Report
Of the Commission of Inquiry
Into the Circumstances Associated with
The Death of Steve Jeffrey Khan,
At Seychelles Hospital
On Sunday 21st January, 2018,
While serving a prison sentence.

by

Hon. Justice Bernardin Renaud
Of the Court of Appeal of Seychelles.

Concluded on 07th July, 2018
And
Submitted to the President on 20th July, 2018

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Chapter 1

Appointment of the Commission of Inquiry

By Letter of Appointment dated 25th January 2018, **(Document A)** in terms of Section 2 of the Commission of Inquiry Act (Cap 39), the President of the Republic of Seychelles Mr. Danny Faure, appointed me as the Commissioner to carry out an inquiry into the circumstances associated with the death of Steve Jeffrey Khan, (hereinafter "Steve") which occurred at the Seychelles Hospital on Sunday 21st January, 2018. Steve was serving a prison sentence at the time.

The appointment was published in the Official Gazette No. 21 dated 21st February, 2018, as entry No. 195 of 2018. **(Document B).**

Before assuming my functions as the Commissioner I took the Oath of Office, before President Faure on 28th February, 2018. **(Document C).**

Having accepted to undertake this Inquiry I endeavoured to complete the assignment as soon as possible, but inevitable delays occurred for reasons beyond my control, primarily due to my other duties and responsibilities. On 7th June, 2018, I informed the President of my predicament and sought extension of time to 6th July, 2018.

In addition to undertaking this inquiry, I simultaneously discharged my function as Justice of Appeal, reviewing appeal briefs and preparing for the sittings the Court of Appeal in April/May 2018.

Chapter 2

Process of Inquiry

A Public Notice was published in the "NATION" newspaper, **(Document D),** and broadcasted on SBC Radio and telecasted on SBC TV, inviting any person who may have relevant information relating to the life and eventual death of Steve Jeffrey Khan (Steve), to contact the Commissioner by phone or SMS or by e-mail - the telephone number and e-mail addresses were also published.

Individual letter was sent to the Commissioner of Police **(Document E)**, the Acting Superintendent of Prisons **(Document F)** and Chief Executive Officer of the Seychelles Health Care Agency, **(Document G),** as it was known that their respective Institution dealt with Steve prior to or immediately after his death. They were invited to submit written Report before the public hearing is held. They were also invited to provide names of any person within their respective Institution who may be able to provided further information. Each of them responded promptly.

The Commissioner of Police forwarded copy of the Police Case Docket of Steve Khan (**Document H)**. The Acting Superintendent of Prisons firstly responded by sending **(Document I)** followed by his Report (**Exhibit J)**. At the request of the Acting Superintendent of Prisons, the Prison Medical Officer submitted a first Report **(Document K)** followed by a second Report **(Document L)**. The Chief Executive Officer of the Seychelles Health Care Agency submitted a Medical Report **(Document M)** and Post Mortem Report (**Document N).** Sincere appreciation is extended to each one of them for their readily forthcoming cooperation and assistance.

The contents of the above-stated Reports were meticulously reviewed and obscure or ambiguous areas taken up and clarified at the public hearings.

The Remand Centre at Bois de Rose in Victoria as well as at the Montagne Posee Prison were also visited.

Chapter 3

Extracts of the Commission of Inquiry Act (Cap 39)

The applicable law which empowered the President to commission such inquiry is the Commission of Inquiry Act (Cap 39) of the laws of Seychelles ("the Act").

Section 2(1) of the Act is as follows:

> *The President may, whenever he shall deem it advisable, issue a Commission appointing one or more Commissioners to inquire into –*
>
> *(a) the conduct of any officer in the public service; or*
> *(b) the conduct or management of any department or the public service, or of any public or local institution; or*
> *(c) any matter relating to the public service; or*
> *(d) any matter of public interest or concern; or*
> *(e) any matter in which an inquiry would be for the public welfare.*

Section 8 of the Act defines the duties of the Commissioner as follows -

> *"The Commissioner(s) shall, after taking the oath or making affirmation prescribed in section 6, make full, faithful and impartial inquiry into the matter specified in the Commission, and shall conduct such inquiry in accordance with the directions (if any) in the Commission, and, in due course, shall report to the President in writing the result of such inquiry; and also, when required, shall furnish to the President a full statement of the proceedings of the Commission, and of the reasons leading to any conclusion arrived at or reported.*

The Act also empowers the Commissioner to regulate the proceedings of the Commission including the power to summons and examine witnesses.

Chapter 4

Extracts of the Prisons Act Cap 180

Prisons Act Chapter 180 of the Laws of Seychelles ("the Act") is the law governing the establishment and operation of prisons in Seychelles for the confinement of prisoners. Such prisons are administered in accordance with the Act. Relevant and pertinent excerpts of the Act are set out below.

The President appoints a **Superintendent of Prisons**, ("SOP") and other prison officers are appointed according to the procedures applicable to employees in the public service and they have prescribed ranks and designations.

The SOP have the administrative command, superintendence, control and direction of the prisons and other prison officers. He is subjected to the orders and directions of the Minister responsible for prisons. In exercise of his functions he may issue orders which are not inconsistent with the provisions of the Act, and he may also visit and inspect prisons.

Any person lawfully confined in a prison is in the lawful custody of the SOP while he is so confined in, or is being taken to or from any prison and while he is working, or is for any other reason, outside the prison in the custody or under the control of a Prison Officer.

In case of sickness or emergency, a Prison Officer may enter a cell of a prisoner at night.

Every prison must have a **Medical Officer of Prison**s ("the MO") who is a Government Medical Officer. Subject to the control of the SOP, the MO have the general care of health of the prisoners and also performs such other duties as may be prescribed by law. The MO

have all the powers, authority, protection and privilege of a prison officer of a rank below that of the SOP.

Where the MO is of the opinion, or in the case of an emergency, the SOP is of the opinion that a prisoner requires treatment in a hospital, that prisoner may be removed to a Government hospital for treatment. So long that such a prisoner remains in hospital he is deemed to be in lawful custody.

A MO in charge of a hospital where a prisoner is admitted, must take such appropriate measures to prevent the escape of the prisoner. Such measures must not likely be prejudicial to the health of the prisoner. Where the MO in charge certifies that the prisoner does not require treatment at the hospital, the prisoner shall be taken back to the prison from which he was removed, if still liable to be confined there.

The Minister may appoint one or more **Prison Welfare Officer** ("the PWO") who shall attend to the welfare of prisoners whilst in, and after their release from, a prison and also perform such other duties as may be assigned to him by the Minister. After giving due notice to the SOP, the PWO may visit a prison and have access to every prisoner therein.

It is a legal requirement to always have in place a **Prisons Advisory Board** ("the Board) appointed by the Minister comprising of five members who are knowledgeable in prison welfare. They hold such office for two years and eligible for reappointment.

The Board advises the Minister on matters relating to prison welfare. It also investigate complaints relating to prison welfare as referred to it by the Minister, and, it also makes recommendations for any remedial action in respect of complaints (referred by the Minister) which it has investigated.

In the discharge of its functions, any member of the Board, after due notice to the SOP, may enter any prison and have free access to every part of it and to every prisoner.

Visits and communications to the prisoners is regulated by the SOP. However, where a prisoner is seriously ill and desires to be visited by any relative or friend the SOP may, on the recommendation of the MO permit a visit to the prisoner by such relative or friend.

Chapter 5

Introductory Remarks

Prior to the start of the public hearings the Commissioner explained that the procedures to be followed will be in accordance with the Commission of Inquiry Act. Any person who wants to give any information shall do so under oath. An Inquiry is not similar to police investigation in a criminal case, but is simply the collection of all relevant information surrounding the issue. It is impartial in that all information obtained both from Steve's relatives and from public authorities are treated with equal importance.

The inquiry will primarily focus on four main issues, namely –

(1) Procedures for communicating information to relatives of sick inmates when sick and/or admitted to Seychelles Hospital;

(2) Medical treatment made available to Steve;

(3) Medical attention made available to Steve, when he was at the Seychelles Hospital;

(4) How Steve was able to easily obtained hard drugs in prison to sustain his addiction.

The objectives of the Inquiry are to establish as factually as possible what happened in the case in issue with a view to find if there are any matter that should be addressed in order to improve or where necessary, avoid similar situation occurring in the future.

It is an opportunity for the public authorities concerned to present their side of the story, including any predicaments they faced in the discharged of their functions.

The Inquiry may also serve to highlight issues for the attention of Government. The findings of the Inquiry will serve as documented records, researchers may refer to, in the future.

Chapter 6

Public Hearings

Public hearings were held on 26th March, 2018 for the whole day and on 3rd April, 2018 in the morning only. The verbatim of the proceedings are appended to this Report as **Document S.**

The following persons testified at the public hearings:

- Steve sisters **Ms. Shannon Allazki** and **Mrs. Lindy Orphee**

- Prison Welfare Officer **Ms. Vicky Rose**

- Prison Medical Officer **Dr. Fred Arissol**

- Chief Executive Officer of the Health Care Agency, **Dr. Danny Louange**

- Acting Superintendent of Prisons **Mr. Samir Ghislain** together with **Ms. Elsia Nourrice** the In-Charge of the Prison Rehabilitation Unit

The substantive Acting Superintendent of Prisons, Mr. Raymond St. Ange, who was travelling overseas could not therefore be able to attend the hearing. He, however, submitted a written statement which is appended in this Report as **Document J.** A synopsis of that statement is part of this Report. He also advised that Mr. Samir Ghislain who will be acting in his absence, will attend the public hearings.

Mr. St. Ange also made a statement at page 5 of the "NATION" of the 26th January, 2018. A photo-copy of the article is **Document U.**

Miss SHANNON ALLAZKI

Steve's sister, Miss Shannon Allazki, gave an interview to the Press on 21st January, 2018. She was present with Steve at the time he passed away. Shannon knows Steve all his life and all her testimonies are from her personal knowledge of him.

Steve was born on 2nd September, 1976, - Birth Certificate **(Exhibit O).** He was neither married, had a partner and nor any children. He normally lived at Foret Noire, Mahe. Steve and his siblings were always under the care of their grandmother in Seychelles.

Steve always lived with his grandmother all his life. His mother Ms. Mona Khan, lived overseas with her husband but she usually comes and goes. She provided Steve and all her other children with their needs. Shannon now lives abroad with her mother and they both use to come to Seychelles for holidays very often. Shannon is of a different father than Steve.

Steve attended NYS and 'A' level studies at the Polytechnic. He trained as a Dental Technician and worked for about 3 years as such. He stopped working because of his drug addiction. He started using drug when he was at the end of his second year at the Polytechnic. He continued to do so and recently he was on heroin.

Shannon came to know that Steve was at Seychelles Hospital through her sister who called her on the 5th January 2018, the day that Steve was admitted for the first time, with severe neck pain. It was their cousin Jennifer Soundy who saw Steve when she was visiting someone at the hospital. No one from the Prison informed any relatives about his admission and they were and are disappointed.

Shannon visited Steve who was then suffering from extreme neck pain and palpitation. He had previously spent 2 days in hospital and then released even though he was still in pain.

Steve was admitted again on the 12th January, 2018 for the same reason except that by then his palpitation had worsened. On that second occasion, his aunt was informed by someone from the Prison.

Steve was tested positive for heroin.

On 15th January, 2018, Steve was alone when he suffered his first stroke. His relatives arrived just in time to see him actually falling down from his chair and they alerted the doctor and the nurse. When Shannon came she saw Steve already hooked to another machine. At the Hospital, Dr. Belle was extremely helpful and invited only immediate relatives to his Office. Dr. Belle informed them that Steve had a stroke and if he was to have another one he was going to die.

Dr. Belle advised the relatives to stay with him day and night. Shannon stayed with him from 8 a.m. to 8 p.m. and then her other sister stayed from 8 p.m. to 8 a.m. Steve could barely do anything. His palpitation was too strong and a simple movement made him loose breathe. They bathed him, fed him and did everything for him. Steve's health gradually deteriorated, and he started to have memory loss and was talking nonsense.

They called their mother and asked her to come to Seychelles. She arrived on a Friday and she spent the night with Steve on Saturday.

Steve slept a lot, did not eat as he had no appetite. When he was admitted in ICU on Sunday afternoon the Doctor said that he would not make it.

Steve passed away later that Sunday 21st January, 2018 at the Seychelles Hospital in the presence of all relatives.

A Post Mortem examination was performed and the findings are contained in the Post Mortem Report. **(Exhibit N)**

Acting Superintendent of Prisons Mr. St. Ange personally came and took the Death Certificate **(Exhibit P)** and authorised for his body to be released to them.

One day when Steve was on the Hospital Ward a Prison Officer Mr. XX (name withheld by me) came to visit. Steve later confessed to his uncle Mr. Mike Labiche that that Prison Officer was actually one of those people at the Prison who supplied the drugs in the Prison.

Steve was always extremely fearful while he was in hospital. He apparently feared his going back to the Prison. He constantly told Shannon that if they could please make alternative arrangement, because of his condition, as he did not want to go back to Prison. That was about 4 to 5 days before he passed away. He knew that he would be in trouble if anybody from the Prison came to know that he had given that information.

Steve's other sister was trying to make arrangement to get him released to them. Steve was very grateful for that as he had a fear of going back especially when Prison Officer Mr. XX visited him. He was extremely fearful and every day he would talk about his fear of going back to the Prison.

He kept telling Shannon that he wanted to change his life. He wanted to get better and did not want to go that road again because of what had happened to him. It was the first time that he was in that critical

condition. He kept saying that he did not want to go down that road anymore and that going back to the Prison was not going to help him change his life.

Steve admitted to her sisters that he became a heroin addict even before he went to Prison. He continued to have access to, and used, drugs even when he was in Prison until he was admitted to Hospital.

He was committed to Prison on 17th September 2015. He was sentenced to five years imprisonment. Shannon once or twice visited him in Prison after 2015 and found him to be extremely frail and skinny. From her observation, Shannon recognised that Steve was still using drugs whilst he was in Prison at that time.

When Steve was in Prison, only his aunt Marie Rose Labiche, sisters Shannon and Lindy Orphee, and his cousin Jennifer Soundy, who would visit him. Someone from the Prison normally called the aunt and she decides who should go.

Nobody form the Prison ever informed them whenever Steve was sick. It was only when relatives visited him that he would let them know. Only on that last occasion that Shannon was informed for the first time by someone from the Prison that Steve was admitted in Hospital.

Steve admitted to Shannon that in Prison he used drugs twice a day. He also admitted that the drugs were circulated in the morning. He further admitted that he acted as the watchdog, and that was how he got his payment - he got paid with drugs.

Steve did not discuss further the issue as to how he got access to heroin twice a day in Prison because of his health condition at the time. Occasionally he would talk about it, otherwise he would never talk about it. In the past his usage of drugs in Prison was something that he never talked about and that was the only time he talked about it. The relatives allowed him to talk about it instead of asking him to talk about it.

When Steve was in Prison on the previous occasion, his siblings asked him about his use of drugs, but he ignored or dodged the question. They told him that they would get help for him when he would be out of Prison. They then questioned him but he never talked about it.

It was evident that Steve got drugs from somebody in Prison because three days before he passed away he no longer had any veins left for the Nurse to insert the antibiotics needle. The Doctor said that the drugs in his body was very strong and he no longer had any veins left. That went to show how his usage of heroin was, when he was in Prison.

Steve being a watchdog whilst in Prison basically means that those inmates who deal in drugs had certain Security Guards that they watched out for and when those Guards were coming round, Steve as the watchdog would communicate that information and they would stop doing their drug transactions and injections.

