care for detainees under their watch (Bruce 1998). According to the United States Department of State (2011), 25 police officers were convicted for custody-related deaths in South Africa in 2010. The Independent Police Complaints Commission (2011) has a statutory mandate of investigating all deaths in police cells in England and Wales with a view to the institution of prosecution of those implicated in wrong-doing whenever necessary (Leigh et al., 1998). From this, it can be deduced that fear of prosecution is deemed an encouragement to execute their duty of care towards persons in police cells in a morally and legally acceptable manner.

Regular independent visits to police cells have an equally important role to play in the prevention of deaths in police cells. The main function of the community visitors' schemes is to make unannounced visits to police cells and independently observe the conditions under which persons in police cells are held while in police cells, thereby fulfilling a preventative role (Dissel & Ngubeni, 1999, Hounmenou, 2010). The lay visitors' system was operational in South Africa, but has since been discontinued despite its apparent benefits due to alleged conflict of interest. The system was reportedly implemented through the Community Policing Forums which interact with the police in crime prevention initiatives, thereby creating a potential conflict of interests (Dissel & Ngubeni, 1999). The independent visitors could, as part of their mandate, determine whether closed circuit television cameras are operational where applicable (Independent Police Complaints Commission, 2011). The preventative value of the community visits to the cells is based on the fact that they are difficult to predict (Dissel & Ngubeni, 2000). It appears as though independent lay visitors to police stations are needed to monitor the conditions under which persons in police cells are kept.

The duty of care towards persons in police cells should be allocated to specific police officers who would serve as custody officers. The primary role of custody officers is to protect the interests of persons in police cells and to communicate to their colleagues, the circumstances and needs of persons in police cells, including medical needs and other risks during handing over of duties at the end of the shift (Independent Police Complaints Commission, 2011). The safety and care of persons in police cells will best be served through the recruitment and training of specific personnel on the management of people in detention of the police (Dissel & Ngubeni, 1999, Hounmenou, 2010). This arrangement will also remove a potential conflict of interests where police officials who detained the suspects are also expected to care for them (Dissel & Ngubeni 1999). From this, it may be concluded that caring for persons in police cells is a responsibility which requires special skills. Inadequate communication between the stakeholders played a role in the deaths of people who were detained in police cells. According

to the Independent Police Complaints Commission (2011), investigators who investigated the incidences of deaths in police cells in the United Kingdom, criticised the way in which police officers and officials from other agencies shared information relating to the safety and security of persons in police cells amongst themselves, particularly information on healthcare issues. The Independent Police Complaints Commission (2011) cited as an example an incident where the police shift reporting for duty was not informed, during the handing over, that one of the persons in police cells needed medication and this omission allegedly contributed to the death of the person in police cells concerned. Leigh et al. (1998), also found that communication breakdown between police officers, healthcare practitioners and between police officers and healthcare practitioners apparently contributed to the deaths of persons in police cells.

3.5 Summary

This chapter was dedicated to gathering information which is relevant to the incidences of deaths in police cells. This review of literature provided information about the causes of and contributory factors to deaths in police cells. The study revealed that the deaths of persons in police cells is mainly caused by suicide, natural causes, injuries sustained prior to custody and injuries sustained while detained in police cells. The abuse of substances such as alcohol and drugs by persons in police cells, as well as possible police negligence are some of the factors which reportedly contributed to the prevalence of the phenomenon being studied. The study also provided data on measures that could be implemented to create an environment which is conducive to the prevention of the phenomenon being studied. These measures include, among others, the training of police officers on the management of persons in police cells so as to empower them to discharge their duty of care over persons in police cells.

CHAPTER 4: THE DESCRIPTION AND ANALYSIS OF DATA

4.1 Introduction

The researcher accessed the dockets in the Gauteng and Limpopo Provinces which were opened and investigated by the Independent Police Investigative Directorate. The dockets related to every incidence of death that occurred in police cells during the period of the study. The dockets were opened to conduct investigations into the circumstances that preceded the deaths of persons in police cells and to determine whether the police officials could be held criminally and departmentally liable for such deaths. Whenever a death occurred in police cells, the Independent Police Investigative Directorate opened either a docket or file, but both serve the same purpose of establishing the role of the police officials in such a death of a person in police cells. For this reason, any reference to a docket in this chapter should be interpreted to be a reference to a file. According to D de Bruin (personal communication April 15 2013), the Database Management Manager at IPD, IPID has a Standard Operating Procedure which defines what is classified as death in police cells and the definition is used as the class when registering the case on the Case Management System.

All dockets that the Independent Police Investigative Directorate had opened are classified in different categories. Therefore, all cases involving the deaths of persons in police cells are referred to as Class 1 cases which include instances where people died while in police cells and those where the deaths occurred in hospitals while the deceased were under police guard. All cases of deaths which occurred in hospitals were not included in this study. A total of 52 dockets relating to the investigations into the deaths of persons in police cells were analysed at the Gauteng and Limpopo Provincial Offices of the Independent Police Investigative Directorate. The contents of the dockets which were accessed are described and analysed below. The description and analysis of data was categorised under four headings. The headings are: the quality of the investigations which were conducted by the Independent Police Investigative Directorate; the causes of deaths in police cells; the compliance of the police officials with the regulations relating to the management of people who are detained in police cells; and the outcome of the investigations thus conducted. The categories were arrived at after the docket analysis forms were manually analysed. The docket analysis forms which were completed at the Gauteng and Limpopo provincial offices of the Independent Police Investigative Directorate were individually allocated unique numbers for control purposes. Therefore, the analysis forms which were completed were allocated identification numbers starting from L1 to L19 for Limpopo and G1 to G33 for Gauteng Independent Police Investigative Directorate offices. This means

that 19 dockets were analysed in Limpopo Province and 33 were analysed in Gauteng Province. The total number of the dockets which were analysed is 52.

4.2 The quality of the investigations

The standard operating procedure of the Independent Police Investigative Directorate dictates that each docket opened by the Directorate for investigation purposes must be assigned a unique Complaint Control Number for control purposes (D de Bruin, Personal Communication April 15 2013). The docket also contains the name of the South African Police Service station where the death has occurred. The following aspects were noticed with regard to the quality of the investigations conducted by the Independent Police Investigative Directorate.

Table 4.1 The quality of the investigations

Actions compromising the quality of the investigation	Number	Percentage
Reason for detention	6	11.538462%
Time of detention	16	30.769231%
Date of detention	2	3.8461538%
Time of death	20	38.461538%
Dockets not compromised	8	15.384615%
Total	52	100%

With regard to the detention of the deceased, 6 out of 52 dockets analysed did not contain the reason for the detention of the deceased; the date of detention was not stated in two of them and the time of detention was also not recorded on 16 of the dockets. The failure to record this crucial information made it impossible to determine the period of time which the deceased could have spent in detention prior to their deaths. The date of the death was recorded in all of the 52 dockets. However, the approximate time of deaths was not recorded in 20 of the dockets. This omission constitutes a substantial number and raises concerns about whether visits to the cells were in fact conducted. In L18 and L19, both deaths occurred at the same police station and on the same date. The information which is contained in L18, including the names of the deceased, is contained in some of the reports that were attached in L19. All these shortcomings tend to undermine the quality of the investigations conducted by the Independent Police Investigative

Directorate. From the above, it can be concluded that the investigators from the Independent Police Investigative Directorate had omitted to obtain and record crucial information during the investigation process.

On the issue of the attachment of the supporting documents, such as post mortem reports and affidavits from witnesses, the following aspects were noted. Twenty-six of the 52 dockets analysed did not contain post mortem reports. This number represents half of all the dockets analysed. Out of the 26 dockets that did not contain the post mortem reports, two had certificates of doctors and another two had the reports from the emergency medical services attached to them. These documents served the purpose of declaring that the deceased were dead and were placed in the dockets in lieu of the post mortem reports. A breakdown in terms of the causes of deaths of the 26 dockets which had outstanding post mortem reports is as follows: seven were suicides, six related to assault of the deceased by members of the community prior to their detention, five of the other dockets involved the deaths of detainees alleged to have died as a result of being assaulted by fellow inmates inside police cells and eight of these incidences were recorded as having resulted from natural causes. From this, it can be deduced that the absence of post mortem reports is an indication that the post mortem examinations were not conducted where necessary.

Out of the 52 dockets analysed, 23 did not contain affidavits from fellow detainees who could have shed light on what could actually have happened at the time the deceased died in the police cells. Persons in police cells were alone in the cells in eleven of the 23 dockets, while seven of the persons in police cells were detained with fellow persons in police cells in seven of the cases. However, there were no records in the remaining five cases from which it could be established whether the persons in police were in the cells alone or not. The attachments from police officials were outstanding in six of the dockets. The importance of interviewing and obtaining affidavits from the family members of the deceased, where it is applicable, in the investigation process is shown by the following incidences. Family members of the deceased were involved in only five of the 52 analysed. In L12, a family member submitted an affidavit in which he/she disputed the allegation made by a police official who processed the deceased's case, that the deceased had mentioned to him that he was taking medication for an undisclosed illness. The mother of the deceased in G23 had submitted an affidavit in which she mentioned that the deceased was suicidal and that she found a suicide note at her house after being notified of the death of her son. It was noted that an attempt was made in L7 to obtain an affidavit from a family member of the deceased who reportedly refused to co-operate. It is evident that the friends of the deceased were not involved at all in the investigation process.

This inference is drawn from the fact that no affidavits appeared to have been solicited and obtained from the friends of the deceased in all of the 52 dockets. The non-availability of the copies of occurrence book entries may be ascribed to the poor quality of the investigation, or to failure of the police to make and maintain records relating to cell visits in terms of the South African Police Service Standing Order (General) 361.6. From this, it appears as if cases were finalised without obtaining and considering the necessary and relevant statements from the potential witnesses.

The investigations which were conducted by the Independent Police Investigative Directorate in the Gauteng and Limpopo Provinces had shortcomings. Some of the dockets did not contain crucial information, such as the reports of *post mortem* examination, where it was applicable. In other dockets, the approximate time of deaths, as well as the date and duration of detention was not stated. The identified shortcomings appeared to have a negative impact on the outcome of the relevant investigations.

4.3 The causes of deaths in police cells

An analysis of the 52 dockets revealed four causes of deaths in police cells. These causes are suicide, natural causes, assault by fellow inmates and injuries sustained prior to detention. Suicide was the leading cause of deaths in police cells, as it accounted for 24 of the incidences out of 52. However, it should be indicated that of the two provinces that formed part of the study, Gauteng had reported the most suicide cases with a total of 21 as compared to three cases which occurred in Limpopo Province. The instruments which were used by the detainees when committing suicide were clothing items such as T-shirts, trousers, strings, shoe-laces, belts, and a sock, pieces torn from blankets and mattresses. The use of clothing items seems to be the preferred method of committing suicide, because it represented a total of 17 incidences of deaths in police cells out of 24. The preferred ligature points from where the persons in police cells had hanged themselves were burglar proof bars on the windows of the cells. This conclusion is drawn from the fact that 15 persons in police cells used the burglar proof bars on the windows of the cells to hang themselves. Thirteen 13 of the 15 incidences of death occurred inside the cells, one took place inside the toilet of the cell and one occurred inside the exercise area of the police cells. The other points from where persons in police cells hanged themselves are the doors and ceilings of the cells, as well as the entrance to the shower area of the cells. There were four incidences in which the points from where the detainees hanged were not specified. For example, a police official who visited the scene in G28 stated in her report that she could not establish the point from where the deceased could have hanged himself, even

though it was alleged that the deceased committed suicide by hanging himself. From this, it appears as though the detainees shall always have access to clothing items with which to hang themselves.

Natural causes and assault of detainees by fellow persons in police cells detainees were found to be the second leading causes of deaths in police cells, as these were found to have led to the deaths of ten persons in police cells each. It was established from the supporting documents attached in the dockets that the persons in police cells whose causes of deaths fell under the category of natural causes were suffering from illnesses. The illnesses included HIV and AIDS, diarrhea, drug overdose, pancreatic cancer and complications associated with the bowels. This information was obtained from the supporting documents such as affidavits submitted by witnesses. According to an employee of the IPID, it is the standard operating procedure of the IPID that *post mortem* examinations should not be conducted in cases where the cause of death is believed to be natural causes. This practice explains the reason for the non-availability of post mortem reports in five of the nine cases which involved the deaths of persons in police cells allegedly as a result of natural causes. The shortcoming of this practice was evident in the fact that the exact cause of deaths which were categorised as deaths due to natural causes could not be established with certainty in two incidences. The importance of performing *post mortem* examinations, even in cases where death is believed to have occurred as a result of natural causes, is evident in L2. In this case, a police official alleged in his affidavit that the deceased was suffering from an undisclosed illness, while a family member of the deceased had, in his/her affidavit, disputed the allegation that the deceased was ill or taking medication for any illness. Furthermore, fellow persons in police cells alleged that the deceased had suffocated, probably due to an illness. However, a *post mortem* report has established in this case that the cause of the death of the deceased was consistent with manual strangulation. From this, it is apparent that *post mortem* examinations are necessary to establish the causes of deaths with absolute certainty.

The following aspects were revealed during the analysis of dockets in relation to the assault of persons in police cells by fellow persons in police cells as the cause of deaths in police cells. As indicated above, this category was the second leading cause of deaths in police cells, as was the case with natural causes. Each of the two categories accounted for ten incidences each, as mentioned above. All ten incidences of death which fall under this category occurred in Limpopo Province. The preferred instruments used to assault the deceased are booted feet and hands,

which accounted for nine incidences. In the tenth incident, a piece of clothing was allegedly used as an instrument to suffocate the person in police cells. In one of the nine incidences, a bar of bath soap was reportedly wrapped in a T-shirt and used as a weapon to assault the other person in police cells, in addition to the use of booted feet and hands in L14. It was alleged in L18 that a person in police cells who played a leading role in the assault of the person in police cells, went to the toilet and returned with a knife which, however, was not used to cause bodily harm to the deceased. In another incident out of the nine incidences mentioned above, fellow persons in police cells alleged that the deceased fell to the ground inside the cell, injuring himself. This was in addition to being kicked with booted feet and punched by fellow persons in police cells inside the police cells in L1. There were no *post mortem* reports attached to the dockets, nor was there any reference made to the outcome thereof, despite the nature and extent of the injuries sustained by the deceased in four of the following five cases. In L13, the deceased reportedly had injuries on his toe, cheek, both hands and on his back; while in another case the deceased was reportedly injured on his right hand and neck. In L18 and L19, both the deceased died at the same station and on the same date. In L18, the deceased was allegedly burned with a cigarette on his stomach. In the case of L19, the reports indicated that the deceased had a burning piece of plastic placed on his body and covered with a blanket in an attempt to burn him and he also had a swollen head. Twenty-six dockets out of 52, as depicted in table 3 below, did not contain *post mortem* reports.

Table 4.2: Dockets without post mortem reports

Causes of death	Total	Percentage
Natural causes	8	30.769231%
Suicide	7	26.923077%
Assault by community members prior to detention	6	23.076923%
Assault by fellow detainees	5	19.230769%
Total	26	100%

With regard to the place where the assault took place, eight out of ten assaults occurred inside the cells, while two were perpetrated inside the shower and toilet of the cells respectively. Six of the incidences were reported to have taken place in the time between 00h00 and 06h00, whereas three took place between 09h00 and 09h20. There was only one incidence that occurred at about 19h30. It was established from the dockets that the reasons for the assaults were about control over the territory, which accounted for two which occurred at the same police station on the same date and a refusal by the deceased to have sex with his attackers. The other reasons were the accusation by fellow persons in police cells that the deceased was a “sell-out”, meaning that it was suspected that the deceased had divulged the identity of the perpetrators of the crime to police officials and a fight between the deceased and his fellow persons in police cells over an unspecified matter, which accounted for one death each. The reasons for the fatal assault were not specified in six of the cases. From this it can be deduced that limbs are as fatal as dangerous weapons when used in attacks.

It was also found during the analysis of the dockets that persons in police cells had also died in police cells as a result of injuries sustained prior to their detention. This category relates to probable incidences of vigilantism. As it was the case where deaths of persons in police cells as a result of assault by fellow inmates were reported only in Limpopo Province, the deaths of persons in police cells due to injuries sustained when detained occurred only in Gauteng Province and none in Limpopo Province. In this category, eight incidences were reported out of a total of 52. The deceased in this category were reportedly apprehended and assaulted by members of the community for their alleged involvement in criminal activities before being handed over to the police. It was only in two cases out of eight under this category that the reasons for the assault of the deceased by members of the community were not specified. However, it could be interpreted from the circumstances of cases G12 and G14, that the probable reasons of the assault were also the alleged involvement of the deceased in criminal activities. The preferred instruments used by members of the community in the assault of the deceased fall under the following categories. In six of the eight cases, hands and booted feet were used. Hands and bricks and/or stones were used in one case, while hands, booted feet and bricks and/or stones were used in the other case. From the discussion above, it can be concluded that vigilantism was prevalent in Gauteng Province.

Four causes of deaths in police cells were identified, namely, suicide, natural cases, assault by fellow persons in police cells and injuries sustained at the hands of the members of the community prior to detention. The identification of the causes of deaths in police cell is important for the prevention of deaths in police cells. It is only through the proper identification and

analysis of the causes of deaths that effective preventative measures could be designed and correctly implemented.

4.4 Police compliance with the regulations

This part of the description and analysis of the docket is aimed at establishing the extent to which police officials had complied with the regulations relating to the management and care of persons in police cells in Gauteng and Limpopo Provinces. The regulations at issue are the South African Police Service Standing Orders (General) which govern the provision of medical care to the detainees, the conducting of visits to the police cells, the searching of detainees and the keeping of records in relation to the manner in which police officials manage people in their care. The police officials generally appeared to comply with the duties imposed upon them by the South African Police Service Standing Order (General) 349. This Standing Order (General) deals with the provision of medical care and the hospitalisation of persons who are detained in police cells whenever the need arises (South African Police Service, 2003a). The fact that police officials complied with the stipulations of South African Police Service Standing Order (General) 349 could be deduced from the following occurrences. Twenty-seven persons in police cells out of 52 needed medical care. The police officials had summoned emergency medical services for 24 persons in police cells out of a total of 27 who were in need of medical care. Eleven of the cases where medical assistance was needed were in Limpopo Province and 16 cases were in Gauteng Province. However, it is concerning to note what had transpired in the remaining three cases. In L11 and L13, persons in police cells expressly requested to consult medical practitioners, but their requests were not granted and the police official provided painkillers to the latter instead. In G33, the deceased was still wearing hospital attire and there was neither a hospital release form attached to the docket, nor an explanation offered for this unusual occurrence.

In G5, the persons in police cells kept inside the same cell as the deceased alleged that they shouted to the police for assistance when they realised that there was something wrong with the deceased. They further alleged that there was no response from the police officials. On the other hand, the police officials alleged that the person in police cells concerned had in fact consulted a medical practitioner before being placed in the cell. Police officials further alleged that they summoned an ambulance again without delay upon becoming aware that the person in police cells needed medical care. A scenario which is remotely related to the issues detailed above occurred in L16. Some of the fellow persons in police cells in this case made allegations that the deceased had requested the police officials to transfer him to another cell the day

before his death and that the police officials refused to grant him his request. There was another allegation by other persons in police cells that they also collectively requested the police officials to remove the deceased from the cell on the day that he had died. According to fellow persons in police cells, a police official left, reportedly to fetch a key for the cell in order to remove the detainee concerned from the cell and that the detainee died before the police official could return with the key. The reasons for the request to have the person in police cells transferred to another cell were not stated. However, it is important to note the fact that the person in police cells concerned had died as a result of being assaulted by fellow persons in police cells. It is also imperative to take cognisance of the fact that the *post mortem* examination indicated that the cause of the death of the d person in police cells was found to be consistent with the injuries sustained during the assault on him. From this, it could be concluded that the failure of the police officials to conduct visits to the cells properly and to heed reasonable requests from the persons in police cells endanger the lives of the persons in police cells.