Steve's mother told Shannon that when she (the mother) was at the hospital with Steve, a Nepalese Prison Guard once called her to the side and suggested to her to try and have Steve removed from the Prison environment. That Guard claimed that they too, are scared of the drug addicts in Prison because even when they (Guards) told those addicts to stop their activities, they would either abuse or beat

them up the Guards. The Guard seemed to know what was going on there. Knowing that her son was a drug addict, the Guard advised her to do whatever it takes not to let him go back there because he is not going to get better since there was no on-going drug rehabilitation program. That was when the relatives came to know that there were drug dealings going on in Prison which would not benefit Steve at all.

Shannon believes that in inmate in Prison is expected to be detoxed and rehabilitated and when he comes back in society he will be ready mentally, emotionally and physically. It is not expected that someone goes to Prison and came out as a worst drug addict than before.

Steve was sentenced on 30th December 2013. In July 2014 while he was serving that sentence, he was sentenced for a further four months. He was released on 21st October 2014. During the period December 2013 to October 2014 he did not have access to drugs in prison, even though he was a drug addict before he went to Prison on 30th December 2013. He came out somewhat rehabilitated. Steve told Shannon that there was no drug in Prison when he was serving those first sentences.

When he was imprisoned on 17th September 2015, he was on heroin and in Prison he continued to have his normal doses of heroin at least twice a day as rewards for being the watchdog. Steve could not report to the prison authorities about the drug dealings because he was also using it.

MRS. LINDY ORPHEE

Steve's sister Mrs. Lindy Orphee, (Lindy) testified that Steve recuperated after his first stroke. On the Sunday 14th January, 2018, Mr. St. Ange (Ag. SOP) and Prison Inspector Labiche came to the Hospital to visit Steve. Lindy approached and informed Ag. SOP that Steve had access to drugs while he was in Prison and that he as the Ag. SOP has to do something about this. Mr. St. Ange gave instructions for the Prison Guard who was keeping an eye on Steve at the Hospital, to leave, so that the relatives can have some privacy with Steve.

Prison Inspector Serge Labiche came in and introduced himself to the relatives. He was not aware that Steve was admitted at the Hospital. Lindy asked him to organize for Steve's clothes and his other belongings to be sent down to the Hospital, which he did.

Among Steve's clothes there were two gadgets which look like *"walkie talkies"* which seems to work with solar energy. She produced gadgets which were similar in make, with the following words on its face - ***www.intouch.org****;* ***"in touch messenger Dr. Charles Stanley English not for sale, free distribution only"*** and on the reverse – ***"on, off",*** with other instructions. Photocopy of the two gadgets are marked as **Document Q.** The actual ones are in my possession.

According to Lindy's researches these gadgets are usually used amongst people in church groups, to record prayers and gospels. The relatives were caught by surprise because Steve had told them that he was a watchdog. Steve even mentioned certain name.

After Inspector Labiche left, Steve gave them some more information. Steve confessed that he was using drugs twice a day in

Prison. He did not say what sort of drugs but said that he was injecting. He also told them that there were times in Prison where prisoners would queue inside the Prison for drugs. Many other illegal businesses were going on there. Steve did not specify whether the queuing took place during the day or during the night.

Lindy was the one who kept night vigil with Steve at the Hospital. Once when she was in Hospital one of the Nepalese Prion Guards handed her his phone to speak to another Nepalese Prison Guard. That other Guard told her that she should have serious talks with Steve who needed to stop taking drugs when in Prison because it is not good for him. He said that he knows that deep down Steve was a good person but he has to change his habit because it would not be good for him. Even another person from the Prison who was at the Hospital also told her the same thing. It seems that the Prison did not have the power to do anything about it.

The name given was that of a Prison Officer who was selling drugs in Prison. From what Steve told her, that Prison Officer was the one supplying drugs inside the Prison. He was taking drugs into the Prison. Steve did not mention names of any other inmates who were handling or dealing in drugs.

On the 4th January 2018, when Lindy was at her home, her aunty Marie Rose, received a call from an unknown prisoner from the Prison who , informed her that Steve was coming down to the hospital because he was sick.

At no time did the relatives received any call from the Prison informing them of Steve's sickness and admission. They only learnt when they saw him at the Hospital. She is of the view that this should change.

Lindy maintained that it is correct to say that the crux of the complaint of Steve's relatives is mainly - how come he had access to drugs when he was incarcerated at Montagne Prison and that as his relatives, they were not informed that he was admitted to hospital.

They got to know about Steve's admission from a co-prisoner who made a phone call to Steve's aunt. At one time his cousin Jennifer Soundy, happened to be at the hospital with her mother-in-law when she saw Steve at the Hospital.

Ms. Jennifer Soundy who was present confirmed that statement.

Lindy does not think that it was right that Steve had to beg the Doctor to admit him in Hospital. His relatives should at least know that he needed to be admitted and there was no need for him to beg for it.

On the 18th January Lindy also requested for a Medical Report from the Ministry of Health when Steve was still alive. She called twice and was informed that the investigation is still ongoing. She never got it until this date. She asked for the Medical Report because she saw that Steve was so sick to go back to Prison and she wanted to take his case to the Medical Board so that he may be released from Prison on medical ground. She was informed that Steve's medical problem had to do with his heart. She was not aware of his other medical problem.

Lindy came to know of Dr. Belle after Steve's admission. On 5th January, when Jennifer, her aunty and herself were there, Dr. Belle asked Steve if he would wish him to talk to him in the presence of his relatives. The Doctor wanted to have a serious talk with him. Steve asked the relatives who were present, to go outside. The next day

Steve confessed that Dr. Belle told him that he had drugs in his system and he needed to stop taking drugs.

The following is a synopsis of the written statement of the Acting Superintendent of Prisons, Mr. Raymond St. Ange, who could not be present at the hearing.

On 19th March, 2018 I wrote to Mr. Raymond St. Ange, and *inter alia* asked him for a written report on Steve Khan who was serving a prison sentence as well as any pertinent matter surrounding his death and if he could provide the following information:

(a) Prison Staffing Structure, indicating the number of staff in posts and vacancies in January, 2018;

(b) Prison population statistics in January, 2018;

(c) Names of the members of the Prisons Board;

(d) Prescribed time for visitors;

(e) Communications procedures from and to convicts;

(f) Type of medical examination performed on convict upon admission

The SOP was also to ask the Prisons Medical Officer to submit a Medical Report on the Steve's health condition, medical complaints and treatment administered on Steve Khan whilst in prison. The SOP was further asked to possibly obtain a Situation Report from the Prisons Welfare Officer during the time that Steve was serving prison sentence.

Mr. St. Ange promptly forwarded his Report **(Document J)** and also informed that he would be out of the country from 22nd March 2018

until 22 April 2018, but would be available to answer any further question or clarifications only upon his return.

The Report reveals that Steve was sentenced on 30th December, 2013 for 12 months. While serving the said sentence he was sentenced to serve a further 4 months. He was released on 21st October 2014. Steve was sentenced for 5 years and 3 years, to run concurrently, on 17th September 2015 and Steve was due to be released on 12th January 2019.

No disciplinary offence was recorded against Steve throughout the period that he was in Prison. He was a participant of the Prison's Day Release Program working at the Port with the Land Marine and IPHS and on a casual basis.

As at 21st January, 2018 the Prison employed a total of 164 staff members who were allocated to various Units, as follows:

Administration and Support Unit -7 Seychellois male and 9 non-Seychellois female.
Custodial Unit - 41 male Seychellois and 67 male non-Seychellois, and, 26 female Seychellois and 3 female non-Seychellois.
Rehabilitation Unit – 4 female Seychellois.
Probation Unit – 2 male and 5 female Seychellois.
Montagne Posee – 40 male Seychellois, 48 male non-Seychellois, 31 female Seychellois and 3 female non-Seychellois.
RDR 1 male Seychellois, 9 male non-Seychellois.
DRF 5 male Seychellois, 6 male non-Seychellois and 7 female non-Seychellois.
Coetivy - 2 male Seychellois, 4 male non-Seychellois and 1 female non-Seychellois.
Probation – 2 male and 5 female Seychellois.

There were 26 funded **vacancies** as at 21st January, 2018, as follows:

1. Research Officer
2. Administration Officer
3. Senior Transport Assistant
4. Store Officer
5. Human Resource Development Officer
6. Director of Human Resource and Administration
7. Project Officer
8. IT Technician
9. Director of Rehabilitation
10. Prison Officers X15
11. Counselors X2

On 21st January, 2018 there were 429 inmates. They were 83 male and 2 female detainees and 330 male and 13 female convicts. An inmate was detained at President's pleasure. They were housed as follows:

Mt. Posee Male Block	-275	Capacity 482
Mt. Posee Female Block	- 15	Capacity 48
Mt. Posee SIU*	- 42	Capacity 60
Mt. Posee VPU*	- 15	Capacity 24
DRC*	- 27	Capacity 28
DRF*	- 19	Capacity 80
Coetivy Prison	- 36	Capacity 85

SIU – Special Incarceration Unit
VPU – Vulnerable Prisoners' Unit
DRC – Day Release Camp
DRF - Detention Remand Facility

The total holding capacity of the Prisons and Remand Centre in January, 2018 is 807 and the total number of inmates and detainees on that date was 429. The Prison is therefore not overcrowded.

The Prison Advisory Board is chaired by Revd. Danny Elizabeth with the following persons as members:

- Mr. Andre Mounac
- Mrs. Marie Ange Denis
- Miss Judy Brioche
- Mrs. Josette Thelermont

Inmates in the various Units at the Mt. Posee Prison receive visitors on Tuesdays to Thursdays between 0900 hours to 1155 hours. Detainees receive visitors Fridays also between 0900 hours to 1155 hours.

Inmates are permitted two adults and two children visitors per month but for inmates working at or outside the Prisons, twice a month. Detainee may receive two adults and two children visitors per week. All inmates are granted one visit upon admission on any working day of the week.

Detainees can send and receive as many letters as they wish. Inmates can send and receive one letter upon admission and two letters per month. However, inmates very rarely use this form of communication.

Inmates can be granted phone calls to families and friends as needed through the Prison Welfare Officer or in some cases by a Senior Prison Officer.

Upon admission, each inmate is granted a phone call by the Admission Officer.

According to the PMO Dr. Fred Arissol, virology and general examination are performed on all inmates upon admission or thereafter.

Ms. VICKY ROSE

Prison Welfare Officer Ms. Vicky Rose (Vicky) is aware of both male and female inmates' issues.

She met Steve for the first time in November 2017 when he came to apply for home visit to his grandmother. It is a requirement that inmates seeking home visits should take a drug test to establish whether they are using drugs or not. Steve's application did not progress because when he was asked to do a routine blood test, he totally refused and told her to forget about the visit. He was advised to come back when he is ready but he did not.

Information collected from inmates who do drug tests go in their respective file. However such information may eventually, slowly and tactfully, be shared with a Drug Counselor for counselling of that inmate. The Prison may also discreetly use this opportunity to try and find out information as to who are on drugs so that the inmate may be referred to a Counsellor with the prior agreement of that inmate.

Steve, was a very quiet and compliant inmate. She never knew or heard about him. If something happened his name never came up. She never heard anybody mentioning Steve's name in relation to drugs.

Through her work she received confidential information about circulation of drugs in Prison. Since these information are very delicate, and as the Counsellors are trying to win the trust of the inmates, it is a very delicate matter. Such information is not written down in the inmate's general file. Somehow the Security Department also would become aware of that information.

Every day inmates come up to her and tell her that he is a drug addict and want to come off. When she gets such information a Referral Form is filled in for the Drug Counsellor. Such information may come to the knowledge of the Superintendent or Intelligent Section, depending if such inmate said that he is tired of using drugs and wanted to detox. In such case, she passes the information to the Counsellor who is the Head of Rehabilitation Unit.

In November, 2017 a **Prison Rehabilitation Unit** was established and a Counselor joined the Prison Staff. The Rehabilitation Unit is headed by Counsellor Ms. Elsa Nourrice with Counsellor Ms. Marvel Mirabeau and Ms. Merna Louis and herself as Welfare Officers.

As Welfare she counsels inmates and if she sees that there is the need to do so, she will refer them to Ms. Elsa Nourrice. These inmates, by their own consent, are moved away from the main prison population and are taken to the Bois de Rose in order to be detoxed. They are not transferred to **Remand Centre** if they do not consent.

When inmates come for counselling it is very rare that someone would actually tell her the source who provided the drugs. She does not know how inmates get access to drugs in prison. She does not know what happened at the Remand Centre regarding treatment of such drug addicts.

Prison Wardens/Guards working at the Rehabilitation Centre are not trained rehabilitation officers.

Vicky emphasised that their Unit needs the support of the public instead of the public pointing fingers at them. At least, the public should not be negative but should instead look at the positive side of what the prison authorities are doing instead of bashing and saying

that the prison is responsible for this and that. They should support Prison Officers and be more positive.

There is no **Public Relation Officer** employed at the Prison. The Prison authorities never carried out any public relation campaign. It will be a good idea if there is a Public Relation Officer employed at the Prison to share information with the public in order to interact with the public, much better.

She never received any specific training on the content of the Prisons Act, but had seen it. She does not know if Prison Wardens/Guards are given any sort of legal training.

Her normal daily routine is basically that when she comes and there is any inmate who has any issue she will help him/her to manage it. That includes if they are looking for work they will come to her Unit and she will try to put them on the program which the Ag. SOP had just started. That rehabilitation program is termed - "**the Project Phoenix".**

The Project Phoenix program is done at three levels. The inmates will come to her Unit, and they would be helped to filled in an application Form so that they may join in program one. Under program one they are made to work around the prison compound but do not go outside. After a while they are moved on to Program two where they are sent to work with IDC on Coetivy Island; Land Marine at the Port; or at STC Warehouses.

Before inmates are allowed to go on any of these rehabilitation projects, her Unit carries out random urine tests for drugs when they go out to work or when they come back from work.

There are no special equipment at the Prison to detect drugs apart from urine or blood tests which are done at the Clinic. These are not done every day or regularly when they pass through the door to go outside to work and/or when they re-enter the door later in the evening. It is only done randomly. This same practice applies to inmates and/or detainees going to attend Court and returning back.

Information collected at the Prison by the Security and/or Intelligence Units or even Prison Clinic is that inmates are using heroin only.

When Ms. Vicky Rose completed her testimony, **SHANNON,** with the permission of the Commissioner, interjected and said – "… *there need to be more communication from the public. May I ask why no one from her Unit came to visit Steve, why no one communicated with the relatives to let them know that he was going to be admitted or he was being sent to Casualty. If they were to communicate with us we would be very willing to communicate with them, but no one came forward to communicate with us, so if she could please clarify that".*

DR. FRED ARISSOL

The **Prison Medical Officer** Dr. Fred Arissol, submitted two Medical Reports on Steve's case, appended as **Documents K and L.** He also gave oral testimonies at the public hearing where he clarified and amplified his Reports. It may appear repetitious, but I believe that it is necessary that both, a synopsis of his Reports as well as a summary of his oral testimonies, are included.

In his **first Medical Report** Dr. Arissol stated that, upon his admission, on 17th September, 2015 Steve had no history of allergies, high blood pressure, bronchial asthma and or diabetes.

Steve was once admitted at the Victoria Hospital for surgery on his right ankle and injury below his right eye. He was a known case of chronic gastritis. Steve complained of heartburns but he had no abnormalities except for *epigastric* tenderness due to his chronic gastritis. He was given medication and discharged with the request for further investigations relating to HIV, hepatitis B and C.