The mandatory searching of persons in police cells is imposed upon the police officials who affect the arrest of a person and also upon any other police official who exercises control over the person in police cells at any stage. This legal obligation to search persons in police cells and seize any dangerous articles is contained in the South African Police Service Standing Order (General) 361 and section 23 of the Criminal Procedure Act (Bekker et al, 2003, South African Police Service, 2003b). The police officials appeared to be partially complying with the regulations relating to the searching of persons in police cells and the subsequent mandatory seizing of dangerous items from them. This conclusion is drawn from the fact that the following items were alleged to have been possessed by persons in police cells while inside the police cells. These items are shoe-laces, belts, knives and drugs. The drugs were reportedly prescribed for and possessed by a psychiatric patient in G21 while in a police cell. The drugs were for the treatment of her psychiatric condition, high-blood pressure and epilepsy. The person in police cells took an overdose of the drugs which resulted in her death. It was alleged that the female police officer who locked up the detainee in a cell omitted to search her as prescribed by police regulations and that there was no record that the persons in police cells had any personal items removed from her. It is significant that two persons in police cells had reportedly used shoe-laces which did not belong to them to hang themselves in G26 and G32. Furthermore, a person in police cells had used his belt, which was not removed from him at the time when his shoe-laces were removed before being placed in a cell, to commit suicide. Even though a fellow person in police cells had produced a knife inside the cells during an assault on the deceased, that knife was not used to attack the deceased in L18. In the last of these cases,

the deceased who reportedly died as a result of natural causes was found with his belt fastened to his trousers. These instances represent a total of six out of fifty-two cases. In L18 and L19, both of which occurred at the same police station on the night of the same day, it was clear that the provisions of the South African Police Service Standing Order (General) 361 were disregarded. The South African Police Service Standing Order (General) 361 provides that smoking in the cells is prohibited for safety reasons (South African Police Service, 2003b). In L18, the person in police cells was burned with a cigarette on the stomach, while in L19 the person in police cells, who was deceased by then, had a burning piece of plastic placed on his body which was then covered with a blanket in an attempt to burn him. From this it could be deduced that police officials failed to comply with the regulations that govern the searching of persons in police cells and the seizing of dangerous articles before placing them in the cells in order to ensure their safety and the safety of other people around them.

The South African Police Service Standing Order (General) 361 provides that the police officials must conduct visits to the cells (South African Police Service, 2003b). The South African Police Service Standing Order (General) 361 further regulates the timeframes in which the cells must be visited by stipulating that ordinary persons in police cells must be visited at least every hour and that persons in police cells who are drunk as a result of liquor or under the influence of any intoxicating substances, unconscious or under restraint, should be visited every half hour until their condition has improved (South African Police Service, 2003b). It was established from the dockets that were analysed that there is a general lack of police compliance with the provisions of the South African Police Service Standing Order (General) 361 with specific reference to the conducting of visits to the cells. There were only two cases, namely G4 and G23, wherein the police officials apparently visited the cells hourly, in compliance with the South African Police Service Standing Order (General) 361 and where documentary evidence was attached to the docket. Further to this, the reports attached to the dockets indicated that there were "regular visits to the cells" in eight of the cases, but there were no documents attached to the dockets in support of the claims. These cases are G1, G3, G6, G11, G17, G20, G22, and G26. In 13 of the analysed dockets, there was neither documentary evidence from which an inference could be drawn that the cells were visited as stipulated, nor was there any indication in the reports to imply that the cells were actually visited. In fact, the persons in police cells alleged in G9 that there were no visits to the cells for the whole night, thereby disputing the reports made in the occurrence book by the police that the cells were visited on the relevant night. The non-availability of the relevant copies of the occurrence book reports in the dockets could be ascribed to the failure of the police officials concerned to record in writing whenever the cells are

visited, as mandated by the South African Police Service Standing Order (General) 361.6. The South African Police Service Standing Order (General) 361.6. stipulates that police officials must record every visit to the cell in the occurrence book and that a full report must be made regarding any matter that calls for attention (South African Police Service, 2003b). In the alternative, the non-availability of copies of such records could be indicative of the failure of the Independent Police Investigative Directorate personnel to request the police officials to avail such records to them. There were nine incidences of deaths where the persons in police cells were either drunk or suspected of being mentally ill. In one of the nine cases, namely L6, the person in police cells had reportedly just been released from a psychiatric hospital prior to his/her death. In all these cases, the cells were not visited at hourly or half-hourly intervals as required by the South African Police Service Standing Order (General) 361.6. In fact, documentary evidence in G21 indicated that the cells where a female person in police cells was detained had received three hourly visits. In this case, the detainee had reportedly died as a result of taking an overdose of drugs which were allegedly prescribed for the treatment of her mental illness, epilepsy and high-blood pressure. In L12, only one occurrence book entry was recorded for a visit to the cell, but the time of visit was not stated therein. The report in G25 indicated that the cell where the deceased was detained was visited three times at the interval of once per hour. However, there were no documents which were attached to the docket to support that claim. In G27, G28 and G32, the persons in police cells were reportedly under the influence of alcohol at the time of their detention. In G28 and G32, the police officials visited the cells one and a half-hour after the detention had taken place. A similar trend was observed in G5. In G27, the cells were allegedly visited irregularly at 23h00, 01h00 and 05h00, regardless of the fact that the person in police cells was reportedly so heavily intoxicated by the consumption of alcohol that he was unable to talk and his names could thus not be established. In the remaining other cases where there were documents to prove that the cells were indeed visited, such documents tended to show that the visits were not undertaken according to the prescripts of the South African Police Service Standing Order (General) 361. For example, the person in police cells in G15 was visited once in the 75 minutes that he was detained. The records in L17 showed that the cells were visited irregularly at 13h55, 15h50 and 16h10. In L15, a police official who was a shift commander at the time of the death of the person in police cells, had alleged that he had conducted four hourly visits to the cells at 03h00, 04h00, 05h00 and 06h00. There was an apparent inconsistency in the affidavit which was submitted by the police official concerned. The shift commander concerned recorded in paragraph two of the affidavit that there were no persons in police cells in cell number ten. However, the shift commander stated in paragraph six of the same affidavit that one of the persons in police cells in cell number ten had

notified another police official that a fellow person in police cells had hanged himself inside the toilet of cell number ten. Furthermore, copies of the occurrence book which were attached to the docket showed that there were three visits to the cells. One of the visits to the cells was reportedly conducted at 22h00 of the night before the person in police cells died in the cells. The other two visits were conducted on the day that the persons in police cells committed suicide. It was during the third visit that the death of the person in police cells was discovered by police officials who went to the cells in response to a notification from a person in police cells that a fellow detainee had died. From this it could be deduced that even though police officials conduct visits to the cells, the frequency with which the cells were visited and the recording thereof were not in compliance with the provisions of the South African Police Service Standing Order (General) 361.

It was established from the dockets that ten persons in police cells at some of the police stations in Limpopo Province had spent many days and even months in police cells pending the finalisation of the criminal proceedings instituted against them, rather than being transferred to correctional services facilities for their further detention. In L5 and L13, the persons in police cells spent eight days in police cells before their deaths. In L11, the person in police cells died after being detained in the police cells for seven days. In L1, L4 and L14, the persons in police cells were locked up in police cells for a period of eleven days, 15 days and 16 days respectively. The persons in police cells had spent exceptionally longer periods in the police cells in L10, L6 and L9 where the period of their incarceration was 36 days, approximately two months and seven months respectively. The period of incarceration could not be established in eleven of the dockets. This was due to the fact that the dates on which the persons in police cells were detained were not stated in the relevant dockets. The persons in police cells referred to above were detained for the alleged commission of serious offences such as rape, murder, assault with the intent to cause grievous bodily harm, housebreaking and theft, as well as stock theft. The reason of detention was not recorded in one of the cases. The cause of death in five of the ten cases was assault of the deceased by fellow persons in police cells. From this, it could be concluded that the safety of the persons in police cells is seriously compromised when they are detained for longer periods in police cells.

The data from the analysed dockets indicated that the deaths of the persons in police cells were discovered by both the police officials and fellow persons in police cells. The police officials had discovered the deaths of 33 persons in police cells while fellow persons in police cells discovered the deaths of the other 19 persons in police cells and subsequently notified the police officials. In instances where the police officials discovered the deaths of the persons in

police cells, such discovery was made under the following circumstances: twenty-four deaths were discovered during visits to the cells, three were during the time when police officials went to the cells to feed the persons in police cells, two were during the change of shifts, two were discovered when police officials went to the cells to detain other persons in police cells and one was discovered when police officials were preparing persons in police cells for their appearance in court. It should be noted, however, that even though it was recorded that the police discovered twenty-four of the deaths, two of these, namely L18 and L19, were in fact noticed by fellow persons in police cells first, but were not reported to the police officials immediately out of fear of reprisal. The two persons in police cells in L18 and L19 were allegedly fatally assaulted by fellow persons in police cells. The deaths of these two persons in police cells occurred at the same police station and on the night of the same date. From this it could be deduced that fellow persons in police cells had noticed the deaths of the persons in police cells, but pretended to be ignorant of the deaths.

The South African Police Service Standing Order (General) 361 provides that female persons in police cells must be detained separately from male persons in police cells at all times without exception and that child offenders must be detained as a last resort and separately from adult persons in police cells at all times. There was apparent complete compliance with the rule that mandates the separation of the different categories of persons in police cells (South African Police Service, 2003b). The perceived complete compliance with the Standing Order 361 could be derived from the fact that the females in G21 and G24 were detained separately from male persons in police cells. In G11, the child offender was also detained in the same cell with a 17 years-old boy separate from adult persons in police cells. It should be noted that of the 52 dockets of deaths in police cells which were analysed, there were only two which involved female persons in police cells and one where the person in police cells was a male child. The majority of the deaths involved adult males. From this, it could be concluded that the different categories of persons in police cells were separated when they were detained in the cells, as prescribed by regulations.

According to section 29 of the Independent Police Investigative Directorate, the station commander or any member of the South African Police Service must immediately notify the Independent Police Investigative Directorate upon becoming aware of the death of person in police cells and to submit a report to the Directorate in the prescribed form and manner (Parliament of the Republic of South Africa, 2011). There was no indication in the dockets that the police failed to notify the Independent Police Investigative Directorate of any death in police cells as prescribed in the Independent Police Investigative Directorate Act. This means that the

police officials seemed to have complied fully with the legal obligation to report the death of any person while detained in police cells.

The following police stations as shown in table 2 below had reported two or more incidences of deaths in police cells.

Table 4.3 Statistics of deaths per station

Province	Station	Year	Total number
Limpopo	Maake	2012,2011,2010,2007	4
	Mankweng	2012,2011,2011	3
	Naboomspruit	*2009, 2009	2
	Haenertsburg	*2011,2011	2
	Seshego	2012,2011	2
	Marble Hall	2013,2011	2
Gauteng	Meadowlands	2012,2009,2009	3
	Johannesburg Central	2009,2009	2
	Lenasia South	2009,2009	2
	Pretoria Central	2009,2009	2

* It means that the deaths occurred on the night of the same date.