He first reported to the Prison Clinic was on **3rd November 2015** and was diagnosed with *pterygium* and was given *glomerulose* eye drops.

On the **04th January, 2016** Steve reported with a history of fall and hitting his right wrist and above the right eye. Diagnosed with soft tissue injury and was given pain- killers only.

On the **08th January, 2016** Steve complained of pain around his right wrist and was given *Diclofenac* tablets for 3 days.

On the **15th July 2016,** Steve presented with lower backache relating to gym workouts. He was given pain-killers.

On the **8th August, 2017** Steve complained of lower backache after being seen at the Anse Boileau Health Centre on the 5th August, 2017 with the same complaints. The pain was located in his left pelvic area which was related to injury he got in the gym 5-6 months before. No abnormalities were found and was treated as *Sciatica* and was advised to continue with the *Ibuprofen 400mg* for the next 3 days and rest.

On the **09th October, 2017**, he presented with neck pain after he had started exercising and had difficulty to rotate his head with the left side being more painful.

On the **06th November, 2017,** Steve presented with neck pain complaining that he had been assaulted. He had difficulty to tilt his head backwards. An X-ray examination was done to rule out lesions of the cervical spine. He was diagnosed with C5-C6 narrowing and cervical *spondylosis* and *hypolordosis.*

On **06th December, 2017**, he was seen with the same complaints. An appointment for MRI scan was booked for 20th December, 2017 at 8.30 a.m. and he was to see the Orthopedic Surgeon. Since the results had not reached the Prison Clinic yet, he received his MRI findings by phone.

The MRI results were as follows - C5 disc - Rt disc. Osteophyte, foramen compression. C6-7 - Rt disc Osteophytes and foramen compression. Steve was referred to the Orthopedic Department for follow-up.

On the 3rd January, 2018 the Nurses at the Prison Clinic reported to the Dr. Arissol that there was a remarkable health deterioration in Steve Khan. He called in and saw Steve the same day and he was complaining of chest pain besides the usual cervical spine complaints.

Steve related the pain to a history of fall during which he injured his neck and ribs on the left side.

Upon examination Dr. Arissol saw no peripheral lymphadenopathy. Steve had a blood pressure of 92/96mmHg, with a pulse rate of 128/min. A systolic murmur rating 1/5, his lungs were clear. Scleral pallor was seen and rated as severe.

Upon abdominal palpation – Dr. Arissol saw no guarding, and no org.
Steve came back the next day for blood investigation to be done at the Anse Royale Health Centre.

On **04th January, 2018**, Dr. Arissol called the Health Centre to trace his blood tests results. The part of the results which caught the most attention was that Steve was *anaemic*, having a haemoglobin count of 8.4g/dl. His ESR - (erythrocyte sedimentation rate) was 50mm/hr. Up to 10mm/hr is fine for men, and up to 20 mm/hr is fine for women. Steve was referred to the Physician at the Seychelles Hospital for review and further investigations. He was discharged on the 06th January, 2018.

Dr. Arissol not being happy with the Steve's Ward Management at the Seychelles Hospital, requested an *ultra-sound* of Steve's thyroid glands as he had a severe weight loss. No abnormalities were detected. A chest X-ray was done on 3rd January, 2018, which also did not show any abnormalities. His diagnosis on discharge from Male Ward at the Seychelles Hospital was as follows:

1. Severe mitral regurgitation secondary to old infectiveendocarditis
2. Mild pulmonary hypertension
3. Pericarditis

Dr. Arissol called the Principal Medical Officer Hospital Services to discuss Steve's case. Since the PMO Hospital Services was not aware of the case, he asked Dr. Arissol to call the Consultant-in-Charge, Medical Department. The Consultant-in-Charge also told Dr. Arissol that he was not aware of the case and that he Dr. Arissol should call the Ward to find out.

Dr. Arissol spoke to a lady doctor on the Ward and told her that he was not happy with the investigations being done on Steve whose ESR was so high. The lady doctor said that it was because of an old infective endocarditis and pericarditis. Dr. Arissol went to do his research as he could not relate such a high ESR to an old infective endocarditis and pericarditis.

Dr. Arissol double-checked Steve's follow-up appointments which were to repeat echocardiography 17th January, 2018 and to see cardiologist 26th January, 2018

On **12th January 2018**, the Nurse at the Prison Clinic called Dr. Arissol and informed him that Steve was not well and that he had come to the Prison Clinic. Dr. Arissol discussed Steve's case with the Physician-on-call and Steve was thereafter taken to the Casualty Department at the Seychelles Hospital and he was admitted on the Ward.

During admission Dr. Arissol called to ask the Nurse/Physician if Steve's HIV/HBV/HCV was known, as it could be an important tool for his further management.

When Dr. Arissol learnt that Steve had had a CVA during his admission, Dr. Arissol again asked for Steve's HIV status.

After Steve had passed away, Dr. Arissol still wanted to find out what went wrong. He asked the Pathologist who did the Post-Mortem Examination to do a *"culture and sensitivity tests"* to find out if there was any abnormal brain fluids or abscess.

Dr. Arissol did the following investigations during Steve's illness at the Montagne Posee Prison:

1. X-Ray of the cervical spine on 6th November, 2017.
2. MRI of the cervical spine on 20th December, 2017.
3. Ultrasound of the thyroid glands on 8th January, 2018.
4. X-ray of the Chest on 3rd January, 2018.
5. Full blood count and Erythrocyte Sedimentation Rate (ESR) on 4th January, 2018.

In his **second** Medical Report Dr. Arissol elaborated further on Steve's situation contained in his first Report.

On **3rd January, 2018** it was brought to Dr. Arissol's attention that there was a deterioration in Steve's health condition.

During Examination results were as follows:
CVS - BP - 92/76 - P-128
Systolic murmur 1:5
Lungs: good air entry both sides
Sclera - pallor ++
Abdomen - no guarding, no organomegaly
MRI - result for cervical spine
C5 - disc osteophyte, compression
C6-7 - Rt disc osteophytes and bramen compression

Dr. Arissol referred Steve to the Orthopedic Surgeon at the Seychelles Hospital.

4th January, 2018
Results given by phone - ESR – 50. Hg B - 8.4. He was further referred to Physician for review and further investigations.

9th January, 2018
Steve's condition was reviewed at the MPHC and his condition was still the same. He was complaining of neck pain, and felt that his heart rate had increased and that he easily got tired.

Dr. Arissol checked Steve's appointments in his discharge referral summary from Male Medical Ward, which showed appointment with Cardiologist on **26th January, 2018** (10-11 00am), and with the Endocrinologist on **24th January, 2018** at Anse Royale Health Centre.

Consequently Steve had also been given Cardiologist's appointment to repeat ECG on **17th January, 2018**, but by that time he had already been admitted at the Male Medical Ward since 12th January, 2018.

Dr. Arissol had enquired through other inmates and found out that Steve was taking his prescribed medication since he was discharged prior to his being readmitted at Seychelles Hospital on the **12th January, 2018**.

Dr. Arissol in his oral testimonies at the public hearing stated that he is a Medical Registrar presently working as the **Prison Medical Officer.**

Medical tests are not done on all inmates immediately upon admission. Sometimes they are admitted without first doing a medical tests. These are done maybe a month or two after initial admission. Sometimes inmates are not seen at all unless they fell sick and reported to the Clinic.

There is no established protocol for an inmate to have routine medical tests on first admission. Inmates are told upon admission that they should take their responsibility to come to the Clinic but actually no Prison staff is specifically entrusted with the responsibility to follow up and see that they do it.

Dr. Arissol is of the view that it is very important for all inmates to compulsorily undergo medical examination immediately upon admission because in the Seychelles' settings there are so many emerging diseases. There are people who had travelled to Seychelles, and who may sometime be arrested upon arrival and sent to prison. There are people who come in as drug addicts, or may have hepatitis 'B' which is very easy to spread. There are people who may have hepatitis "C" which is very much easier to spread than HIV aids. It is therefore very important that these medical tests are done at the time of admission.

Dr. Arissol is not happy for detainees kept at the Remand Centre when it was originally opened. That was an opportunity to screen thoroughly all people who come to Montagne Posee because originally they were at the Remand Centre where it was easier to find them. He goes there on Tuesdays and Fridays and it would be easier for him to screen all those detainees.

By the time detainees are committed to Montagne Posee, if and when convicted, their medical situation would have been already known. The problem now is that once those inmates who are on drugs get in Montagne Posee Prison, they already know other inmates who were their known friends. The Guards will tell them go and get yourself a bed and they started hunting for a place to sleep. They will join the same inmates with whom they were mixing when they were outside.

Upon their admissions, inmates are not necessarily allocated a bed according to a preset plan but are normally left to themselves to select their own beds. Many times inmates are told to go and find himself a place or to join his friend. A week prior, he heard the friend of a new inmate saying - *'sa mon zwer sa, men vin kot mwan'*. Because of this routine it is very difficult to have control inside the Prison.

When he started working as the PMO in February 2014, he used to do all tests on inmates immediately, including liver function tests.

Dr. Arissol clarified medical terms that he had used in his Report - "*epigastic tenderness*" means a pain in the epigastria; "*chronic gastritis*" means gastritis that has been there for a long time; "*Human Immunity Defficiency Virus"* is HIV"; *"steregeum"* is when tissue starts covering one corner of the eye and goes across it. Steve first came to his Clinic with those kind of issues.

Whenever an inmate came and complained that he had been assaulted by another convict Dr. Arissol would only treat him and leave it at that, unless it is very serious, like an open wound, or if the inmate had been severely beaten.

Dr. Arissol received Steve's MRI result by phone that C5 right disk was *osteo 5* - this is when acidic-like matters forms on the bone and

start growing like small pinnacles along the bones which pinched the smaller nerves and caused pain.

"histolic murmur" –is when one hears unusual sounds because Steve was a thin person and anemic. If a person is healthy one would hear a murmur maybe from one but rarely up to two because it is graded from one to five.

The words - *"clearum spanner"* – means that when Dr. Arissol was looking at Steve whilst talking to him, part of Steve's eye was really pale and he noticed that there was something wrong.

At the Prison there is a bus which leaves by 10:30 a.m. which carried the blood samples to Anse Royale Hospital so that it did not get spoilt. Steve's blood test showed that he was anemic with hemoglobin count at 8.4.

The word *ESR* is when one has an infection going on within his body. The red blood cells would gather a certain amount of protein out of the bacteria which is spreading. This will rise and the speed with which it rises and fall to the bottom where you doing the test - this is how *ESR* is calculated.

A Physician is someone who had done medical training in internal medicine. Dr. Arissol was called a Physician when he was a junior doctor working at the Hospital. The patients he saw said that he was not a Physician even he signed medical papers on behalf of the Physician. Dr. Arissol was sure that Steve was discharged on the 6th but not by the Physician but rather by somebody who was an "in-house", usually a doctor who was on-call that day.

Five years ago, the norm was that the Consultant would come in the morning and did Ward rounds with the junior doctors that were

supposed to be there are the Hospital. Once they finished, they will see all the serious cases only and then the Consultant will leave the junior doctors to manage the Wards. Dr. Arissol stated that he was not happy with the Ward management of Steve.

As the PMO Dr. Arrissol requested for ultra-sound of Steve's thyroid glands as he was having a severe weight loss. The ultra-sound did not detect any abnormality. An X-ray was done on 3rd January 2018 which also did not show any abnormality. Those findings were diagnosis made from the chart at the Male Medical Ward.

Severe mutual .... - is when blood is flowing from the artery and out to the left atrium because the valve is affected and it falls back again, it goes up but not fully. That was due to an *old infective ....* that relates to the heart valve problem which Steve had in the past.

Mild pulmonary hypertension - is because Steve's left atrium was fighting to push the blood and the heart is under pressure and will react under the coronary artery and brought about hypertension.

Steve had .... - That is an envelope which covers the heart, the infection is supposed to be around that.

Around that time Dr. Arissol as the PMO called the Principal Medical Officer at the Hospital in Victoria to discuss the issue but was not aware
of Steve's case and advised Dr. Arissol to call the Consultant-in-Charge at the Medical Department and the Consultant-in-Charge told Dr. Arissol that he was also not aware of the case and asked Dr. Arissol to call the Ward.

Both the Physician and the Consultant did not know about Steve's case.

It was not the first time that Dr. Arissol had that sort of problem. He is of the view rightly or wrongly that when an inmate goes to the Seychelles Hospital there is this perception that the inmate is malingering and as such, he believes, that at times, no adequate care was being given to them.

Last year, Dr. Arissol had a case involving an inmate who is a drug addict. He sent him to see the Physician. The inmate left Montagne Posee at about 1.30 p.m. and when Dr. Arissol reached home about four o'clock, the prison Nurse called and informed him that if he was aware that that inmate was back in Prison. Dr. Arissol was perplexed as to why an inmate who was so sick had been sent back. Dr. Arissol made phone calls all evening trying to convince the concerned medical authority that that inmate had to be admitted back at the Seychelles Hospital. That inmate was eventually admitted at the Seychelles Hospital after 7 p.m. and he spent few days there.

Dr. Arissol formed the perception that if you are a normal patient you are treated as a normal human being but if you are an inmate you are a secondary one. He added that even before Steve's incident he had been asking for a meeting with the Consultant-in-Charge for Medical Medicine in order to discuss his views as to how he views a patient at the Casualty Department and a patient on the Ward. Dr. Arissol said that he wanted to put to him issues and facts, that there are things that the Hospital authority has to consider and not simply rush and go.

Once Minister MacSuzy Mondon and Minister Jean Paul Adam visited the Prison and Dr. Arissol said that he again informed Minister Adam of the situation and the latter asked Dr. Reginald that such joint meeting should be held, but until now, Dr. Arissol have had no such meeting. He wanted to bring up such matters in the interest of the inmates.

Another issue that Dr. Arissol brought up was that, he is of the view that, when an inmate is handed over to the Prison authority, it is the same as when an inmate or anybody is admitted on to the Ward. At the Prison the Superintendent or the Prison Medical Officer will be responsible. But when the PMO handed over an inmate to the Hospital Services, the Consultant, where one is involved, should know the case. Strangely, you have an inmate on the Ward with all his medical problems and yet the Consultant said he does not know or recall the case.

Dr. Arissol is of the further view that if for example Steve was HIV positive he suspected that Steve could have had a stroke - what is called *toxoplasmosis*, which is an infection of the brain when your immunity lowers. That would indicate if Steve ever had that, or if he had had any

Other fluid, one would find food in that fluid or any other micro-organism and would know what caused all these complications, for future purpose in similar issues arose.

Dr. Arissol as the PMO was not aware if Steve was HIV positive or neither Steve nor anyone else had shared such information with him.

Dr. Arissol disagreed with what was written in the Social Security certificate which indicated that the diseases or condition directed to Steve's death is - *septic shock*, *infective endocarditis*. He said that in his opinion *septic shock* is when you have so much viruses, not talking about HIV aids only, any other viruses or bacteria in your system, and this would bring about a lot of disturbances to the nerves, and one organ will fail and then the person will go into shock.

Infective Endocarditis, is when the hard muscles in the layer of the heart is infected. According to him this finding and/or diagnosis contradicts the report of the Physician.

Dr. Arissol noted the remarks in the Postmortem Report about - *body surface-pallor, abnormal coloration, reddish lesion left side of the chest* – Dr. Arissol said that he could not understand how can one identifies the body and said that the body is pale - all dead bodies are pale.

Dr. Arissol also hold the view that the remarks - *reddish lesion left side of the chest* - is an unprofessional diagnosis. As to the remarks - *there is no colour* – Dr. Arissol observed that obviously there would be no colour. He added that in medicine, when a patient dies you put the clinical diagnosis, and then you have the pathological diagnosis. You cannot put that the patient is pale when he is dead, this is not diagnosis and is unprofessional.

"*Subarachnoid hemorrhage right parietal and left occipital region*" –is what is called the high membrane. In the brain there is the *arachnoid* and there was bleeding from there. This is where the main blood vessel from your spine as they go up. Probably there was a bleeding from one of the branches.
"*Brain, moderate brain edema, small intraparenchimal hemorrhage (1cm), right parietal lobe"* means that there was swelling of the brain. Probably there was blood accumulated in the pocket in the parietal.

Dr. Arissol observed that the cardiomegaly was unremarkable and did not indicate anything. *Cardiomegaly, dilatation of cavities, multiples vegetation of mitral valve, yellowish areas of the myocardium,* this is from the heart. Steve's heart was enlarged. When the left ventricle is trying to push blood, it is supposed to work together in all chambers, so it is adding more pressure.

Moderate aortic and coronary atherosclerosis that was congested – it was congested with fat. *"Liver, hepatomegaly, chronic passive congestion"* – it was an enlarged liver.

Dr. Arissol had stated on numerous occasions that when inmates are being seen by him at the Clinic, it should happen at a time when inmates are not causing interference at the Clinic. When inmates come to his Clinic they create so much disturbances and that make it difficult for him to concentrate on what he is actually doing.

Secondly when he refers patients to the Seychelles Hospital, they should not be attended to casually, so to speak, because they are inmates. There complaints should be carefully investigated like it is done for anybody else.

Regarding the drug issues in the Prison, Dr. Arissol admitted that he does not know how drugs are introduces in prison. He has had so many thoughts over the years that he had been working there but frankly up to now he did not see anything.

As to the Prison layout, Dr. Arissol commented that the building is not in such a way that makes it easier to manage. The location of the various buildings being not in a position where all inmates on first admission have to pass through medical examination before admitted to their cells.

When inmates are sick they come to the Clinic they do not have privacy, when he is seeing one, the others are making noise outside. Sometimes, not only simply making noise, they will bang the door, saying *'dokter pankor fini*' "Doctor have you not finished?"

There is noise when inmates come for welfare and visitation matters or those who were working outside coming in for their money. For them it is only their money which matters and nothing else is important to them at that particular time. The door of the Clinic is just nearby the Welfare Office serviced by the same corridor and the inmates will all be sitting in the corridor. One cannot imagine the stress that PMO and his staff have to go through.

Dr. Arissol said that he has had discussions with the Prison authorities regarding the medical facility in Prison. The Clinic was previously inside the Main Block and there is now some place outside which is supposed to be the Clinic but this is now being used by Ms. Rose of the Welfare Unit and also by the older inmates. Those older inmates were invaded by the young ones who disturbed them if they are all kept together. The authorities have put them there and are trying to rehabilitate them.

Dr. Arissol said that he also discussed with the Prison authorities, and they are trying to get a container at least to put part of the medical service outside. For the time being he is trying to move it outside near the Administrative Block.

Dr. Arissol stated that a day's work as the PMO is not easy when inmates are shouting in the corridor everywhere.

There is no facility for admission of inmates at the Prison Clinic. If there is any admission, the Prison authorities take them to Anse Royale Health Centre or to Seychelles Hospital.

Dr. Arissol is of the view that the Prison medical facility should be independent and should be located in a conducive environment.

MR SAMIR GHISLAIN – Acting Superintendent of Prisons (Ag SOP)

Mr Samir Ghislain was present at all the sessions of the public hearing.

Mr. Ghislain confirmed Steve was first admitted in Prison on 30th December 2013 to serve a sentence of 12 months. Whilst serving that sentence, he was again sentenced to another 4 months. Steve was released on 21st October 2014 but was re-admitted on 17th September 2015. On 12th January 2018 Steve was admitted to the Seychelles Hospital where he died on the 21st January 2018. He was due to be released on 12th January 2019.

Whilst in Prison Steve did not commit any disciplinary offence. He participated in the Prison Day Release Program working on a casual basis at the Port with Land Marine and Ile du Port Handling Services (IPHS).

The Prison employed a total of 164 staff members as detailed in the written Report. **(Document J).**

The newly opened Bois de Rose the **Detention Remand Facility (DRF**) is holding about 39 detainees including 6 Somalese and is managed by Seychellois Prison Inspector Santache. There are no Rehabilitation Officers or Welfare Officers or Rehabilitation Counselors stationed there but they make regular monthly visit or at the request of an inmate or convict. This same applies in the case of Coetivy prison.

The DRF was opened to keep only detainees because there was a need to separate them from convicts. There are certain convicts who wanted to get off drugs and they approached and expressed their wish

to live in situation where there is no drug activities going on. They were sent to the DRF. The only other available Prison facility is on Coetivy Island apart from the DRF.

All of the convicts were using drugs previously. When they came to DRF they tested positive after urine test and now they are all cleaned. Some of them volunteered information about drug usage at the Montagne Posee Prison, including information about Prison Officers dealing in drugs. There are allegations that even Senior Prison Officers who are involved in letting drugs coming in and not doing anything to stop it.

The Prison Authority works in collaboration with the Anti-Narcotics Bureau (ANB) and periodically carry out searches even on Prison Officers, but so far nothing has been uncovered.

A new **Rehabilitation Unit** and **Probation Unit** operating together, was set up recently with the appointment of a professionally qualified Counsellor and Probation Officer **Ms. Elsa Nourrice.** She is assisted by **Ms. Marvel** and **Ms. Vicky Rose.** Certain inmates need professional counselling which is done by well-trained Counsellors, while others may only need counseling on minor issues. Certain religious leaders also come to do mentoring.

The dedicated Counsellors had done in-house training and experience- sharing. Each one of them is able to deliver probation and rehabilitation assistance to inmates, under the overall charged of Ms. Nourrice.

As at 21st January 2018, there were 26 funded vacancies in the Prison Service. There is neither position of Research Officer nor Administration Officer and nor Transport Officer. Presently these

functions are discharged by a Senior Prison Officer in addition to his normal duties.

There is a need for the more than 15 extra Prison Officers to be recruited. Staff turnover is very high as Prison Officers resigned because of the inhospitable working environment. They felt overstressed doing multiple tasks. They are not given proper training when they joined.

Prison Officers have to do multiple tasks and this prevent them from concentrating on their own specific tasks or duties. This may be a reason why things may not be functioning well.

The prison is built like a house and if an emergency arises it may be critical - what will happen there, nobody knows.

The existing physical layout of the prison structure is such that an inmate is able to watch the movement of the single Guard on duty and when the latter approaches, the inmate is able to alert the drug dealers and users. There is only one entry point and one exit point. This is very critical shortcoming.

New detainees are kept at DRF but separate from convicts. Detainees always asked the Court to remand them at Montagne Posee instead at DRF. The simple answer to that, is because at Montagne Posee the drugs addicts knew that they will get more facilities to continue having access to their drugs and non-addicts will get cell phones and other facilities.

The level of supervision at Montagne Posee is very low in view of the staff shortage in relation to the number of detainees. The available Prison Officers have to be divided into four shifts and sometimes

there are Officers who are on sick leave, maternity leave etc. Anyone can understand how stressed the Prison Officers are.

There must be minimum standard for a quality prison administration. Standard is required to be set out for male, female, youth, children, first offenders and those on medical program. Such standards are required to measure if the standards are being met.

The inmates at Montagne Posee are presently housed as follows –

Male Block there are 275 persons and the capacity is 482;
Female Block there are 15 persons and the capacity is 48;
Secure Incarceration Unit there are 42 persons and the capacity is 60;
Vulnerable Unit there are 15 and the capacity is 24;
Resettlement Day Release Unit there are 27 persons and the capacity is 28;
Detention Remand Facility there are19 persons and the capacity is 80;
Coetivy there are 38 and capacity is 85.

The original intended holding capacity of DRF when it was built were 85 but it was later realized that 10 persons could be not kept in one cell. After discussion it was agreed that the capacity be reduced to 40 only.

At the DRF it is made sure that the detainees get everything from their relatives who are invited to visit and that opportunity is taken scold the misbehaved detainees in the presence of their relatives in order to obtain their support because as part of their rehabilitation.

SIU stands for Secure Incarceration Unit which did not exist before. This Unit is more secured and with better control. Detainees or

convicts kept there are those who caused trouble and are hard to handle, especially in the Male Block which holds 300 to 400 persons.

The visiting time for relatives of inmates is from 9 a.m. to 12 noon, every day except on Mondays when there is no visit. They are divided into two Units so that it is not crowded and in view of the number of staff available. This practice is in accordance with the Prison Act. Pass may be withheld as a disciplinary measure.

Sometimes there are Experts and sometimes Special Advisors at the Prison. Actually there is an Adviser from the UNODC who had just arrived and will be here for 3 months. That same Advisor had been in and out for the past 6 to 7 years.

The present Prison Advisory Board meets but he (Mr. Ghislain) had never been invited to their meetings. They possibly meet among themselves or meet with the Superintendent.

At that point Mr. Ghislain was accompanied at the hearing by the Prison's Director of Rehabilitation Ms. Elsa Nourrice

Vulnerable prisoners are mostly the older ones or maybe ex-police officers or someone who does not cause trouble but will be vulnerable if put in the Male Block.

Very low risk prisoners are the trusted ones who are allowed to work outside, and are kept at the THF.

Even there are fences separating the three Units, it is possible for inmates to communicate, meet or talk during their leisure times even they are not supposed to be able to interact. They find ways to do so, such as when taking food from the kitchen to their different Units.

If an inmate wants to communicate with another one, say in the SIU, if he is not able to do so personally, he might use an inmate like those serving food, who have common access to all three Units. There is always a system that they used. There is a common meeting point even if there are these separate Units. Through others, inmates have access to the other Units. There is only one kitchen which is shared. Inmates also travelled in the same vehicle when attending Court. They also communicate among themselves by mobile phones.

Steve was kept in the Secured Incarceration Unit (SIU). Although he was a very good inmate, sometimes he caused trouble and sometimes also he asked to be removed from the main prison population. There is record available to show which period he was at SIU and which period he was at Male Block.

Inmates communicate with their relatives through letters or also through visits. They also receive visits from their families. Every morning there is patrol by Prison Officers and inmates who have issues will pass it to the Officer on duty.

Detainees also may send and receive as many letters as they wish. Convicted inmates can send and receive one letter on admission and two letters per month, however inmates very rarely use this form of communication.

All parcels, items, and correspondences for the inmates are first received at the Security Unit which is under the charge of an Inspector with a team of subordinate Officers. Each of these are then opened and its contents inspected, in the presence of the Officers and covered by camera footage. The letters are normally in an envelope, and that envelope may contained any small object although it is forbidden. The letters are thereafter dispatched to its addressees.

Over the last two years Mr. Ghislain never saw any inmate sending a letter to their relatives. Inmates only write when asking for home visit. There is an Officer who helps inmates to draft their letters such as when requesting for pardon or when they want to enter an appeal or is seeking any other official help or applying to work outside. They may not be writing letters to their relatives most probably because they are able to communicate through other means such as cell phone.

Inmates are allowed fixed lines' phone calls to their relatives and friends as needed. It is done through the Prison Welfare Officer or in some cases a senior prison officer. They have to go to a specific place where they are given the phone.

A Register is kept of the phone numbers and duration of call. The Prison Welfare Officer follows the same procedures. The Welfare Officer dialed the number, verify if the right person answers and the inmate comes on the speaker phone.

Names of visiting next-of-kin are recorded in the Visitors Book. The Prison Authorities refers to the Visitors Book and then inform that contact in case of a serious medical issue or anything like that. But with times, especially if someone has been in prison for five, six years, this contact may have been broken, especially with wife and/or husband, but then there may be other friends/visitors that can be contacted if there is a problem.

A Prison Officer goes round with the Visitors Request Form to find out if any inmate wants to have a visitor. To obtain visits inmates are assisted to fill a Request Form, indicating the name of the visitor and phone number.

An Admission Register is kept at the Prison. Each inmate has three files – a Penal file which is opened upon admission; a Welfare file for inmate following welfare program and a Medical file which is kept by the PMO.

An Admission Form is filled in by the Officer doing the admission. Names of close family members and next-of-kin are recorded and used in case they need to be contacted.

There is no specific system or procedure to be followed in case of emergency involving an inmate. In practice, at the Remand Centre, when an inmate is taken ill the relative is not called immediately unless the detainee/inmate requests for this to be done. The Officer-in-charge thinks twice before doing so otherwise by the time the sick inmate arrives at Health Centre many relatives would have arrived to visit him and this created a lot of problems.

When an inmate is admitted in Hospital, the accompanying Prison Officer will inform the Officer-in-Charge at Montagne Posee of the admission who in turn, if it is during the day, will then informed the Duty Officer. If the relatives are to be informed it will done by the Duty Officer. The Prison Officer accompanying the inmate must stay with that inmate at the Hospital until he is formally relieved. Such event is recorded in the Prison Occurrence Book.

It is not the duty of the accompanying Prison Officer at the Hospital, to inform the relatives when an inmate is admitted. That Prison Officer has only to inform the Officer-in-Charge at the Montagne Posee and the latter is also not bound to inform next-of-kin of the admission.

In practice and for security and safety reasons the Duty Officer will inform his Shift Supervisor, and the latter will, at his discretion,

decide whether to call the relative or not, and if he calls he would record that call in the Occurrence Book as proof that the relative was informed.

There is no set down procedure for informing next-of-kin that an inmate has been admitted in hospital. The Prison Administration only keep the record.

Certain inmates never want to have their relatives informed when they are sick or is admitted in Hospital. The reason they give is that it will trouble their loved ones. When they are better they will then relate it themselves. If the inmates is able speak, they can then request that their relatives be informed or they may refused. Their wish is recorded in the Occurrence Book.

Usually the inmate asked for visitors, but sometimes callers request to visit an inmate. The caller's full names and phone number are recorded and advised that he/she will be contacted later. The inmate is then informed about that request who may agree or may not agree and the caller is advised.

When an inmate is sick or is admitted in Hospital, if he conscious, the Officer asked the inmate if he wants his relatives to be informed. If he wants to, he is then asked as to who should be informed. If the inmate is unconscious or in a serious condition then it is matter of common sense that this person needs his love ones to be closed to him, then the Duty Officer will definitely make the call to inform them.

For security reasons the Prison Authorities cannot tell where an inmate is at any moment in time. There are inmates, depending on the seriousness of the matter especially if it is murder or rape, by informing the relatives of their whereabouts, words may be spread to

other parties may come to the Hospital and may cause harm to that inmate, thus affecting his security and safety.

It is not known whether the nurses or the doctors at the Seychelles Hospital are restricted by law not to divulge the presence of an inmate in Hospital because by divulging such personal information about a sick inmate could endanger his safety and security. The doctor and/or nurse on their own should not phone the relatives to inform about an inmate who had been admitted in Hospital.

Once an inmate is admitted at any Clinic or Hospital, within few minutes, anybody who knows that inmate will be there by his side - mobile technology is quick!

Inmates who are admitted at Seychelles Hospital are kept on the Ward where they are admitted. If the inmate is aggressive, or for security reasons or is mentally ill, the inmate is put at Psychiatric Ward where there is a medical room with a secured door.