Table 4.3 above shows that most deaths in police cells occurred at Maake, Mankweng and Meadowlands police stations. This means that police officials involved had fully complied with the legal obligation imposed upon them to report every death which had occurred in police cells. From the discussion above, it is clear that the police officials had partially complied with the regulations relating to the management of people in police cells. The failure of the police officials to search and seize the dangerous objects in the possession of the persons in police cells, to visit the cells as prescribed and to summon emergency medical assistance whenever the need arose, among others, had endangered the physical wellbeing of persons in police cells under their care.

4.5 The outcome of investigations conducted

The primary purpose of the investigations which were conducted by the Independent Police Investigative Directorate appeared to be aimed at establishing whether police officials concerned could be held criminally liable for the deaths of persons in police cells while in police cells. In 50 of the 52 cases of deaths in police cells which were investigated by the Independent Police Investigative Directorate, the outcome was that the cases were “unsubstantiated”. An unsubstantiated outcome of an investigation means that there was no legal basis for holding the police officials criminally accountable for the deaths of persons in police cells in police cells. The ruling that the cases were unsubstantiated was reached in all 19 cases which were investigated in Limpopo Province where no other additional ruling was made. This meant that there was only one case in which it was recommended to the prosecution authority that police officials who were involved in the detention of the deceased be prosecuted for culpable homicide. The recommendation to prosecute was made in G21 on the ground that the negligence of the police officials involved led to the death of person in police cells. The police officials were found to have been negligent because they failed to take the necessary and reasonable steps to search and remove the tablets from the person in police cells before detaining her in the cells. The person in police cells concerned died inside the police cells after taking an overdose of the tablets. In the second case which is G32, the investigation was still pending at the time the dockets were analysed. It is interesting to note that even though the finding ‘unsubstantiated’ was made in G28, the Independent Police Investigative Directorate further indicated that the person in police cells was potentially murdered. The suspicion that the person in police cells was murdered was partly based on the contents of an affidavit submitted by a senior police officer who visited the cell where the person in police cells had allegedly committed suicide by hanging himself. In the affidavit, the senior police officer concerned indicated that the deceased was found lying on his back on the floor of the cell and that he had a swollen eye. The senior police officer stated further that she could not establish the point from where the persons in police cells could reasonably have hanged himself and that there were no objects lying around either. According to the result of the post mortem examination conducted, the cause of the death of the person in police cells was consistent with the application of force to the abdomen while the person in police cells was still alive. The Independent Police Investigative Directorate in Gauteng made additional recommendations in 12 of the cases apart from the outcome that the cases were unfounded. In nine of the cases, it was recommended that the station commanders concerned institute disciplinary proceedings against the relevant members. The recommendations that disciplinary proceedings be instituted against the police officials

emanated from the findings that police officials concerned had contravened the regulations relating to the conducting of cell visits, searching of and removal of dangerous objects from the persons in police cells and to making false entries in the occurrence book regarding cell visits. The investigations also established that there were potential human rights violations in three cases namely G21, G23 and G28. The conclusion that the human rights of the persons in police cells were potentially violated is based on the fact that there were potential violations of sections 7, 11 and 12 of the Constitution of the Republic of South Africa. Section 7 provides that the state must respect, protect, promote and fulfil the rights contained in the Bill of Rights (Parliament of the Republic of South Africa, 1996). Section 11 entrenches every person's right to life, while section 12 protects everyone against all forms of violence from either public or private agencies and against torture (Parliament of the South Africa, 1996). The reference to a potential infringement of section 12 of the Constitution was made particularly in relation to G28 which was discussed above. In addition to the finding in G4 that the case was unfounded, the Independent Police Investigative Directorate made an additional recommendation that the station commander of the police station where the death of a person in police cells had occurred be given general advice. Therefore, the station commander was generally advised to remove the items which could be used by persons in police cells to harm or kill themselves or other people around them. The national commissioner or the relevant provincial commissioner to whom recommendations relating to disciplinary issues were referred in terms of section 7 of the Independent Police Investigative Directorate Act, must initiate disciplinary proceedings within 30 days of receipt of the recommendations from the Independent Police Investigative Directorate (Parliament of the Republic of South Africa, 2012). The relevant commissioner must also inform the Minister of Police in writing that they have instituted the disciplinary proceedings as recommended and provide copies of the report to the Executive Director of Independent Police Investigative Directorate and Secretary for the Police Service in terms of section 30 of the Independent Police Investigative Directorate Act (Parliament of the Republic of South Africa, 2012). The commissioners concerned must report quarterly on the progress of the disciplinary proceedings which were instituted and are also legally obliged, in terms of section 30 of the Independent Police Investigative Directorate Act, to report on the outcome of the finalised matters (Republic of South Africa, 2012). Taking into account the legal obligations of the relevant commissioners regarding reporting on the progress of disciplinary proceedings instituted against police officials, it is alarming to note that feedback on the outcome of the disciplinary proceedings was provided only in G21. The outcome thereof was that all the members concerned were given verbal warnings. However, the outcome of the decision of the prosecution authority, relating to the recommendation that police officials concerned be

prosecuted for culpable homicide, was not stated in the docket in G21. Therefore, feedback on the remaining eight cases was still outstanding in the dockets. From this, it could be deduced that the relevant commissioners have not complied with the legal obligation which mandates them to provide reports regarding the progress or outcome of the finalisation of disciplinary proceedings to the relevant authorities.

In almost all the dockets of deaths in police cells which were investigated, the outcome was that the cases were unfounded or rather unsubstantiated. In some cases, recommendations stated that the police officials involved be disciplined. In the majority of the cases where the institution of disciplinary proceedings was recommended, the outcome thereof is outstanding. This means that a conclusion could be made that the police officials were seldom held personally accountable for their apparent unlawful conduct or omission.

4.6 Summary

The quality of the investigations which were conducted by the Gauteng and Limpopo Provincial Offices of the Independent Police Investigative Directorate is questionable. Important documentary evidence such as post mortem reports and affidavits from potential witnesses were not obtained and filed accordingly in some of the dockets. Four causes of deaths were identified during the analysis of the dockets. The four causes are suicide, natural causes, assault prior to being placed in police cells and assault by fellow persons in police cells. The police officials were partially complying with the regulations which deal with the management of people who are detained in police cells, particularly regulations dealing with visits to the cells, searching of persons in police cells and seizure of dangerous objects and the keeping of records. The outcome of the investigations which were undertaken had exonerated the police officials of criminal liability in all but one incident of death of a person in police cells in the police cells.

CHAPTER 5: THE INTERPRETATION OF THE DATA

5.1 Introduction

This chapter involves the interpretation of data which were collected from the IPID Provincial Offices in Gauteng and Limpopo. The data were contained in the dockets which were opened to investigate the circumstances surrounding the deaths of persons in police cells. The interpretation of data is divided into four headings, namely, the quality of the investigation, the causes of deaths in police cells, police compliance with the regulations and the outcome of the investigations which were conducted. The discussion under each heading consists of the description of the theme and an indication of how the empirical data relate to the particular theme. It also entails the integration of the viewpoints in the literature and indicates the extent to which the opinions of the authors support or contradict the research data. Lastly, the interpretation of the data would provide an indication of the benefits that the IPID and SAPS could derive from it.

5.2 The quality of the investigations

The Database Management Manager at IPID indicated that each docket opened by the IPID for the purpose of investigating the deaths of persons in police cells in police cells is registered on the Case Management System and assigned a unique Complaint Control Number for control purposes in accordance with the Standard Operating Procedure of the Directorate. Therefore, the name of the police station where the death occurred is also indicated on the docket. It appears that the quality of the investigations which were conducted by the IPID was compromised in respect of aspects relating to the detention of the deceased, the circumstances surrounding the deaths of persons in police cells and the non-availability of corroborating documentary evidence. Some of the dockets did not contain important information such as the *post mortem* reports, affidavits from family members and acquaintances of the deceased. Furthermore, the dockets did not reflect the date, time and reason for detention, as well as the approximate time of death.

The IPCC (2011) used different types of evidence in its investigations into the deaths in police cells. The different types of evidence obtained during the investigation process were *post mortem* reports, toxicology reports, statements from arresting officers and custody staff, as well as statements from members of the community, medical history of the deceased, custody records and close circuit television footage from the cells and other areas (IPCC, 2011). The

finding that IPID does not attach *post mortem* reports to dockets is supported by Dissel and Ngubeni (1999) who also found that IPID did not attach post mortem reports in some of the dockets. The availability of different types of evidence in a docket served to point out inconsistencies in the account of events provided by police officials related to issues such as the sequence of events, cell visits and time of death amongst others (IPCC, 2011). According to Dissel and Ngubeni (1999), the ICD had relied only on a notification of death report received from the police to conclude that there was no police involvement in the death of the person in police cells. They established in their study that post mortem reports were not attached in three of five deaths investigated by the ICD (Dissel & Ngubeni, 1999). The time of death was not reflected in one docket while in another docket, the *post mortem* report indicated that the death of the person in police cells was consistent with the abuse of alcohol, but had no report indicating whether the person in police cells had displayed withdrawal symptoms or whether he was intoxicated (Dissel & Ngubeni, 1999). In the United Kingdom, the Crown Prosecution Services provides advice to the IPCC on legal and evidential matters in order to ensure that investigations into deaths in police cells are carried out properly (JCHR, 2004). The protocol on co-operation between the IPCC and Crown Prosecution Services makes provision for the involvement of the families of the deceased through the family liaison officer (JCHR, 2004). From this, it could be surmised that South Africa could greatly benefit from the UK practice of classifying custody management as a specialised occupation through the selection, training and appointment of custody officers.

The IPID should be aware of the significance of the *post mortem* examination as a prerequisite in determining with certainty the cause of death. *Post mortem* reports are crucial in indicating the direction that the investigation should follow. Obtaining statements from arresting officers and other independent witnesses such as acquaintances and family members of the deceased may be helpful in highlighting inconsistencies of the evidence provided by the police officials.