There is a Prison Officer on 24 hours shift standby in case that inmate may need something. If an inmate is in Hospital the services of three Prison Officers have to be allocated on shifts, to the Hospital. As the Prison is already short of manpower, the Prison is otherwise deprived of the services of these three Officers.

At the moment, if for example three inmates are admitted in Hospital at the same time, only one Prison Officer is allocated to attend to all three, although ideally there should be at least two because there should never be only one Prison Offer working alone as anything may happen, and you cannot leave an inmate alone. A Prison Officer also have the need to attend to call of nature, too. At least one Prison Officer has to be there on standby round the clock to keep an eye on that inmate.

Prison Officers do not have formal training apart from in-house training done by senior Officers. Those Officers passed on to others what they have learnt from another Officers. If what they had learnt is not proper, then they may not be passing the right training to their subordinates. There should be formal training in all relevant fields for all Prison Officers. At the moment there is no such training. Everything is working as a matter of practice. Explanation is not training *per se*.

The Welfare Officers are normally stationed within the Prison compound where they operate. However, they may go outside to visit an inmate, if that inmate is admitted in Seychelles Hospital including at North East Point Hospital.

The Welfare Officers do not normally stand by as a trained officer to provide care to the inmate. They go and visit, check if everything is alright and then returned back. They also consider and assess their wellbeing. The request a special visit from his relatives at the Hospital, and the Welfare Officer can push to have the Senior Officer to be at the Hospital.

On male Wards a male Officer is sent and on female Ward a female Officer is sent. There is no special group of Prison Officers of whatever ranks who had been trained with emphasis on social and welfare aspects who will be allocated to hospital duties. This is something useful that we have now just started with only four Officers as we do not have sufficient staff.

These four Prison Officers have in-house training on welfare aspects. All Prison Officers are trained on all the aspects of welfare, escort, security and administration. If an inmate needs specialized in-depth

assistance then the Officer will take note then transfer the case to a Welfare Officer or Counsellor.

When inmates are admitted in hospital they are not kept in handcuffs unless is aggressive. If the Officer is alone and has to go to the restroom for few minutes, for security reason he will handcuff the inmate. There was a shortage of handcuffs and a few sets have just received few months ago for the use of the Security Unit. Before handcuffs are issued to them, Prison Officers are given training about their use. Handcuffs are not being issued to any other Officer for the time being.

It had happened in the past that inmates had escaped from the hospital and ran away.

Prison escort starts from the Prison. Inmates are classified as low, medium and high risk. They are classified medium or high risk based on information possibly received from the Intelligence Officer that the inmate is only malingering for him to visit someone or take something where he is going. Then handcuffs are used. When the inmate goes to the Clinic, sometimes the Doctor asked that handcuffs are removed and the Prison Officer to wait outside. The Officer follow the order of the Doctor. If there are two doors at least door is locked and then the Officer will stand by the other one; or he may advise the Doctor that that inmate is such a person who may harm him if he is left alone with him. If the Doctor insists then the Doctor has the right to do so. Certain Doctors may say that they do not want to see that inmate unless he/she is handcuffed and if he/she is not handcuffed, the Doctor will not attend to him/her; because that inmate may have had a history with that Clinic.

Once an inmate is admitted on a Ward, be he/she a medium or low risk inmate, he/she would not be handcuffed but if he/she is a high

risk definitely he/she will be handcuffed, especially if kept in a Hospital room where there is a balcony, or where there is facility to escape quickly.

This problem would be resolved only if inmates are kept in a special Ward at the Hospital. There again, the Prison may not have sufficient staff to run such Ward. This could reduce the pressure because sometimes there may be five prisoners at one time being admitted at the Seychelles Hospital for specialized attention. Inmates must be treated the same or else they will discriminated. They are Seychellois professionals who always point fingers on inmates.

Inmates do not use any uniforms at the Hospital and even at the Prison no uniforms is issued to inmates. Prison Officers guarding inmates at the Hospital mostly wear their civilian clothes. Nepalese Officers are issued with green trousers only but not shirts because Prison do not have uniforms for now. Staff will be issued with uniforms in July.

There is a sure necessity for a system of medical examination of inmates upon admission. All inmates are always examined by the PMO Dr. Arissol, albeit, it may not be done on the day of admission.

The procedure now being developed, is that upon admission, an inmate, will remain in a specific Unit until he is medically processed. It is true that sometimes when inmates are allowed into the main prison population they may have been already infected and within two days they could have already spread that infection. Sometime they are lost in the prison population even if called they may not come, in the end you have to drag them out for them to be medically examined.

The new Ag SOP Superintendent has introduced a **Care and Transition Unit** where inmates are kept before being admitted within the prison population.

Since January 2018 induction is being done, including medical examination and interview with the Ag. Superintendent. No inmate is now allowed in the general area until cleared by the Ag. SOP for medical, security and also welfare.

Steve remained under the prison charge although he discharged himself from the Hospital and he was back to prison.

This was not the first time that the Hospital do that, sometimes inmates are very ill, they go to the Hospital but after 3 to 4 days when they are getting better, they create trouble at the Hospital, because they do not want to stay. The Doctor asked the inmate if he wants to be released from the Hospital and they signed their release. The Prison Guard would then call for transport to take the inmate back to the prison.

For medical purpose an inmate can either accept or decline the medical treatment. Even if the inmate is ill and the PMO order that he is transferred to the Seychelles Hospital to be admitted, that inmate can still decline.

Inmates sometimes stay in bed 24 hours a day or just walk around the various Sections on all the three floors. Some of them do not even get out to get their food and asked their friends to bring it for them. They are counseled to go out for exercise but they do not want to because they may be depressed.

Ms. Lindy Orphee was permitted to interject here and stated that on Wednesday 17th January 2018, around 6:30 to 7 p.m., Andy Reginald

an ex-inmate who was released that same day, came to the Ward and when he saw Steve and he came and stood there talking to the Nepalese Officer and staring at Steve. Steve then asked him what was he doing there and in reply he said he had come to visit someone on the Ward. Steve said in Creole, - *'in vin vey zakson'*, meaning – 'to mind other people's business.' It is not known what was the purpose of his visit, as he never went to see anyone else, he just stood there for a while and then about 15 minutes later he left the Ward.

Shannon: Steve neither welcome nor reacted towards him as he normally did to others. After about 3 to 4 minutes, Steve asked him – *"are you here to see me, what are you doing here?"* He replied saying - *"I am just here to visit a friend".* He was quite agitated, could not stand still and seemed to be scared of Steve. After he left, they asked Steve who was he and then Steve said – *"ah it is not important, I do not really have anything to say to him."* It was clear that he had come with an intention to talk to Steve but was not expecting others to be present. Shannon felt that he may have information that most of them did not have.

Patricia Francourt with leave of the Commissioner: She was supporting the family and observing the comments that were coming out. She referred to the point that the Prison Authority made in terms of an inmate discharging himself and going home, and what came to her mind, **was the duty of care** and most of all the ethical issues involved, the impact of which has to be seriously considered.

Mr. Ghislain continued: The said Mr. Andy Reginald is a drug addict who was at the Remand Centre for a short term but he was not taking drug. He was not going through withdrawal symptoms as he was not a heavy user. He went to Orion Mall to steal a small table fan and then when the judge asked why he stole the fan, he replied that the weather was hot. Although he stare at people, he does not

have bad intention. There may be a possibility that because of his mental state, someone else might have got him to undertake an assignment at the Hospital.

Presently there is no electronic security screening system or prison dog. Anybody entering the Prison is not screened. This is the main manner that is being used to bring drugs inside the Prison. Visitors are physically searched and if they are acting suspiciously, they are also stripped-searched behind closed doors assisted by another Officer.

It is not the visitors who bring items nowadays, it is the inmates who go outside, who usually bring the items inside their body. There was an inmate who was found with three mobile phones in his lower orifice. **How can someone insert three mobile phones inside him together with 20 cigarette wrapped in cling film as well as a bag of hashish in his orifice?**

When information is obtained, the inmate is brought to the hospital for CT Scan. The hospital being already so congested, the staff tend to tell that too many people is being brought for scan. When they bring inmates for CT scan, the Prison Authority already have our information that inmate is wrapping the stuff in carbon papers and then stuck it inside their orifice. If the medical staff is not experienced, they would believe that it is normal and that there was no foreign object. There are those who can similarly carry money from outside and taking it inside the prison.

At present there is no special equipment installed for screening inmates. It is under discussion how to find out how mobile phones and other illegal objects entered the prison. There is an equipment called a **boss-chair**, which can help in detecting any foreign object in a human body. The inmate sits on that chair which is supposed to

detect electronically somewhat like a little X-ray what is the body. It is a very expensive piece of equipment costing in the region of two hundred thousand rupees. In the meantime the usual systematic search is done by getting visitors to leave all their items they have brought for whoever they are visiting. These items are then searched and kept with the Officers who will then deliver them to the inmate concerned. The same system applies in the case of inmates.

Prison Officers are told not to allow inmate under their care to take or eat anything from outside. But when the inmates come to Court, their relatives bring samosas, juice, lots of items and if the Officers do not take these, the relatives will swear at them. Relatives are free to attend court cases, but those stuffs sometimes may have drugs inside.

There is this serious constraint of drug entering the Prison. Not all food items are available at the Prison. At times the Doctor recommended that an inmate genuinely needs fresh local fruits. When the drug dealers see that some local fruits are being brought in every day, they try to make a deal with that supplier who will then put the stuff in the fruits for the inmate.

Cells of inmates are routinely searched, and surprise checks done for mobile phones. As soon as one group of inmates is being moved to another floor, they passed their phones to the many inmates who are able to insert and hide three phones inside their body orifice. When the searches are being done maybe only chargers or wires they have connected to the tube-light operating as chargers are found.

There is no electronic system for searching for mobile phones. Prison Authorities intend to get **trained dogs** to carry out such searches.

Telephone jammers were installed but it jammed all mobiles phones including for Prison Officers, except in certain areas. The Ag. SOP is

addressing this issue but the appropriate technology is not available here. Experts have to come and re-assess the situation and this takes time. May be by July 2018 jammers will be operational.

There are **CCTV cameras** installed only at certain points in the Prison but not everywhere because of budget issues. Ideally it should be installed everywhere. This is also a matter of concern to the security of the prison staff in order to avoid wrongful allegation. These are also for the security and care of inmates. This issue is being presently discussed. The few CCTV cameras already installed are too many for one Prison Officer to monitor. It will be ineffective for one person to monitor 26 screens. That Officer is required to do both the monitoring the screen and at the same time locating Officers to transfer phone calls. He is also the same person who is answering the radio calls.

There are technologies nowadays that when you pass on a person it will indicate if there is a phone signal coming from anywhere. If the phone is off, then 'canine' can be used but this is at a huge cost. More staff are required, more technology are needed, and canine should also be provided in addition to training of Officers.

Recently certain new detainees and convicts wanted to be transferred from the DRF at Bois de Rose complaining that the place is bad. They do not want to go to DRF because there are no drugs and no phones there and most inmates there, are drug free.

Apart from equipment, staff, technology, and canine, there is also the issue of training. There are no drugs at that DRF because there are no cell phones. The Facility is being controlled. Montagne Posee would like to do the same, since all Prisons fall under the same Prison Authority. But then again, the number of staff and the physical layout of the structure of the Prison itself is adding to worsen the situation.

Prison should be properly designed and electronically managed. Use of electronic equipment can help to reduce pressure or to even reduce the number of staff.

There is a Prison Advisor from overseas at the Prison now. He is Mr. John Wilcox who is there to help develop capacity to manage the Prison, maybe to divide it into Units, to advise on the security systems, to develop procedures – and to advise in almost all other relevant aspects where there are weaknesses. He is from UNODC but then he is helping the Prison Authorities, he is like a mentor, he does analysis, he helps the Prison Authorities and then provides his Report to the Ag. SOP who decides what to do with it.

The drugs and phones situation in Prison are problems known for many years. Other people in higher authority know the problem. They talked about it, but not much was done about it. Advisors came and went, may be they write a Report. The Prison Staff also raised the issues and then nothing much happened. Somewhere, some place things are stuck.

Classification of inmates in different Units is a good way but the problem is that there are no sufficient space at the moment to do that. That is why there must be a Prison of a proper standard.

There are some professionals out there, including good ex-police officers suitable to become Prison Officers, but as soon as five are recruited, three left because of the working environment.

The Prison Authorities have a Working Plan which cannot be put into practice for lack of funding. This is what is happening and sometimes Prison Officers get frustrated also. When the Prison wants to make changes based on local experiences, people concerned do not listen but will listen to Advisor.

Ag. SOP gave a press statement which is at page 5 of the 'Nation' newspaper of the 26th January 2018.

At this point **Ms. ELSA NOURRICE,** the **Head of Rehabilitation and Welfare Services** at the Prison commented on the issue of the Prison Advisory Board.

Ms. Nourrice stated that she met with the Prison Advisory Board a couple of weeks ago to get acquainted with the newly appointed members. The main role of the Board is supposed to advise the Prison Authorities on welfare issues in prison including staff welfare. They are supposed to visit the inmates, have meetings in general and also one on one interviews.

At the meeting the Board was invited to be more pro-active, and needs to come forward, and be more involved. The members said that they will come any time soon. They also said they are working on an Action Plan and that they will make their recommendations after their visit.

The existing Prison Act has been reviewed and the reviewed version is probably with the AG's Office now. The new Acting Superintendent is going through the Reviewed Act (Bill), so if there is any more changes, it can be done. In the reviewed Act, the name Prison Services is renamed Correctional Services.

In September 2016, the Probation Service was with the Social Affairs Ministry but now it has moved to the Home Affairs Ministry. The Probation and Prison Services are under the same Department and that is why they want to change the name of the **Prison Department to Correctional Services.**

There is now in place a project called **"Project Phoenix".** It is a rehabilitation project comprising of three programs. The Project is laid down in writing, in the Project Memorandum.

Program 1 includes working within the Prison compound, as well as educational, vocational and recreational activities.

Program 2 includes working outside the Prison such as at the Ile du Port Handling Services, STC and Land Marine and also on Coetivy Island. There are 37 inmates on Coetivy now.

Program 3 is for those inmates who are on licensed or have been pardoned.

An inmate has to go through program 1 and 2 and before becoming a candidate for licence or pardon. At the moment these programs are still at its early stages.

Vocational program is supposed to fall under Rehabilitation Unit. At present there is a Chief Inspector in charge of maintenance who is the overseeing the parts on craftworks or maintenance works around the Prison. They are also working very closely with the Employment Department since they can tap into private sectors on behalf of the Prison to get jobs for the inmates.

Rehabilitation program, is not an activity done only by the Prison. The President set up a high level committee with five sub-committees. One sub-committee is for rehabilitation program and is chaired by Ms. Nourrice with representatives from Education, Employment, civil society people and other wise persons. They work as a team on the program. The issue of physical infrastructure is one of the concerns they have raised at their meetings. They can work on programs but the infrastructure is not helping. They do classify

inmates and do risks assessment. When it comes to separating the inmates, it cannot happened or it is not easy to do so.

The Ag. SOP is coming up with new concepts of **Unit Management**. If there are smaller prison units, it will be better for the control of inmates. For example at the DRF it is easier to control inmates because there is a Management Unit there. When there will be other Management Units it will be easier and better qualified and quality staff may joined.

Budgeting is not really part of the Project, but like all other Government institutions, they also have the PPPB, and have a budget for Rehabilitation and part of which is for salary of staff.