5.3 The causes of deaths in police cells

Four causes of deaths in police cells were identified during the analysis of dockets. The four identified causes are suicide, natural causes, assault of persons in police cells by fellow persons in police cells and injuries sustained by persons in police cells prior to their detention. The leading cause of deaths was suicide, followed by natural causes and assault by fellow persons in police cells, both of which accounted for an equal number of the deaths, with injuries prior to detention being the last of the four causes. The majority of suicide-related deaths occurred in Gauteng Province while Limpopo Province accounted for the majority of deaths as a result of

assault by fellow persons in police cells. The persons in police cells used items such as belts, shoe-laces, T-shirts, pieces of clothing torn from blankets and mattress, as well as swallowing an overdose of drugs among others, to commit suicide. Although the preferred ligature points in committing suicide were burglar proof bars on the doors and windows of the cells, there were dockets in which the ligature points were not specified. With regards to deaths of persons in police cells due to the injuries sustained prior their detention, it was revealed that members of the community had apprehended and assaulted the persons in police cells for allegedly committing crimes before handing them over to the police.

A review of literature on the causes of deaths in police cells had mainly ascribed such deaths to suicide, natural causes, injuries received prior to detention and injuries sustained in police cells (IPCC, 2011, ICD, 2009a, Dissel & Ngubeni, 1999). However, in a study conducted by the ICD (2009a:9) the phrase "circumstances of deaths" was used when referring to the causes of deaths. Apart from the four primary causes of deaths mentioned above, the deaths of persons in police cells were also found to have been a result of overdose, restraining action, use of alcohol or drugs, attempt to escape, possible police negligence and other unknown causes among others (IPCC,2011, Bruce,2000, Dissel & Ngubeni 1999). The IPCC (2011) attributed more deaths to natural causes followed by suicide, while Dissel and Ngubeni (1999) found that suicide was the leading cause of deaths followed by natural causes. According to ICD (2009a), suicide was the main cause of deaths followed by injuries sustained in custody. Fairex NZ News (2012) also found that suicide was the leading cause of deaths in Australian police cells. The deaths of persons in police cells as a result of injuries sustained prior to detention had accounted for a lesser number of the deaths (IPCC, 2011, ICD, 2009a, Dissel & Ngubeni, 1999). The findings of this study are in line with most of the other studies.

As indicated above, an analysis of the dockets which were investigated by IPID revealed that the causes of deaths in police cells were suicide, natural causes, assault by fellow persons in police cells and injuries sustained prior to detention. The data contained in the analysed dockets are supported by the findings of various authors. For instance, research studies indicated that the four causes referred to above caused the deaths of people in police cells (IPCC, 2011, ICD, 2009a, Dissel and Ngubeni, 1999). However, drug overdose, restraining action, use of alcohol or drugs, possible police negligence and other unknown causes were identified as other causes of deaths (IPCC, 2011, Bruce, 2000, Dissel & Ngubeni, 1999). According to the data contained in the analysed IPID dockets, the leading cause of deaths in police cells was suicide, followed by natural causes and assault by fellow persons in police cells. These two causes resulted in an equal number of deaths. The injuries sustained prior to detention accounted for fewer

deaths. This finding is partially supported by research findings which identified suicide as the leading cause of deaths in police cells (ICD, 2009a, Dissel & Ngubeni, 1999). However, the ICD (2009a) found that natural causes were the leading cause of deaths followed by suicide. Dissel and Ngubeni (1999) found that natural causes and injuries sustained prior to detention were the second and third leading causes of deaths respectively. The IPCC (2011) found that more deaths in police cells were as a result of natural causes followed by suicide. The fact that persons in police cells used instruments such as shoe-laces, belts, torn pieces from blankets and mattresses, T-shirts or overdosed on drugs is consistent with the findings of other research studies (IPCC, 2011, ICD 2009a, Dissel & Ngubeni, 1999, Leigh et al., 1998). Whereas the researcher could not ascribe the death of any person in police cells to unknown causes, other studies found that persons in police cells died in police custody due to unknown causes (ICD, 2009a, IPCC, 2011, Bruce, 2000).

The fact that research studies have consistently identified suicide, natural causes, injuries sustained in detention and injuries sustained before detention as the main causes of deaths in police cells should be beneficial to endeavors to prevent the deaths of persons in police cells in police cells. The fact that suicide was found to be the leading cause of deaths and that items such as belts, shoe-laces, guns drug overdose and fire were used to commit suicide suggests that more effort should be taken for the proper implementation of the stipulations of the SAPS Standing Orders (General) relating to the search and seizure of dangerous items, medical care and hospitalisation of persons in police cells and conducting of regular cell visits, as well as the maintenance of records related thereto. Regular cell inspections may contribute to the reduction of deaths caused by assault by other persons in police cells. In an attempt to prevent suicide in police cells, police forces in England and Wales were instructed to close hatches of the cells at all times whenever the cells are occupied (Gunnell, Bennewith, Hawton, Simkin and Kapur, 2004). The closure of cell hatches is a proactive measure which is aimed at ensuring that the cells remain ligature-free (Gunnell et al., 2004). Another measure intended to prevent suicide in police custody is in the form of a recommendation that shoe-laces, belts and other items which could be used as ligatures should always be seized (Gunnell et al., 2004). According to Gunnell et al.(2004), some police forces in the UK have resorted to issuing clothing items and blankets which are hard to tear in an effort to prevent suicide in police cells.

5.4 Police compliance with regulations

The management and care of persons detained in police cells is regulated through the SAPS Standing Orders (General). The different SAPS Standing Orders (General) make provision for the medical care of persons in police cells, visits to the cells, searching of persons in police cells and subsequent searches for dangerous articles, as well as proper record keeping. The primary aim of the different SAPS Standing Orders (General) is to ensure the efficient and effective management of persons in police cells. The data contained in the IPID dockets indicated that police officials had generally attended to the needs of the persons in police cells in respect of medical care and hospitalisation when the need arose. There was evidence of partial police compliance with the SAPS Standing Order (General) 361 which stipulates that persons in police cells must be searched and dangerous items removed from them before their placement in the cells. The inference that police partially complied with the relevant regulation was drawn from the fact that items such as belt, and dugs featured in the suicide cases. The police officials fully complied with the regulations which deal with the separation of the different categories of persons in police cells based on gender and age of the persons in police cells.

Research studies found that police officials were negligent in the performance of their duties with regard to the management and care of persons in police cells (ICD, 2009a, IPCC, 2011, Dissel & Ngubeni 1999). The findings that police were negligent in the performance of their duties arose from the fact that some of the persons in police cells had used items like belts, shoe-laces and guns, torn blankets, trousers, elastic from tracksuit pants or bandages covering their injured legs to commit suicide and from the fact that cell visits were not conducted at hourly and half-hourly intervals, as stipulated by the regulations (Dissel and Ngubeni, 1999, ICD, 2009a, IPCC, 2011, JCHR, 2004). The research findings therefore clearly indicate that the persons in police cells were not searched prior to their detention (JCHR, 2004, IPCC,2011, ICD, 2009a). The deaths of persons in police cells due to natural causes related to their poor medical conditions which were associated with heart, lung, liver and brain problems, epilepsy and HIV/AIDS, pneumonia, as well as multiple organ failure and other unknown causes (Dissel & Ngubeni,1999, IPCC,2011, Bruce, 1997). The standards and procedures set for the provision of medical care were not adequately practised (JCHR, 2004, Dissel & Ngubeni, 1999). According to Dissel and Ngubeni (1999), police officials often disregarded complaints from persons in police cells who were intoxicated with alcohol and the same was found in this study.

The data contained in the analysed IPID dockets indicated that police officials had partially complied with the regulations aimed at ensuring the safety and wellbeing of persons in police

cells. The data particularly showed that police officials had failed to search persons in police cells and to seize dangerous articles from them, had failed to conduct regular cell inspections and to keep relevant records. They also failed to ensure that persons in police cells receive medical care when the need arose. The fact that police officials failed to comply fully with the said regulations is supported by other research studies. Research studies found that persons in police cells had committed suicide using items like belts, shoe-laces, poisoning, fire arms and even setting themselves alight (IPCC, 2011, ICD, 2009a, Leigh et al., 1998). It was also found that police officials failed to conduct regular cell visits and to keep records thereof (JCHR, 2004, IPCC, 2011). Police officials also failed to ensure the provision of adequate medical care to the persons in police cells (JCHR, 2004, IPCC, 2011).

The SAPS should ensure that cell visits, as well as thorough searches and seizure of possible dangerous items are conducted as prescribed and that proper custody records are maintained, because most of the deaths in this study could have been prevented, if cell visits were regularly conducted. The correct adherence to the regulations relating to custody management will help prevent the deaths of persons in police cells or alternatively be helpful during investigations. The strict compliance with custody management regulations is important in maintaining the reputation or legitimacy of the police in the community, thus enabling the police to fulfil their constitutional mandate and other mandates imposed upon them and the country by international instruments in relation to the protection of human rights. The regulations which are in place to ensure proper custody management should be implemented correctly at all times in order to protect the interests of the detainees. Persons in police cells should always be searched and any dangerous articles found in their possession seized.

5.5 The outcome of investigations conducted

In all but two dockets which were analysed at the IPID Provincial Offices in Limpopo and Gauteng, the outcome of the investigations was that the cases were unfounded. An unfounded outcome of an investigation has the effect that the police officials concerned are not criminally liable for the deaths of persons in police cells. In one of the two cases it was recommended that the police officials concerned be prosecuted for culpable homicide and the investigation was still pending in the other case. The recommendation to prosecute the police officials concerned for culpable homicide was based on the finding that they had omitted to search the deceased and seize the drugs with which the person in police cells subsequently committed suicide through taking an overdose thereof. The IPID made recommendations that disciplinary proceedings be instituted against the police officials in nine of the cases which were investigated. The outcome

that disciplinary proceedings be instituted against the police officials concerned was based on the findings that they had contravened the specific police regulations relating to the management and care of people detained in police cells. However, the outcomes of those disciplinary proceedings were outstanding in all the cases except one. The outcome of the finalised departmental case was that the police officials concerned received a verbal warning, but the decision of the prosecuting authority whether to prosecute them for culpable homicide or not was still outstanding.