Mr. Ghislain added that there is not only the issue of the welfare of inmates but the **welfare of the staff** which is equally important. Very few people want to work with inmates at the moment. Those who takes decision on the remuneration and other terms and conditions of employment of those who work with prison inmates especially in the prevalent drugs situation need to be more considerate. Their conditions of work and especially to avoid corruptions – prison staff should be paid well.

At present Prison Officers are underpaid for the amount of stress they go through. Comparing the work of prison staff to Police Officers, the kind and amount of work that a prison officer has to deliver under such conditions, with under staffing, inadequate physical structure, getting sworn at, inmates throwing objects at you - how many Prison Officers have been wounded. This is why Prison is losing staff who are going elsewhere nowadays.

The other thing that we must accept is the truth. As soon as a Prison Officer takes an actions against an inmate who has committed an

offence, the inmate called their relatives and their relatives would go to the higher authority which then started to interfere in prison business on Facebook and people get agitated. If something is being done wrong, is report is sought, or visit made in order to verify if everything is being done in a legal manner to maintain security. This is better appreciated than hearsay, and badmouthing the Prison will thus be avoided.
Not all things are bad at the Prison which is being managed as best as possible and this is the true situation. Seeing the present situation as compared from what it was many years ago, definitely now there a drug problem and this drug problem brings other problems.

The Prison must be given its autonomy to operate, Prison staff know what they need to do and how to do it on a standard level. Standard structure, training, all equipment be given and then let the prison runs.

Ms. Nourrice added that the Prison has just launched its Facebook page and Tweeter; so that all the good and bad things are published.

The promotion concept is being used under the Project Phoenix. For example to go to program 2, an inmate has to be in program 1 for at least three months with good behavior; inmate has to meet the standard before being allowed to work outside. If when working outside program, the standard is breached, that inmate will go back inside for maybe three months before being allowed to return go back again on program 2.

In some European countries there is a new arrangement people serving short prison sentence. Such people are not sent to prison in the first instance because it is costly. It is not known if Seychelles can adopt the same. Such a recommendation may be made in this Report. For example for Family Tribunal cases, if they breached orders, they will go to prison for two, three months.

Mr. Ghislain added that as soon as the Prison receives an inmate or a detainee, his immediate cost is about SR20,000.00. He has to be provided with a new mattress, bed sheets, towels, soap, and so. Then during the stay of that person in prison the wife goes to Welfare for financial support because the inmate lost his job as no employer waits for him but will employ another person.

The community is crying for help, asking why such people are not employed on community work. Even then, with the drug situation, that person may face all kinds of problems, his wife may have left him etc. and he started using drugs.

Ms. Nourrice said that in Steve's case, probably his offence was drug related. The new Misuse of Drug Act provides for such people to be placed in rehabilitation but such services are not available now. The residential facility is not available. Those people who are committing drug related offences need help.

We have just been going in circle. There are inmates who come to the Welfare Officer requesting to be moved from the Main Block to avoid using drugs, but there is nowhere else to put them.

Discussion took place with the Agency for Drug Prevention, and according to them they are getting a bus, so that the Prison can have a program with them. The bus can come at the Prison to provide methadone. This is still in the discussion phase. The mentor is not necessarily in favour of the methadone in Prison.

Ways are now being found to help inmates who are on drugs. It is a challenge for the Prison especially the traffickers who are sentenced. There used to have Marie-Louise Island where they were sent but this is now closed. It is not known if there are traffickers among the

victims. It is also not known if this also is making the matter worse at the Prison because the traffickers and users are there altogether.

DR. DANNY LOUANGE, CEO of the Health Care Agency.

Dr. Louange submitted a Medical Report (**Document M**) regarding Steve's treatment at the Seychelles Hospital, prior to his death. He also gave **oral testimonies** at the public hearing where he clarified and amplified his Report.

Steve was a known case of intravenous drug user for the last 2 years. He had *Infective Endocarditis,* and was previously admitted and treated with healed vegetation on mitral valve. He was again admitted on the **4th January, 2018** with a diagnosis of *pericarditis* with severe mitral regurgitation with *mild pulmonary hypertension* and he was discharged on the **6th January, 2018**, to be followed up in SOPO in 2 weeks' time.

Medical examinations and tests on Steve were carried out on 4th, 5th, 12th, 15th, 16th, 20th and 21st January, 2018, and the results were as stated the Report.

On **12th January, 2018** Steve was referred by the PMO to the at Casualty Department with complaints of palpitations and generalized body pain and fever.

Vitals at time of admission: Temp- 38.4 B.P- 100/46 B.S-4.9 SP02-99% R.A HR-125 min. Mr. Khan was alert, conscious and oriented.
Cardiovascular system: SI S2 Heard/Tachycardic and systolic murmur
Respiratory system: Chest clear bilateral
Per Abdomen: Soft, Non tender
CNS: Normal
ECG was done and it showed sinus tachycardia.
CXR was done and it showed bilateral haziness middle and lower zones.

Steve was admitted as suspected *Infective Endocarditis* and *Anaemia.* He was treated with I.V. Dextrose normal saline 1.5 litres/day, I.V Flucloxacillin Ig QID, l.V Panadol 19 TDS, l.M Haloperidol 5mg PRN, Diazepam 10mg Nocte. Blood MSC*3, Stool for Fecal occult blood, ova, parasites and serum Iron/Ferritin were requested.

On 13th January, 2018 – Steve was seen on Medical Male Ward by Physician diagnosed *pneumonia* with *infective endocarditis* and ordered transfusion of 1 unit pack cells. Cardiologist reported on Steve's 'echo findings' of *Dilated Left Atrium*, *Old Infective Endocarditis* and severe *Mitral Regurgitation.* Metoprolol 25mg B.D was added to the treatment.

On 14th January, 2018 - Physician saw that Steve's palpitations had improved and he advised to do post transfusion HB. Cardiologist and increased Metoprolol to 50mg morning and 25 mg evening.

The Nurse informed the Physician-on-call that Steve had collapsed. Steve was seen and CXR, CK, CKMB, Troponin and D-Dimer were requested and results obtained.

Cardiologist advised to decrease Metoprolol to 25mg B.D and to add digoxin 0.25mg 0.D.

Steve also complained of difficulty to lift left side limbs and mouth deviation to the right. He was given Aspirin 300mg stat and I.V Ranitidine 50mg and Heparin 5000 units T.D.S. CT Scan Brain was requested and was normal.

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The 2nd On-call-Physician was informed and D-dimer to be repeated the next day.

On 15th January, 2018 – The Cardiologist, Physician and Neurologist saw Steve on the MMW. His condition was more stable but still with SOB and palpitation. The same treatment was kept and routine MRI of the brain was requested. ABG and D-Dimer were repeated and results obtained. Steve was already on Heparin 5000units TDS.

On 16th January, 2018 – The Physician and Cardiologist found Steve to be better but with palpitation and dizziness sometimes. He had spike temperature at night but afebrile on Ward morning round. Losartan 25mg 0.D was added. FBC, U&E and CRP was repeated.

On 17th January, 2018 - The Physician found an improvement in power of the left lower and upper limbs but with poor oral intake. I.V. fluids DNS 1.5 litres/day was started and MRI Brain was done which showed recent Right Insular cortex and posterior Right Frontal lobe, ischemic infarction with evidence of diffusion restriction. No haemorrhagic components.

The Neurologist found his neurological condition was stable with mild left side hemiparesis. CVA due to cardio-embolisation with mild left side pyramidal weakness and mitral endocarditis.

On 18th January, 2018 - Steve was seen and he was better with no SOB, no palpitations or chest pain. Cardiologist, Neurologist and Physician stopped Heparin and started Aspirin and Trimetazidine 20mg TDS. Steve's condition was also explained to his brother and sister.

On 19th January, 2018 - Steve was complaining of fatigue, pain in calf and loss of appetite. Blood culture showed Non Hemolytic Streptococcus species sensitive to Arnoxicilin, Ceftriaxone, Penicillin and Azithromvcin. IV Ceftriaxone 2g 0.0 was added and Carotid

Doppler showed mild Atherosclerotic change, Internal Jugular vein had turbulent flow. A repeat FBC and U&E was requested.

On 20th January, 2018 – Steve was complaining of SOB, chest pain right and left side and poor appetite. IV Flucloxacillin was stopped and Steve was advised to eat light diet 4 - 5 meals/day.

On 21st January, 2018 - The Physician and Cardiologist saw Steve who was complaining of difficulty to swallow and also right side limb weakness. Poor prognosis of patient was explained to his mother.

ECG showed ST elevation V2-V5 with suspected coronary embolism. 02 by mask 5L/min, MRI Brain, CXR and blood for CK, GK, MB, Troponin was sent. Losartan and Lasix were stopped. Dopamin infusion was started 200ml in 50 ml saline at 5ml/hour.

Later during the day, Physician-on-call was informed that Steve was not responding. Steve's BP 50/30, SP02 -74-78% on 10litre/Oxygen. Dopamine was increased to 8ml/hour and Intensivist reviewed Steve's condition. Steve was intubated, catheterized, NG Tube inserted and he was shifted to ICU for ventilatory support. Right subclavian venous cathether was also inserted when he was in ICU who by then he was in coma. Noradrenaline was started at 1ug/kg/min and dopamine was continued at 8ug/kg/min.

Steve's prognosis was very poor and his condition was again explained to his relatives.

FBC showed WBC: 23.3; Gran: 88.5%; Hb: 8.3; PLT: 117; INR: 7.69;
ABG showed pH: 6.826; PC02: 37.3; HC03: 6. He was given sodium bicarbonate and his ABG showed pH: 7.171; PC02: 38.1; HC03: 13.6.

Steve was given more sodium bicarbonate and dobutamine was started at 1Oug/kg/min. Steve was found to have extreme *Bradycardia then Asystole* and he finally **passed away with multi-organ failure, mixed shock and infective endocarditis.**

On **22nd January, 2018**, a Post Mortem Examination on Steve's body was requested by the Police and was duly performed at the Mortuary on 23rd January, 2018 by Surgical Pathology Dr. Mirna Batista Santos, with Mr. David in attendance. The **Post Mortem Examination Report** is appended as **(Document N).**

External examination revealed nothing significant.

Internal examination revealed focal subarachnoid hemorrhage of the right parietal and left occipital region. The brain was of moderate size weighing 1360 grams with edema, small intra-parenchimal hemorrhage (ICM) right parietal lobe.

Nothing remarkable was found about the thoracic cavity, mouth, tongue, tonsils, esophagus, larynx, trachea, bronchi and thyroid. There was mucous secretion in the lumen of trachea, thymus glands and bronchis.

The **lungs** (including pleurae and diaphragm) were heavy with congestion, consolidation areas and edema. The right lung weighed 1150 grams and the left one weighed 1100 grams. Nothing remarkable was found about the Pericardium.

Heart examination, including, size, cavities and contents, Cardiomegaly, dilatation of cavities, heart muscles and coronaries, revealed multiples vegetation of mitral valve. The heart weighed 350 grams, with yellowish areas of the myocardium (myocarditis?).

Aorta, pulmonary and major blood vessels showed moderate aortic and coronary atherosclerosis.

Nothing remarkable was found regarding abdominal cavity ascites, stomach and contents, peritoneum, intestines and its contents, appendix, mesenteric glands etc.

Examination of the **liver**, including gall bladder, revealed hepatomegaly and chronic passive congestion. It weighed 1700 grams.

The **spleen** weighed 250 grams and showed reactive splenitis.

As to the **kidneys**, examination revealed congestion of the medulla and abscess in the surface. The right kidney weighed 160 grams and the left one weighed 160 grams as well.

There was nothing remarkable about bladder, urine, suprarenal glands, pancreas, generative organs, breast, prostate etc. There were no internal injuries.

The **causes of death** as per the result of the examination was that Steve's disease and/or condition directly led to his septic shock death. The antecedent causes or morbid conditions, giving rise to the above causes, were infective endocarditis. The conclusion reached was that Steve died due to ***septic shock and infective endocarditis.***

Other findings were - ***severe bilateral bronchopneumonia, pulmonary distress, reactive splenitis, right-side kidney infarction, moderate brain edema with focal subarachnoid and intra-parenchimal hemorrhage.***

These findings do not mean the mode of dying, e.g. heart failure, asthenia, etc., it only mean that the disease and/or injury are complication causing death. Tissue sample was taken for histopathological evaluation.

At the public hearing, **Dr. Louange** clarified the contents of his Report as well as the Post Mortem Examination Report and also provided other medical information.

Jeffrey Steve Khan was 41 years at the time of his death and was a known case of intravenous drug user. He was previously admitted at the Seychelles Hospital with *infective endocarditis* and he was accordingly treated. He had a healed *vegetation on mitral valve*.

Infective endocarditis - is a condition of the heart valves and the lining of the inside of the heart. It is the infection of the lining of the heart and the valve.

Vegetation on mitral valve - after Steve was previously treated and healed, there some small nodules around the mitral valve of the heart.

Pericarditis, is the inflammation of the membrane around the heart.
Mitral regurgitation is the incompetency of the valve of the heart so that when the heart is trying to pump out the blood, the blood flowed back- it regurgitated.

Pulmonary hypertension arose because of the regurgitation and pushed back pressure into the lungs.

Dr. Louange explained the abbreviations stated in his Report as follows.

GRAN stands for Granular side;
HB is Hemoglobin;
PLT is Platelet;
ESR is a factor retrocide sedimentation rate which indicates whether there is inflammation going on;
NA is Sodium;

K is Potassium sulfate;
UREA is urine;
CREAT is Creatinine;
AST is Liver enzyme;
ALT is also liver and enzyme;
CK is Creatinine kidney;
CK MB is Creatinine kidney specifically for the heart; and
CRP is another indicate for inflammation.

Steve's WBC was borderline on **15th January, 2018,** at 11.7 and was highly elevated on the **21st January, 2018**. It was infection that caused it to jump. On the granular side, 75 to 80 is about the range but it was high on the 15th and 21st January. It showed that there was specific bacterial infection in his body. HB at 8.3 was a bit low, as the normal is about 10. The HB result was bit low which showed that there was an infection. Platelets (PLT) were all within the normal range of 150 to 400. ESR was always above 10, an indication of an inflammation due to infection. Sodium (NA) was within the normal range. Potassium (K) was within the normal range as well. UREA was insignificantly elevated. Creatinine (CREAT) indicating that renal function was within normal range.

AST is the function of the liver and the normal is below 35.54 which is borderline and 274 is elevated, which showed liver impairment.
ALT is the alkaline transfer - 167 is elevated and the normal is less than 45.

The CK indicates the functions of the heart and the normal CK is 171. CK MB relates specifically to the heart and both the CK and CK MB blood tests were done. The normal CK MB for the heart is less than 25. The result showed that his muscles were undergoing changes as if there was an infection or a tear in his muscles. If, there was any injury or any conditions affecting his muscles, the CK and the CK

MB will elevate. When he was admitted, there was a slight elevation, but for the last day there was an elevation. CRP is an indicator of inflammation somewhere in the body. It is normally less than 10 and when it is elevated it is an indication that there is a significant infection.

Steve was admitted by the on-call Dr. Belle who is an Intern Medical Officer and then the next day he was seen by the Physician Dr. Anna who is a doctor trained in Internal Medicine. He was being treated with cardiac medication to reduce the circulation volume in order to reduce the pulmonary hypertension.

Dr. Belle discussed Steve's case with Dr. Anna who is a qualified Physician and they agreed to do the blood tests, put him on symptomatic treatment whilst awaiting for the Cardiologist to see him.