According to the JCHR (2004), police officials in the United Kingdom were rarely prosecuted for the deaths of persons in police cells. Ninety-seven cases were marked for criminal prosecution between January 2002 and May 2004 (JCHR, 2004). Five of 97 cases were prosecuted, but all ended in acquittals (JCHR, 2004). In the United Kingdom, 67 of 333 cases of deaths in police cells which occurred between 1998/99 and 2008/09 (IPCC, 2011) were forwarded to the Crown Prosecution Service for a decision whether to prosecute or not. The Crown Prosecution Service prosecuted seven of the 67 cases, which resulted in 26 police officials and one staff member being charged. One police officer and one staff member were subsequently convicted for “misconduct in public office” and both of them were sentenced to six months imprisonment (IPCC, 2011:1). However, the sentence imposed on the police official was suspended for one year (IPCC, 2011). The conviction emanated from the failure of the police officer and the member to conduct the required inspections on persons in police cells (IPCC, 2011). An additional charge of failure to maintain custody records was brought against the staff member (IPCC, 2011). Four other cases resulted in the prosecution of three police officers and a doctor, following the deaths of people in police cells since 1999 (JCHR, 2004). In South Africa, the ICD (2010) recommended that 112 of the 860 dockets it had investigated be filed for prosecution. The 860 dockets included deaths in police custody and deaths as a result of police action, and no distinction was made between the two categories. Twenty-five police officials were convicted for both categories of deaths (ICD, 2010). The decision of the prosecution authority was outstanding in one docket (ICD, 2010). Furthermore, the ICD (2010) made 132 recommendations for departmental proceedings relating to deaths in police custody and deaths as a result of police action, without making a distinction between the two. Of the 132 recommendations calling for disciplinary measures to be taken against police officials concerned, five resulted in convictions (ICD, 2010). Hundred and seventy-one police officers and 23 staff members were charged with misconduct (JCHR, 2004). Of the 52 analysed dockets, the IPID made one recommendation that the police officials concerned be prosecuted for culpable homicide, but the decision of the prosecution authority was still outstanding at the

time when the dockets were analysed. The IPID also made a further recommendation that the police officials be disciplined internally for failing to search the person in police cells and to seize the drugs on which the person in police cells overdosed and died. In this case, the police officials concerned received verbal warnings. Eight more recommendations for the institution of disciplinary action against the police officers concerned were made. The outcome of said recommendations was outstanding at the time the docket analysis was conducted. Of the 67 dockets recommended for prosecution, only seven were actually prosecuted, resulting in the conviction of 27 police officers (IPCC, 2011). The finding that there is a low prosecution rate of police officers is supported by the JCHR (2004). The JCHR (2004) found that only five of the 97 dockets recommended for prosecution were actually prosecuted, resulting in the acquittal of all police officials implicated. The above information has confirmed the view that police officials are rarely called to account for the deaths of persons in police cells.

The prosecution of police officials who fail to perform their duties diligently will have a deterrent effect on their colleagues. In order for investigation to have a deterrent value, independent investigators need to gather all the relevant evidential material so that informed and factual decisions could be taken. Police management should consistently consider the recommendations made, take appropriate corrective steps to remedy the situation and provide feedback.

5.6 Summary

Some of the dockets which were analysed after being investigated by the IPID have a number of shortcomings. The identified shortcomings relate to the non-availability of important documentary evidence like *post mortem* reports and other relevant information, such as the approximate time of death as well as the date, time and cause of detention. This information is necessary in order to make the correct decisions. Four main causes of deaths in police cells were identified. The identified four causes are suicide, natural causes, assault by other detainees and injuries sustained prior to their detention. It is apparent that police failed to comply with the regulations which deal with custody management. Persons in police cells committed suicide in the cells using instruments such as belts, shoe-laces and by taking an overdose of drugs. Police officials failed to maintain proper custody records and records relating to cell visits. Only a few police officials were prosecuted and disciplined internally for misconduct. Feedback on the outcome of the recommendations emanating from investigations is outstanding in many of the dockets.

CHAPTER 6 CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The printed and electronic media have often reported on the deaths of persons in police cells in South Africa. The media coverage of the deaths of persons in police cells became a cause of concern to the researcher. It was that concern that led the researcher to choose this topic for the research study. Through the undertaking of the research study, the researcher has sought to determine the circumstances which led to the deaths of persons in police cells, to establish what custody management regulations are in place and the extent to which police officials complied with any such regulations. Furthermore, the researcher wanted to determine the best practices employed by the international community in the prevention of deaths in police cells. Lastly, the researcher sought to establish the difficulties, if any, which were faced by the authorities who are legally tasked with the investigation of deaths in police cells. The researcher has followed the approach which was suggested by Trafford and Leshem (2008) when constructing this chapter. In this chapter, an overview will be given of the methodology utilised in the study, the legal framework pertaining to deaths in police cells, the literature on deaths in police cells and the research findings. Lastly, recommendations will be made.

6.2 An overview of the methodology

The researcher conducted empirical research, using a descriptive qualitative research methodology. The researcher collected data relating to deaths in police cells by means of docket analysis. A docket analysis schedule was compiled for this purpose. The geographical demarcation of the research study was limited to Gauteng and Limpopo Provinces, where the dockets were analysed at the provincial offices of the IPID, formerly known as the ICD. Initially, Gauteng and Kwazulu-Natal Provinces were chosen for the study due to the high number of deaths in police cells in these two provinces in the period of study, which is 1 April 2009 to 31 March 2010. However, Kwazulu-Natal was replaced with Limpopo Province due to logistical constraints. The saturation sampling technique was used which resulted in the inclusion of all deaths in police cells in the study. The researcher sought and obtained written authorisation from the IPID to access information contained in the dockets which were opened for the purpose of investigating the deaths of persons in police cells. The research was also undertaken within the confines of the Code of Ethics of the University of South Africa. When completing the docket analysis forms, the researcher refrained from recording any information which could potentially be used to identify the parties involved in the study in order to ensure

their anonymity. The data contained in the docket analysis schedule were analysed manually by the researcher by categorising them into different themes and a frequency analysis to indicate the rational proportion.

6.3 An overview of the legal framework pertaining to deaths in police cells

The researcher identified the relevant South African and international instruments which constitute the relevant regulatory framework for the prevention of deaths in police cells. The South African instruments which form part of the regulatory framework include the Standing Orders (General) of the South African Police Service which regulate the custody management matters and the IPID Act. The international instruments included the declarations which were passed by the United Nations and the Organization of African Unity to protect the fundamental human rights of the inhabitants of member countries. The international instruments also included the Code of Conduct of Law Enforcement Officials which was passed by the European Court of Human Rights.

6.4 An overview of the literature on deaths in police cells

The researcher conducted a review of the literature applicable to deaths in police cells in South Africa and other international communities. The review of the literature revealed that the persons died in police cells in South Africa and abroad as a result of natural causes, suicide, injuries sustained in police custody and injuries sustained prior to their detention. It was further found that the consumption of alcohol, the use of drugs and police negligence contributed to the deaths of people in police cells. The measures recommended for the prevention of deaths in police cells were the proper training of custody staff on human rights, first aid, medical care and how to recognise the signs of substance abuse in persons in police cells. Other recommended preventative measures included the conducting of risk assessments when persons in police cells are processed, the searching of detainees and their visitors, the seizure of dangerous objects from them and the conducting of regular cell inspections. Ensuring that the persons in police cells receive medical attention whenever the need arises and the improvement of the physical conditions of the cells have the potential to contribute to the prevention of deaths in police cells.

6.5 An overview of the research findings

From the description and analysis of the data contained in the dockets which were opened to investigate the deaths of persons in police cells, four causes of deaths were identified. It was found that the deaths of persons in police cells resulted from suicide, natural causes, injuries sustained in custody and injuries sustained prior to detention. It was found that 24 out of 52 persons in police cells committed suicide, thereby positioning suicide as the leading cause of death in police cells. Twenty-one of the 24 suicides occurred in Gauteng Province and the remaining three were reported in Limpopo Province. It was also found that the most common instruments used to commit suicide are clothing and bedding items, strings, shoelaces, belts and by taking an overdose of drugs. The burglar proof bars on the windows of the cells were the preferred ligature points. The second leading cause of deaths in police cells were natural causes and assault by fellow persons in police cells, which accounted for ten deaths each. All ten deaths due to assault by fellow persons in police cells were reported in Limpopo Province. The instruments which were most commonly used in the attack were booted feet and hands, with the exception of one case where a bar of bath soap, reportedly wrapped in a T-shirt was allegedly used to assault a persons in police cell. With regards to natural causes, it was established that the deaths of persons in police cells were associated with illnesses such as HIV and AIDS, as well as pancreatic cancer among other illnesses. An analysis of the dockets further revealed that eight out of 52 deaths occurred as a result of injuries sustained at the hands of members of the community prior to the detention of the people concerned. All the deaths under this category were reported in Gauteng Province and none such deaths were reported in Limpopo Province.

In relation to the quality of the investigations into the deaths of persons in police cells which were conducted by the IPID, it was found during the analysis that information which was crucial to the outcome of the investigation was not obtained or attached to the relevant dockets. The specific information referred to above relates to the non-availability of *post mortem* reports, reason for detention, date and time of detention. Twenty-six out of 52 dockets did not contain *post mortem* reports.

The docket analysis indicated that police officials had generally summoned medical assistance for persons in police cells in compliance with the provisions of the SAPS SO (General) 349. Medical assistance was called in for persons in police cells in 24 out of 27 cases. However, police officials failed to grant reasonable requests from persons in police cells to consult with medical practitioners and to be transferred to another cell and the persons in police cells

concerned died in the cells later. In another case, a person in police cell died in the cells in circumstances which suggested that he was not properly released from the hospital where he was admitted. Police officials were found to have had complied partially with the legal mandate imposed upon them to search the persons in police cells and seize any dangerous articles found in their possession. The persons in police cells were found in possession of items such as shoe-laces, belts, knives and drugs while they were inside the police cells. Some of the mentioned items were used to commit suicide. Two persons in police cells committed suicide by using shoe-laces which did not belong to them as ligatures. One person in police cells used his own belt to hang himself. Two more persons in police cells were reported to have been deliberately burned by fellow persons in police cells inside the cells.

There was poor police compliance with the regulations which stipulate the manner and frequency of visits to the police cells and the keeping of records related thereto. Police officials conducted hourly cell inspections and kept proper records in only two of the 52 dockets. It was indicated in eight of the dockets that the police officials had visited the cells regularly, but the relevant supporting documents were not attached in the dockets concerned. There was neither any indication in the 13 dockets that the cells were actually visited, nor was any documentary evidence attached in the dockets from which it could be inferred that the cells were visited. In one docket the persons in police cells reported that the cells were not visited during the entire night, which contradicted a police report in the occurrence book that the cells were visited. The persons in police cells who were intoxicated from alcohol were also not afforded the stipulated half-hourly visits in the cells.