At the time of his admission all these background information were in his medical file. When anybody is having any special disease it also recorded in his medical file so that any doctor could see what disease the patient was suffering from. The two doctors who initially dealt with Steve on that first day were aware of his condition because they were documented. However, if Steve was suffering from any transmissible disease, **HIV for example, the two doctors would not know that. As they were not aware of this, they had given the treatment without that knowledge.**

The procedure is that when a patient comes in at night, an entry is made on an Admission Sheet and when the patient is admitted the next day the notes of the patient will be in the patient's file including his historical information. The doctors would be armed with the knowledge of his condition when treating that patient.

Steve came back again on **12th January**, **2018,** and was seen at Casualty Dept. with complaints of palpitation, generalized body pain and fever. Vital signs at the time of his admission were - temperature was 38.4; BP100/46; BS4.9; SPO99%; RA HR 25/min. which shows that his temperature was elevated.

His blood pressure was on the on borderline of the low side. Blood sugar was normal; saturation was normal; and heart rate was normal. Steve was alert, conscious and oriented. His cardiovascular system read - S1 S2 heard/tachycardic and systolic murmur.

Upon examination cardiovascular system, there was an abnormal heart beat. S1 S2, indicated that there was a murmur, there was an abnormal heart sound, and there was tachycardia which was very fast. The heart was pumping fast with a sound. When you listen in the stethoscope, there was very distinct heart sound but if there was a murmur it showed that there was something abnormal with the valve of the heart.

Examination of his respiratory system revealed that his chest was clear bilateral and there was no problem with the lungs. The abdomen was normal being soft and non-tender. The Central Nervous System was normal on admission. ECG was done and it showed *sinus tachycardia* and the result showed sinus. Sinus tachycardia, is when the heart is beating fast but at the upper half of the heart, not the ventricles. Going back to the vital signs on admission, the heart rate was 25 per minute, so this was low and it did not correspond with the findings that they found in the ECG and upon heart examination.

According to Dr. Louange RA HR 25/min and sinus tachycardia does not read properly together. It does not tally, there was a mistake. The correct heart rate according to the chart was 120 beats per minute and not 25, by this correction it now tallies with other reading.

Steve was admitted with suspected infective endocarditis and anemia. Infective endocarditis means infection of the lining of the heart including the heart valves, and, anemia, because of the hemoglobin was 8.3. Going back again on the chart, on the documentation by the doctor, it reads 125 beats per min - this a typo error.

Steve started treatment with IV dextrose normal saline 1.5 liters/day , IV flucloxacillin 1g QID, IV Panadol 1 g TDS, IM haloperidol, 5 mg PRN, diazepam 10 mg Nocte. That treatment targeted the infection. The flucloxacillin together with Panadol, targeted the pain, and the haloperidol and the diazepam also targeted the fact that he had a history of drug abuse.

The dosage was normal as they targeted his conditions. These are treatments that any professional, including himself, would have given him.

Regarding the blood tests - MSC is blood test for microscopic and culture. Three samples were taken to look whether there was any microorganism in the blood because of the elevated temperature. The stool fecal occult blood, ova parasite, was because of the hemoglobin that was low and then the serum ion/ferritin was also to investigate why there was a low hemoglobin. The blood was taken on **13th January, 2018** for blood culture. The results show non-himolitic stratococus, that is a bacteria in the blood. This bacteria could be caused by anything that had been introduced in the blood and is usually related to intravenous injections.

The working diagnosis was of *infective endocarditis with anemia*. On the basis of all the tests carried out, that initial conclusion was correct and any doctor would have reached the same.

Steve was seen on the **13th January 2018** when he was at Medical Male Ward by Physician Dr. Sonil. Dr. Louange was asked to verify and confirm whether Dr. Sonil is a qualified Physician or whether he was only using that title. Dr. Louange undertook to confirm to do that.

Steve was seen by the Physician and was diagnosed with pneumonia and infective endocarditis in view of IVDU (Intravenous Drug User) and was advised to transfuse one unit pack cells which are blood products. Pneumonia is a chest infection and was diagnosed by means of his clinical history; by the examination, including all the information collected; together with palpation. This is called a working diagnosis.

Steve was also seen by a qualified Cardiologist Dr. Zhu. Dr. Zhu repeated the echo cardiogram and her findings was a dilated left atrium and infective endocarditis. Dr. Zhu made the diagnosis through the complications of the outcome of an old infective endocarditis which leaves scars and nodules which in turn indicates that there was infection. It could not be determined whether that infection took place during the time that he was in prison or prior to that. Dr. Zhu further diagnosed severe mitral regurgitation which was due to the incompetency of the valve.

Metoprolol is a medicine prescribed to reduce the heart rate. The 25 mg of metoprolol that was prescribed in addition to the other treatments, appropriate in the circumstances.

On the **14th January 2018** Steve was seen by another qualified Physician Dr. Mahmoud who is the Consultant-in-charge of the Internal Medicine Unit. At that time Steve's palpitation had improved. He asked for the blood MCS (microscopic culture and sensitivity) which takes at least 45 hours for the result to come in and

he ordered post transfusion, meaning to check the hemoglobin after the transfusion. The MSC test result was still in the Lab and Dr. Mahmoud went to get that result as he needed it for him to do the post transfusion of hemoglobin. The MSC was ordered on the 14th January and was done on the 15th January. Steve was again seen by Dr. Mahmoud who increased the dosage of metoprolol to 50 mg in the morning and 25 mg in the evening.

The result of the fecal occult blood neither trace of blood in the stool and nor any parasite.

On **14th January,** 2018, at 15:49 the Nurse informed the Physician on-call that Steve had collapsed. The Physician had seen him that morning and he collapsed in the afternoon. Collapse is very broad term. It could be the patient was not feeling well and to the extreme where he was not responsive. The Doctor came immediately and Steve was found to be alert but was complaining of palpitation and shortness of breath. His parameters was 99, blood pressure 99/57, heart rate was elevated at 110, saturation of oxygen was normal and the Doctor ordered CXR (chest x-ray) and to do a cardiac enzyme. Steve's DNS was 5%; so 500ml of Troponin and D-dimer and oxygen was given. Troponin and D-dimer has to do with the heart and pulmonarism.

ECG was done, which showed tall QRS, Tall T V3-V5, low voltage-ABG (Arterial Blood Gas).

The Cardiologist was then contacted and he advised to decrease metoprolol to 25 mg and he added digozin 0.25 mg. These medicines were duly administered.

Steve also complained of the difficulty to lift left side limbs and his mouth had deviated to the right. He was given aspirin 300 mg, a brain scan was done and the result was normal.

To recap – on **14th January, 2018**, at 3:49 Steve collapsed. Dr. Belle and Dr. Gayon came and they called the Physician Dr. Mahmoud who came and gave all those instructions. Then the Cardiologist Dr. Zhu was also called and she came and advised to decrease what she had prescribed before.

Dr. Belle and Dr. Gayon saw Steve on the **15th January, 2018** at 3:45 p.m. when they were called. Dr. Belle and Dr. Gayon (Medical Officers) operated under the supervision of Dr. Mahmoud. It was Dr. Belle who contacted the Cardiologist Dr. Zhu on the 14th January at 5:20

With regard to the difficulty lifting left side limbs and mouth deviating towards the right - that was reported the same day at 17:20. Steve was given aspirin and IV ranitidine. He was seen again on the same day by Dr. Gayon and Dr. Belle at 17:20 and he was complaining of palpitation and weakness of the left limbs. They did an examination and thereafter contacted the second-on-call and a brain CT scan was ordered.

At that point, Steve's relatives were informed that Steve's current condition was unstable and they were also informed of the current management. If there was a weakness in one side of the body it meant that there was an event in the brain, so that was why a CT scan was done.

Henceforth, all the relatives took turn to stay with Steve at the Hospital 24 hours. The relatives reported that Dr. Belle did his best and related very well with them.

At 20:15 the same day Dr. Belle reviewed the CT scan which was normal. Steve had regained some strength in his arm. At 20:30, Dr. Belle reviewed the Steve again and informed Dr. Mahmoud of the latest situation and Dr. Mahmoud advised to give heparin, that is anti-coagulant, and also to repeat a D-dimer to evaluate his blood clotting capacity.

All these were done by the Dr. Belle in collaboration with the Cardiologist Dr. Zhu and the Physician on-call Dr. Mahmoud.

The next day, **15th January 2018** at 9:30 a.m. Steve was seen on the Male Medical Ward by three Specialist together, these were Cardiologist Dr. Zhu, Physician Dr. Mahmoud and this time a Neurologist Dr. Alexander was also present. His condition was more stable but still with shortness of breath and palpitation. The same treatment was maintained. MRI of the brain was requested. ABG (arterial blood gas) and D-dimer were repeated. ABG reading was within normal range. D-dimer was applied and continuation of the regular medicine that he was on. Steve was already on heparin treatment.

On **16th January 2018** Steve was seen by the Physician and the Cardiologist. He was better but had palpitation and dizziness at times. He had spike temperature in the middle of the night but afebrile at the time of the Ward morning round. He was given additional medicine losartan 25 mg. OD was added, FBC, U & E and CRP was repeated and they maintained that.

On the **17th January**, **2018,** Steve was seen by the Physician who observed an improvement in the power of the left lower and upper limbs but with poor intake by mouth. IV fluids DNS 1.5 liters/day was started and MRI brain scan was done as planned.

The MRI brain scan result showed recent right insular cortex and posterior right frontal lobe, ischemic infarction with evidence of diffusion restriction, but no hemorrhage components. That means that the blood circulation to the right side of the brain had reduced. That may be due to cardio embolism, that is, an embolus is like a blood clot, because the heart was not regurgitating, it can throw small clot up to the brain. There was no active bleeding in the brain.

The Neurologist reviewed Steve's condition after the MRI and found that his neurological condition was stable with mild left side hemiparesis which means weakness in the limbs - vascular accident – which had to do with brain.

The next day **18th January 2018**, Steve was seen by the Cardiologist Dr. Zhu on her Ward round and Physician Dr. Mahmoud and later he was seen by the Physician Dr. Sounil. Steve was doing better with no SOB, palpitation had improved, with no chest pain. After discussion with the Cardiologist, Neurologist and Physician, there was an agreement that the cardio embolism was due to sepsis, meaning vegetation from the heart that had gone to the brain and not blood clots.

They altered the medication and heparin was stopped and aspirin was started, and trimetazidine was added. Steve's condition was explained to his relatives by Dr. Belle. Sepsis means infection materials from the heart. The first impression was that it was a clot because of the abnormality from the heart. A clot in the heart had gone up to the brain and blocked vessels that supply the left side of

the body. Then after their review, their impression had changed, instead of clot they felt that it was an infective particle from the heart that had gone up to the brain which was stuck in the blood vessel that supplies the right side of the brain thus giving weakness on the left side. So that was the reason why they stopped the heparin.

On the **19thJanuary, 2018,** Steve was seen on the Ward round and he was complaining of fatigue, pain in his calf and loss of appetite. Blood culture showed non hemolytic, streptococcus species sensitive to amoxicillin, ceftriaxone, penicillin and azithromycin.

It was observed that when Steve was initially admitted none of these were recorded. It was explained that this came about because the result blood tests that were done on the morning of his admission came the next morning, after 48 hours.

On the **19th January, 2018,** IV was given and carotid Doppler was requested which showed mild atherosclerotic change. Carotid Doppler is an ultra sound machine to look at the potency of the carotid arteries, that is where the blood goes up, and to make sure to exclude or to rule out if there was any blockage or any vegetation there. Internal jugular vein with turbulent flow. Repeat FBC and U&E was requested. Ceftriaxone was added because of the sensitivity. That was why they also stated that the internal jugular vein which is also in the neck had some turbulent flow and that was non-conclusive.

On the **20th January 2018**, the Steve was seen on Male Medical Ward and he was complaining of SOB, chest pain right and left side and poor appetite. He was on IV of Flucloxacillin which is an antibiotics which he started on admission. A new antibiotic was introduced. IV was stopped and Steve was advised to eat light diet 4

to 5 meals a day. Apart from that there was nothing else for the doctors to order or prescribe.

On the **21st January, 2018,** the function of Steve's kidney was mildly impaired as his the liver enzyme, T/Bilirubin which indicated the liver function was mildly elevated and was nonspecific and not serious.

On the **21st January, 2018,** Steve was seen by Physician and Cardiologist and he complained of having difficulty to swallow, right side limb weakness - poor prognosis of patient was explained to his mother. ECG was requested which showed ST elevation V2-V5 with suspected coronary embolism. It was ordered to start dopamine infusion for his heart. By that time they have concluded that there was not much medically they could do, yet they still kept trying every possible avenues. The Physician on-call was called at 12:25 p.m. and was informed that Steve was not responding. Dopamine was increased to 8ml per hour and Intensivist (Specialist in the ICU) was contacted.

The Intensivist reviewed Steve's condition and Steve was intubated, catheterized, NG tube inserted and he was shifted to ICU for ventilator support. Right sub-clavian venous catheter was inserted when he was in IUC. Steve was in a comma and noradrenaline was started and dopamine continued. The prognosis was very poor and his condition was again explained to his relatives.

Treatment with sodium bicarbonate was given and ABG was repeated. He was given more sodium bicarbonate and dobutamine was started. He was found to have extreme bradycardia then asystole and he finally passed away.

Doctors dealing with a terminally ill patient usually tried to do everything that they could possibly do even they may know that the patient might not survive. Steve was found to have had extreme bradycardia then asystole.

The Dopamine was administered with a view to improve the heart function and also to increase the heart support by introducing noradrenaline to help the heart to beat. Bradycardia means that the heart rate had reduced and continue to reduce until there is a flat line and there is no heart rate and then he passed away.

Steve had multi organ failure, mixed shock and infective endocarditis. That is known because of the blood test that was done. The liver was involved, kidney was involved, and lungs were involved because of the infection and brain as well. That was the last minute of the late Steve Jeffrey Khan.

Post Mortem examination was done and the conclusion is that Steve died due to *septic shock* and *infective endocarditis.* This simply means that the function of the body had stopped. Everybody who died is called shock. Shock does not have the same meaning that we usually used in Kreol. Shock means when the blood circulation has collapsed or has stopped functioning because of infection. When infection has taken over or when there is overwhelming infection, it has an effect on the heart muscles; it also has an effect on the blood vessels and then the other organs. It can pull the blood such that the heart being weak by an infection to cope with, does not have enough power to pump the blood, despite even antibiotics.

Endocarditis is an infection of the lining inside the heart.

Other post-mortem examination findings were - *severe bilateral bronchopneumonia*; *pulmonary distress; reactive splenitis; right*

kidney infractions; moderate brain edema with focal subarachnoid, and *intraparenchymal haemorrhage.* This is a picture of an infection due to a bacteria that had been introduced into the system.

There is a possibility that if a person had taken intravenous injections with dirty syringe, one could be putting dirty things in one's blood stream. If you take something infected and you put into your blood stream you can get this same infective endocarditis.

The most common infective endocarditis is staphylococcus which is one of the rare causes, but is it possible. If you take the blood sample of a patient with fever who has sepsis (infection in the blood), it is very difficult to isolate the bacteria in the blood. Even the Laboratory Technician cannot find it. That was why they did three blood tests to detect whether there was bacteria in the blood. In the majority of cases the patient has fever, as evidence of features of sepsis, but they cannot isolate or detect the bacteria in the blood. But in Steve's case it was found and that was significant.

There are indirect ways to detect that - like the EESRCRP but again it is not conclusive. In the case of Steve, such test was done right from the start because they had information that he may have been using dirty needles for intravenous intake of drugs.