It was established from the dockets that ten persons in police cells at various police stations in Limpopo Province were detained in police cells for long periods. They were detained in the police cells pending the outcome of the criminal proceedings instituted against them instead of being transferred to correctional service centers for their further detention. The period of detention in police cells ranged from eleven days to seven months. In eleven dockets, the period for which the deceased persons in police cells were detained could not be determined owing to a lack of relevant information in the dockets. The persons in police cells referred to in this paragraph were reportedly detained for the alleged commission of serious crimes like rape, murder and assault with intent to cause grievous bodily harm.

With regard to the discovery of the death of the persons in police cells, it was found that police officials discovered the deaths of 33 persons in police cells, while 19 were discovered by fellow persons in police cells. However, it was inferred from the statements of fellow persons in police

cells that the deaths of some of the persons in police cells were first discovered by persons in police cells who refrained from reporting the discovery to the police out of fear of reprisal. The persons in police cells had apparently decided against reporting the discovery of the deaths because the deceased persons in police cells were allegedly fatally assaulted by other persons in police cells inside the police cells. The legal obligation imposed on the police officials to notify the IPID of any deaths in police cells was fully discharged. Maake and Mankweng police stations in Limpopo Province, as well as the Meadowlands police station in Gauteng Province reported the highest number of deaths, accounting for three or more deaths in the police cells over the period covered by the research.

Fifty of the 52 deaths which were investigated by the IPID were found to be unfounded. The recommendation to prosecute the police officials involved was made only in one docket. The recommendation to prosecute was made based on the grounds that the police officials concerned negligently contributed to the deaths of the person in police cells. The investigation was still pending in another case. In Limpopo Province, it was ruled in all the 19 dockets that the involvement of the police officers in the deaths of the persons in police cells could not be established. Although the outcome of the IPID investigation in another docket was that police involvement could not be substantiated, the Directorate indicated that the person in police cells was potentially murdered. The recommendations for the institution of the disciplinary proceedings against the police officials involved were made in nine dockets for the contravention of various regulations which govern the management and care of persons in police cells. The investigations revealed that there were potential human rights violations in three dockets. In another case, it was recommended that the commander of the police station concerned be given general advice to remove any dangerous articles which could cause harm to the persons in police cells or those around them. The feedback to the nine recommendations that police officials involved be disciplined was only provided in one docket, whereby the police officials involved were reportedly given verbal warnings. In this same docket it was also recommended that the police officials concerned be prosecuted, but the decision of the prosecution authority was outstanding at the time the docket was analysed.

The *post mortem* reports, affidavits from the family members and acquaintances of the deceased persons in police cells should always be incorporated into the dockets. The deaths of persons in police cells were ascribed to suicide, natural causes, assault by fellow persons in police cells and injuries sustained prior to detention. The police officials had generally ensured that the persons in police cells receive medical care and hospitalisation. However, police officials failed to seize dangerous items from persons in police cells in some instances and to

conduct regular cell visits in most cases. In almost all the investigations into deaths in police cells, the IPID found that the cases were unfounded. The feedback from the management of the police regarding the recommendations from the IPID that police officials concerned be disciplined was not provided in eleven of the 12 dockets. The lack of feedback from the police is contrary to the provisions of the IPID Act. The police officials involved were rarely prosecuted or disciplined internally for their perceived role in the deaths of persons in police cells.

6.6 Recommendations

It is imperative that the deaths of people in police cells be prevented. Having established the causes of and the factors which contribute to deaths in police cells, recommendations are made below. The recommendations made relate to suicide prevention, the implementation of standing orders pertaining to custody management, investigations of deaths in police cells, long detention periods in the police cells and training relating to custody management.

6.6.1 Suicide prevention

It was found that the majority of the persons in police cells who died in police cells had committed suicide. Some of the persons in police cells who committed suicide had hanged themselves using ligatures which are not allowed in the cells, such as shoelaces and belts. Bedding and clothing items were also used as ligatures. Suicide was also committed through the taking of an overdose of drugs. The presence of these ligatures and drugs inside the police cells provide the persons in police cells with the means to commit suicide. Linked to this is the failure of the police officials to comply with the stipulations of the standing order pertaining to the searching of persons in police cells and the seizure of dangerous or potentially dangerous items from them. Thus the following recommendations are made regarding the prevention of suicide in the police cells:

- (a) Commanders, particularly shift commanders, must ensure that each and every person in police cells is thoroughly searched and any items which are found in their possession and which could potentially be used as ligatures are seized without exception before placing the persons in police cells. Metal detectors should be procured and be used to search persons in police cells for hidden dangerous articles as an alternative to conducting intimate searching which could, in terms of the legislation, only be conducted by medical doctors or registered nurses.

- (b) All ligature points in the cells should be identified and removed. Hard-to-tear bedding and clothing items should be procured and issued to persons in police cells to prevent them from strangling themselves.
- (c) Cells should be properly ventilated, thereby eliminating the need for windows which are preferred ligature points.
- (d) Risk assessments be conducted on persons in police cells to determine their vulnerability to suicide before placing them in the cells, as is the standard practice in the United Kingdom.

6.6.2 The implementation of standing orders pertaining to custody management

It is encouraging to have found that police officials are generally complying with the obligation imposed upon them to ensure that persons in police cells receive medical care and hospitalisation whenever the need arises. The research findings revealed several patterns of regulations violations by police officials. The manner in which police officials implement standing orders pertaining to the management and care of persons in police cells is alarming. Police officials neglect to conduct regular visits to the cells and to keep proper records related thereto, as mandated by the standing orders. The authenticity of some of the entries which were made in the occurrence book is questionable. The failure to conduct cell visits could have contributed to persons in police cells fatally assaulting one another in impunity. Therefore, it is recommended that:

- (a) The management of the police station reinforces proper command and control of their subordinates to ensure that the cells are visited regularly, thereby improving the monitoring of the activities of the persons in police cells.
- (b) Disciplinary regulations be stringently applied against commanders and their subordinates who neglect to ensure that the cells are visited regularly and who fail to keep records of their activities.
- (c) Occurrence book pages be numbered to prevent pages being torn out and to prevent the falsification of entries.
- (d) Closed circuit television cameras be installed in the cells to supplement the physical monitoring of detainees in the cells, thereby enabling quick response to emergencies in the cells.

6.6.3 The investigations which were conducted by the IPID

The quality of the investigations which were conducted by the IPID was compromised by the non-availability of the *post mortem* reports inside most dockets predominantly in Limpopo Province. The reports from paramedics who declared the persons in police cells dead at the scene replaced the autopsy reports. The challenge relating to the non-availability of the autopsy reports could not be established from the contents of the dockets. The only reasonable conclusion to be drawn is that the post mortem examinations were not performed. This is contrary to the IPID regulations which make it mandatory for the investigators from the Directorate to attend *post mortem* examinations. This omission means that the exact causes of the deaths of the detainees could not be established with certainty through the application of medico-legal science. Linked to this, is the omission by the management of the police stations to provide feedback about the outcome of the recommendation by the IPID that police officials be disciplined for the violations of police regulations. Thus, it is recommended that:

- (a) The management of IPID strictly enforce the rule that *post mortems* be conducted and to ensure that relevant reports are attached to the dockets.
- (b) The provincial commissioners of the SAPS ensure that the station commanders provide feedback to the IPID, within the timeframes stipulated by the IPID Act, regarding the outcome of the recommendations that disciplinary proceedings be instituted against the police officials concerned. This will have an individual and a general deterrent effect on police officials, thus encouraging them to perform their duty of care towards detainees diligently.

6.6.4 Longer detention period in police cells

It was found that some persons in police cells had spent many days detained in police cells in Limpopo Province, pending the finalisation of the criminal proceedings which were instituted against them. This led to the persons in police cells fighting over control of the territory of the cells, resulting in fatalities. Therefore, it is recommended that the persons in police cells, who have pending criminal proceedings against them, be transferred to the detention facilities of the Department of Correctional Services for further detention as soon as possible.

6.6.5 Training on custody management

IPID investigators found evidence of potential human rights violations by police officials in some of the dockets. The findings related to violations of the constitutional obligation imposed upon the state and its organs to respect, protect, promote and fulfil the rights enshrined in the

Constitution of South Africa. The human rights of the persons in police cells related to the preservation of their lives and to be free from any form of violence from private and public agents were not fulfilled by the police. It is imperative that the police officials always display great sensitivity towards the human rights of the persons in police cells. Therefore, the following recommendations are made:

- (a) Training of police officials on human rights should be intensified to enable them to be sensitive to the human rights of persons in police cells.
- (b) The management and care of the persons in police cells be made a specialised field of occupation, whereby only individuals who successfully undergo a specialised training programme for custody officers are appointed and perform duties as custody officers, in the same way as it is successfully implemented in the United Kingdom.
- (c) Joint inter-departmental training workshops involving the SAPS, IPID and Department of Correctional Services be held to develop and maintain their working relations.

South Africa, as a constitutional state and a signatory to the United Nations instruments enshrining the respect for and protection of the human rights, has legal and moral obligations to prevent the deaths of detainees in police cells. The duty to comply with these obligations is delegated to the police service. The benefits of preventing deaths in police cells include an improvement of the reputation of the police service as a legitimate law enforcement agency in the eyes of the inhabitants of the Republic and of South Africa as a country which enforces a culture of respect for human rights in the eyes of the international community. However, the failure to prevent deaths in police cells seriously damages the relation between the police and the community. It may also bring enormous financial hardships for the families of the deceased detainees who may, in turn, institute lawsuits against the police service.

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Appendix A

Docket Analysis Schedule: Period 1 April 2009 to 31 March 2010

Province: Limpopo

File/Docket no.:	Station:	Date of incident:	Date r
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Manner of death

Suicide	Natural causes	Assault by fellow inmate	Assault by police official	Drug overdose	Injury sustained in cell	Injury sustained when detained
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Description of manner in which death occurred:

Instrument used:

Belt	Clothing	Plastic bag	Rope	Shoe-laces	Str
Firearm	Knife/sharp object	Booted foot	Bricks/Stones	Drowning	Por
Mattress	Set self alight	Electrocuted	Suffocation	Hands	Oth

Place in cell where death occurred:

Appendix A

Statements taken from:

Fellow prisoners

Police officials

Family members

Friends

Post mortem report

Information from statements:

Information about detention: (a) Reason: (b) Date: (c) Time:	Time of incident:	Length of time spent in cell before death:	Was the deceased locked up alone in the cell? Yes/No If no, how many other detainees were locked with the detainee?
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Appendix A

<p>Cell visited? Yes/No</p> <p>(a) If yes, how many times?</p> <p>(b) At what intervals was cell visited?</p> <p>(c) What are the Occurrence Book reference numbers for each cell visit?</p>	<p>Were any complaints received from the deceased? Yes/No</p> <p>(a) If yes, what was the nature of complaint (s) received?</p> <p>(b) How was the complaint dealt with?</p>	<p>Were any complaints received from fellow prisoners? Yes/No</p> <p>(a) If yes, what was the nature of complaint(s) received?</p> <p>(b) How was the complaint dealt with?</p>	<p>Who discovered the deceased?</p> <p>(a) Fellow prisoner(s)</p> <p>(b) Police official(s)</p>
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Outcome of the investigation:

Prosecution	Disciplinary action	Dismissed	Demotion	Written warning
Words of advice	General advice	Unsubstantiated	Other	

SOUTH AFRICAN POLICE SERVICE



SUID-AFRIKAANSE POLISIEDIENS

Verwysing Reference	11/3/1
Navrae Enquiries	Brigadier Gossmann Colonel Ngum NT
Telefoon Telephone	(012) 334 3727 (012) 334 3819
Faksnommer Fax number	(012) 334 3563

**GENERAL RESEARCH AND CURRICULUM DEVELOPMENT
HUMAN RESOURCE DEVELOPMENT**

**PRIVATE BAG X 177
PRETORIA
0001**

The Divisional Commissioner
HUMAN RESOURCE DEVELOPMENT

REQUEST TO CONDUCT RESEARCH WITHIN THE SERVICE: THE PREVENTION OF DEATHS IN POLICE CELLS: NO 0534594-4 CAPTAIN MAKGOPA L: IN-SERVICE TRAINING: DIVISION: HRD.

1. The abovementioned member hereby applies to access the statistics of Police members trained in Human Rights.
2. This office has received information from the office of Independent Police Investigative Directorate.
3. Your approval will be highly appreciated.

Kind regards

A handwritten signature in black ink, appearing to be 'LL Gossmann', written over a horizontal line.

**MAJOR GENERAL
SECRETARY: RESEARCH COMMITTEE
LL GOSSMANN**

DATE: 2013-08-09

REQUEST TO CONDUCT RESEARCH WITHIN THE SERVICE: THE PREVENTION OF DEATHS IN POLICE CELLS: NO 0534594-4 CAPTAIN MAKGOPA L: COMPONENT: IN-SERVICE TRAINING: DIVISION: HRD

APPROVED / NOT APPROVED

COMMENTS



MAJOR GENERAL
SJ KWENA

LIEUTENANT GENERAL
DIVISIONAL COMMISSIONER: HUMAN RESOURCE DEVELOPMENT
CN MBEKELA

DATE: 2013-05-16

Addendum B



IPID

Department:
Independent Police Investigative Directorate
REPUBLIC OF SOUTH AFRICA

Our Ref: IP/34/2012 GT
Enq: Tsimane GMM
Date: 22 August 2012

Attention: Mr Lazarus Makgopa
P.O. Box 910
OLIFANTSFONTEIN
1665

SUBJECT: APPLICATION FOR ACCESS TO INFORMATION IN IPID CASE DOCKETS

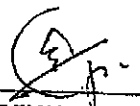
Receipt of your letter dated 16 March 2012 is hereby acknowledged.

We have further received a confirmation letter from UNISA Ethics department on the disclosure of information provided to yourself by the department (IPID).

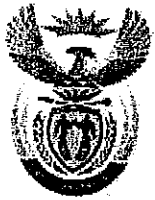
You will be given access to the case dockets, with shaded particulars of involved parties. You will further be provided with copies of annual reports that will assist you with statistical information.

The Directors: Investigations in Gauteng and Kwa-Zulu Natal will assist you with access to information limited to your research programme. You can contact those offices at the following numbers IPID Gauteng: 0112201500 and IPID Kwa-Zulu Natal 031 310 1300.

The Director: Legal Services will monitor compliance with the application for access to information.

PP 
MR F BEUKMAN
EXECUTIVE DIRECTOR
INDEPENDENT POLICE INVESTIGATIVE DIRECTORATE

Addendum C



ipid

Department:
Independent Police Investigative Directorate
REPUBLIC OF SOUTH AFRICA

Enq: Tsimane GMM

Date: 08 February 2013

Attention: Mr Lazarus Makgopa

P.O. Box 910

OLIFANTSFONTEIN

1665

SUBJECT: APPLICATION FOR ACCESS TO INFORMATION IN IPID CASE DOCKETS

Receipt of your letter dated 21 January 2013, wherein you requested to conduct research in IPID Limpopo is hereby acknowledged.

Kindly be informed that the Director: Investigations, Mr Khuba, in Limpopo provincial office will assist you with access to information for research purposes. You can contact those offices at the following numbers Limpopo: 015 291 9800.

You will be given access to the case dockets, with shaded particulars of involved parties. You will further be provided with copies of annual reports that will assist you with statistical information.

For further information please contact Mr Tsimane: Senior Manager-Legal Services at 0123990066.


MS KC MBEKI

ACTING EXECUTIVE DIRECTOR

INDEPENDENT POLICE INVESTIGATIVE DIRECTORATE

Addendum D

DECLARATION

I, Maria Petronella Roodt, declare that I edited the dissertation titled *The Prevention of Deaths in Police Cells* by L Makgopa (3078413-1). I have the following qualifications: MA (Applied Linguistics) and an MA (Higher Education Studies) and have extensive experience in the editing of dissertations.

My contact details are:

M P Roodt

Lecturer: English

School of Teacher Education

Central University of Technology, Free State

Bloemfontein

082 2025167

mroodt@cut.ac.za

Docket Analysis Schedule: Period 1 April 2009 to 31 March 2010

Province: Limpopo

File/Docket no.:	Station:	Date of incident:	Date reported:
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Manner of death

Suicide	Natural causes	Assault by fellow inmate	Assault by police official	Drug overdose	Injury sustained in cell	Injury sustained when detained	Other
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Firearm	Knife/sharp object	Booted foot	Bricks/Stones	Drowning	Poison
Mattress	Set self alight	Electrocuted	Suffocation	Hands	Other:

Place in cell where death occurred:

Statements taken from:

Fellow prisoners

Police officials

Family members

Friends

Post mortem report

Information from statements:

Information about detention: (a) Reason: (b) Date: (c) Time:	Time of incident: Length of time spent in cell before death:	Was the deceased locked up alone in the cell? Yes/No If no, how many other detainees were locked up with the detainee?
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Cell visited? Yes/No	(a) If yes, how many times?	(b) At what intervals was cell visited?	(c) What are the Occurrence Book reference numbers for each cell visit?
Were any complaints received from the deceased?	Yes/No	(a) If yes, what was the nature of complaint(s) received?	(b) How was the complaint dealt with?
Were any complaints received from fellow prisoners?	Yes/No	(a) If yes, what was the nature of complaint(s) received?	(b) How was the complaint dealt with?
Who discovered the deceased?	(a) Fellow prisoner(s)	(b) Police official(s)	

Outcome of the investigation:

Prosecution	Disciplinary action	Dismissed	Demotion	Written warning
Words of advice	General advice	Unsubstantiated	Other	



SUID-AFRIKAANSE POLISIEDIENS

SOUTH AFRICAN POLICE SERVICE

Verwysing Reference	11/3/1
Navare	Brigadier Gossman
Enquites	Colonel Ngum NT
Telefoon Telephone	(012) 334 3727 (012) 334 3819
Faksnummer Fax number	(012) 334 3583

GENERAL RESEARCH AND CURRICULUM DEVELOPMENT HUMAN RESOURCE DEVELOPMENT

PRIVATE BAG X 177
PRETORIA
0001

The Divisional Commissioner
HUMAN RESOURCE DEVELOPMENT

REQUEST TO CONDUCT RESEARCH WITHIN THE SERVICE: THE PREVENTION OF DEATHS IN POLICE CELLS: NO 0534594-4 CAPTAIN MAKGOPA L: IN-SERVICE TRAINING: DIVISION: HRD.

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MAJOR GENERAL
SECRETARY: RESEARCH COMMITTEE
LT GOSSMAN

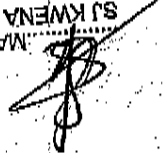
DATE: 2013-05-09

DATE: 2013-05-16

DIVISIONAL COMMISSIONER: HUMAN RESOURCE DEVELOPMENT
CN MBEKELA

LIEUTENANT GENERAL

MAJOR GENERAL
S J KWENA



COMMENTS

APPROVED / NOT APPROVED

REQUEST TO CONDUCT RESEARCH WITHIN THE SERVICE: THE PREVENTION OF
DEATHS IN POLICE CELLS: NO 0534594-4 CAPTAIN MAKGOPA L. COMPONENT:
IN-SERVICE TRAINING: DIVISION: HRD

IPID

Department
Independent Police Investigative Directorate
REPUBLIC OF SOUTH AFRICA



Our Ref: IIP/34/2012 GT
Enq: Tsimane GMM
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The Director: Legal Services will monitor compliance with the application for access to information.

MR F BEUKMAN

EXECUTIVE DIRECTOR

INDEPENDENT POLICE INVESTIGATIVE DIRECTORATE

Ed

Department
Independent Police Investigative Directorate
REPUBLIC OF SOUTH AFRICA

ipid



Eng: Tsimane GMM
Date: 08 February 2013

Attention: Mr Lazarus Makgopa

P.O. Box 910

OLIFANTSFONTEIN

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SUBJECT: APPLICATION FOR ACCESS TO INFORMATION IN IPID CASE DOCKETS

Receipt of your letter dated 21 January 2013, wherein you requested to conduct research in IPID

Limpopo is hereby acknowledged.

Kindly be informed that the Director: Investigations, Mr Khuba, in Limpopo provincial office will assist you with access to information for research purposes. You can contact those offices at the following numbers Limpopo: 015 291 9800.

You will be given access to the case dockets, with shaded particulars of involved parties. You will further be provided with copies of annual reports that will assist you with statistical information.

For further information please contact Mr Tsimane: Senior Manager-Legal Services at 0123990066.

MS KC MBEKI

ACTING EXECUTIVE DIRECTOR

INDEPENDENT POLICE INVESTIGATIVE DIRECTORATE

DECLARATION

I, Maria Petronella Roodt, declare that I edited the dissertation titled *The Prevention of Deaths in Police Cells* by L Makgopa (3078413-1). I have the following qualifications: MA (Applied Linguistics) and an MA (Higher Education Studies) and have extensive experience in the editing of dissertations.

My contact details are:

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