Immediately on admission it was found that there was staphylococcus. He was administered flucloxacillin right from the day of his admission. This is called empirical treatment which means it was assumed that he had an infection in the blood and that it could be staphylococcus. When confirmed report was received the treatment was then changed to therapeutic antibiotics. The Post Mortem findings also correlate to findings in the heart.

The **Post Mortem Report (Document N)** drawn up by Pathologist Dr. Mirna Bastista Santos. Dr. Louange explained that there is a difference between a Forensic Pathologist and a Clinical Pathologist. A Clinical Pathologist looks at histology issues; a Forensic Pathologist does the Post Mortem which includes the autopsy. Some Clinical Pathologist can carry out autopsies but there is also Forensic Specialist in Seychelles who does this.

The PMR states body surface-pallor, abnormal coloration. The Pathologist found reddish lesion left side of the chest. The reddish colour on the left side corresponds to the cardiac massage at the ICU when he collapsed. This will have an effect on his colour.

On the internal examination, pericardium is stated. Pericardium also existed on the 4th January, 2018. There also the issue of pericarditis. That is inflammation of the membrane around the heart. But the PMR states that this could not be found as it was unremarkable. It could have resolved during that period. Pericarditis was not a cause of death.

On first admission it was suspected to be pericarditis. On the second admission it was endocarditis, the lining inside the heart. On page 2of 3 after the word 'pericardium', that is where the pathology or the lesion being insignificant for the heart, there is cardiomegaly, this is enlarged heart. An enlarged heart usually happens over weeks or months due to incompetency of the structure of the heart, so it cannot pumps.

This heart problem could be congenital but it is more likely to be related to the other features that are present, like multiple vegetation of the heart valve. This relates to the injecting of bacteria into the system because you can only get vegetation if you have infection in the blood system. Then there is the reddish areas of the myocardium

that is an indication that there is infection of the myocardium, the heart muscles.

The cause of death is stated as *septic shock* and *infective endocarditis* but when you read through the internal examination, you see that there are other organs that were affected like lungs, liver, splint, kidney, etc. so it is a multi-organ involvement. One organ is linked to the other organ, the weakness of one is linked to the other one. When one is affected, the other one also is affected.

It was put to Dr. Louange by the Commissioner that at the Prison there is a Prison Medical Officer who operates in a very difficult environment and under a lot of stress and difficulty. It is a small Unit which include one or two nurses and/or assistants. They have to manage all the 400 odd inmates who are not all so gentle clients. As per the Prison Act the Prison health facility is under the Prison Medical Officer who in turn falls under the Health Care Agency. But the law shows that it is the Principal Medical Officer of Community Health Services who has to approve the appointment of the Prison Medical Officer. In practice now it is the Health Care Agency which provides the Prison Medical Officer who is now answerable to the Agency.

Dr. Louange confirmed that he had visited that Clinic and he knows about its environment and everything. The Agency, however, has not formally done any further analysis of its situation. The Agency is looking at the number of cases that the Prison Medical Officer have to attend to. These are the parameters that they used to decide on the allocation of human resources.

As to the physical environment, besides the Clinic, its privacy etc. that falls under the jurisdiction of the Prison. Only the technical aspect of the Clinic is under the Agency. They planned to build a

new clinic outside the main prison but within the administrative block within the same campus.

There is no structured way of holding meetings between the Agency and the Prison Medical Officer but they do consult. Dr. Louange has direct contact with the prison authorities. One of roles of the PMO is to bring any issues to the Agency through that route.

Dr. Loaunge stated that from his understanding there is a policy for all inmates to be clinically examined upon admission.

Dr. Louange explained that this is what is happening now. The PMO is currently Dr. Arissol. Dr. Arissol will examine/assess an inmate and then decides where to refer the inmate. The inmate will not be sent to a Clinic if Dr. Arissol could treat the inmate. If the inmate needs specialized care, Dr. Arissol's role is to call the Specialist and if Dr. Arissol is yet not satisfied with the Specialist, he will escalate as he has done before. Dr. Louange stated that Dr. Arissol had even called him personally on few occasions because the referral Doctor had not entertained his requests. He (Dr. Louange) had to intervene. That is the structure that exists.

Dr. Louange stated that the best way is to empower the PMO Dr. Arissol. If he had requested for referral then the Specialist at the Seychelles Hospital should respect his decision. This can be reinforced.

The Acting SOP Mr. Samir Ghislain interjected to make the point that even inmates, bullied Doctors at the Seychelles Hospital in order to get a discharge back to the Prison without the order of the Consultant or the Doctor treating them. Even though they are not well they insisted a lot and argued that they need to go back to prison and therefore urged the doctor for that.

Chapter 7

LOCUS IN QUO

I visited the Remand Centre at Bois de Rose Avenue in Victoria and the main Prison at Montagne Posee, in order to be able to put in context what I heard at the hearing and read in the other document.

Remand Centre – Bois de Rose Avenue

On the 21st June, 2018 at 2.15 p.m. I was welcomed at the Remand Centre by Mr. Samir Ghislain, Ms. Vicky Nourrice and other Prison Officers as well as a UNODC Officer and a Somali representative.

I note that the whole facility is air-conditioned.

The outside area of the Centre is fenced and the building is well secured, with relevant signage. There are two living quarters within a very short distance from the Center, which are occupied mainly by the Nepalese Prison Officers.

Detainee comes to the Centre by escort bus coming inside, the gate is then locked and secured procedure is followed prior to allowing them inside.

Visitors are allowed to visit detainees at the Centre every Tuesdays in the morning and on Thursdays in the afternoon. Visitors give their names two days prior and must produce ID Card to the Guard at the gate on the day of the visit before they are allowed inside the Centre. They have to wait at the special area outside until they are called inside the Centre, for the visit. A list of visitors is given to the Officer managing the gate that day to facilitate this process.

Prior to actually meeting the inmate, the visitor is taken to a private Search Room where appropriate check and search are done. When visitors come with bags of fruits, the Officers thoroughly checked their bags and contents. All checks are done visually and by hands verifications and no gadgets, equipment or detector are used because these are not available.

Similar search procedure is done prior to inmates being allowed inside the Centre. The actual search is done in a room where there is surveillance camera to avoid allegation by inmates of wrong doing by Prison Officers.

The main entrance door of the Centre remains closed and bolted at all times and can only be opened by the Prison Officer standing on guard outside. If anything, like fire, riot etc., happened inside the Centre and the Guard is not present at the gate outside everyone will have to remain inside and suffer the consequence.

An Occurrence Book is kept where the names of all detainees and convicts are recorded. Although both detainees and convicts are kept at the Centre, they are managed according to different regime. They are kept in different cells which are closed and locked during the night. During the day all cells are kept opened, and all inmates are all allowed in the common area where visits take place.

There were 36 inmates - **26 detainees and 10 convicts,** on the day of my visit. Convicts kept at the Centre are those who want to detox or want to work outside. No detainees or convicts who are on drugs are kept there. All inmates are subjected to urine check every week. Even those inmates coming to the Centre, from Montagne Posee, are similarly tested for drugs.

The Centre was meant only for detainees but because there is drug problem at Montagne Posee, therefore some compliant inmates from Montagne Posee who are not on drugs are also housed there.

New inmates/convicts are issued with uniform, towel, bed sheets, new mattress, and toothpaste – everything new. Whatever the brought with them on admission are not allowed inside, other than three sets of their own clothes for them to use when they go to Court. When they are inside all the inmates wear uniforms provided to them by the Prison which comprised of t-shirt and shorts.

There is no room facility for induction of inmates. There is a kitchenette, where inmates can only make tea, but for lunch and dinner they are provided with "take-aways" just like other prison staff.

There is a camera monitoring room but there is no designated Prison Officer monitoring the cameras. The only purpose of the surveillance cameras for evidence if anything happens, one can rely on the camera footage. This recording is kept for one month.

The treatment that the inmates opted to have in the Centre is - to detox. They get medical assistance every Mondays and Fridays, when the PMO comes. That has nothing to do with Dr. Herminie's program. During the weekend 23/24th June, a survey on the status of all the inmates will be undertaken, for management purposes.

I observed that the Remand Centre at Bois de Rose is a claustrophobic place not properly designed and built for the purpose it is supposed to serve. There is only a single entrance and exit door to the cells which have no windows. A cell housed over 10 inmates who are provided with fixed bunk beds. There is only one fixed light in a cell which is switched on at night when the single steel door is locked for security reason.

I also observed that smooth and easy evacuation, in case of fire, is very hampered if the steel doors to the cells are not promptly opened and secondly the only single steel door leading outside is not opened, by the Prison Guard using the keys to those doors, not being on the alert.

I further observed that the area, where inmates are supposed to get outside fresh air and be able to walk and exercises, measured about 5 metres by 7 metres with no sun or rain-proof roof. In my consideration, such a space is too small for that purpose. Because of the small area available, inmates are permitted to use that facility by small groups for about an hour each day, as it cannot accommodate more inmates at the same time. The inmates, being both detainees

and convicts, lived within the four walls for long period during the day.

Montagne Posee Prison

At the Montagne Posee Prison I met the Ag. Superintendent of Prison, Mr. St. Ange and I informed about the various issues which came up during the inquiry. Mr. St. Ange shared with me his futuristic concepts and new approaches to prison administration as well as his views and plans for the physical development of the Prison infrastructure.

There is a Master Plan of Action contained in a comprehensive document entitled – **Seychelles Prison Service – Reform – Rehabilitate – Be Better! Improvements to Montage Posee Prison – a way forward.** This document is appended hereto and marked as **Document S.**

Document S is very useful to guide the future administration of the Prison Services in Seychelles and will facilitate the better administration, accommodation, education and rehabilitation of prison inmates before they are released back to society.

Recently, a commendable project called **"Phoenix Project**" was conceived by the Prison Authorities. It incorporates new approaches and concepts in the management of inmates by laying great emphasis on the welfare and progressive rehabilitation of inmates.

I also visited various offices and met with the dedicated Prison Officers e present. In particular I observed the Prison Clinic and the Welfare Office which are located next to each other on the same floor. The Clinic was closed at the time as the PMO and his staff had left, being well past 4.00 o'clock.

Chapter 8

Avoiding Entry of Drugs in Prison

In a Press Statement **(Document R)** at page 5 of the 'NATION' newspaper of 26th January, 2018, the Ag. SOP Mr. R. St. Ange stated that - *"every prison in the world wants to achieve one common objective which is a drug free prison. So evidently this is not an issue unique to Seychelles."*

He added that – *"We want a better management system for the ills of our societies that unfortunately also enters our prison system." "Inmates are using these mediums (mobile phones) to call, threaten and extort money from people outside of the prison in order to fund their addiction. For this reason, we want to work in close collaboration with telecommunications companies to curb the use of phones in our prison."*

The Prison's Authorities are endeavouring to achieve the objective of a drug free Prison in Seychelles. In order to address issues relating to the dealings in, and, abuses of illegal drugs within the Prisons, they have devised a **Prison Master Action Plan (Document S)**. The Plan contains well-thought out short, medium and longer term Plans of Action for the management of the Prisons in the future.

Essentially, the Plan identifies **11 Key Areas** that needed to be addressed and implemented in order to improve the existing facilities at Montagne Posee Prison and its **Administrative System.**

The Plan is based on best International Practice and Standards; Technical Guidance for Prison Planning; and, Standard Minimum Rules for Treatment of Prisoners. The latter Rules is stated to have incorporated the "Nelson Mandela Rules" and "Beijing Rules" for juvenile offenders. Apparently, the Plan also incorporates the Seychelles own best practices and lessons learnt over the years.

It may be true that some elements of the Plan may be costly to implement in the short term, but there are other important, effective and useful elements that ought to be implemented at lesser or no great costs and in a very short time.

Certain salient features of that Plan are highlighted hereunder. These features have direct relationship to the prevention of drugs entering the Prison, the use and consumption of such drugs by inmates within the Prison, the health, welfare and rehabilitation of inmates as well as human resources.

The Plan addresses the existing **poor security controls** at the Montagne Posee Prison. Its fencing is not layered, hence allowing easy access from one area of the Prison compound to another. There are poor security coverage and with no control areas in place. There is an immediate need to put in place multiple layers of security fencing and link to make it functional and robust.

The use of **drones** in monitoring the Prison surrounding perimeter is not a luxury in the present circumstances and its use will be given due consideration.

The Plan envisages the setting up of a **Dog Unit**. Trained dogs that can primarily detect drugs entering the Prison, is an essential and urgent necessity in order to assist in furthering the effective control of the entry, possession and usage of illegal drugs by inmates.

There is a necessity to screen staffs, inmates and visitors when entering and leaving the Prison. Presently, goods or other supplies are allowed in the Prison without having gone through prior thorough and effective searches for any contrabands that these may contain.

These searches cannot be efficiently and effectively done as there no appropriate facilities for that purpose.

The Plan envisages a dedicated and adequately equipped **Search Room** for the searching of inmates upon their re-entering, after being outside the Prison during the day.

All Prison Staffs entering the Prison will likewise have to follow similar search procedures, as the inmates and visitors, when entering the Prison, albeit, that they will not be processed at the same time and in the presence of visitors and inmates.
Better and more appropriate physical infrastructures will obviously facilitate the effective management and control of entry of inmates, visitors and prison staff thus curbing the dealing in illegal drugs in Prison.

The construction of a properly equipped Search Room needs to be proceeded with as soon as possible. The cost of putting this in place is comparatively not that prohibitive. It is understood that Planning Approval has already been obtained for this particular infrastructure.

To effectively manage visitors who at present may include those introducing drugs in Prison, a new **Visiting Complex** as proposed in the Plan is a fundamental requirement. Entry of visitors in the Prison will be by a different entrance to that used by inmates.

Furniture in the Visiting Complex is planned to be of such design that will prevent the passing of any contraband under the table. Special arrangement will be made for closer monitoring of those inmates or visitors suspected of introducing illegal drugs in Prison.

Another essential physical structure that is planned to be put in place is the facilities for an **Induction Unit.**

Presently, inmates are admitted into the Prison without having gone through any proper induction, proper medical examination to identify cases of communicable diseases or drug addicts. Background information of inmates, their personal, social and welfare backgrounds are presently not collected immediate on admission. Such essential Induction is presently not being properly done because of the lack of facilities. Such information will greatly assist when categorising and segregating inmates before their final allocation to the appropriate Unit.

Health and Welfare Services in Prison, which were hitherto very limited, are included in the Plan and are now being given greater attention. These are commendable as the successful rehabilitation and eventual re-insertion of inmates back to society, very largely depend on the availability of such services.

It must always be borne in mind that inmates in Prison are the "wards" of the State and the latter is vicariously liable for them and has a duty of care towards them. Failing in that aspect may even lead the State to incur liquidated damages. Above all, the inmates are citizens of Seychelles and are entitled to appropriate health and welfare cares.

The present **Health and Welfare Facilities** are situated in locations not necessarily suited for their purposes.

There is an urgent need to construct an appropriate **Health Clinic** where inmates may be able to consult the PMO in confidence outside the hearing of others.

Ideally, there should at least be a **two beds Hospital** within the Montagne Posee Prison compound for inmates to be admitted for

observation and treatment, thus avoiding the necessity to always have them admitted at the Seychelles Hospital, even for non-complicated medical issues.

The Plan envisages an appropriate physical structure and other related facilities required by the **Probation and Welfare Unit** in order to enable them to more efficiently and effectively discharge their functions and duties as foreseen in the new Plan.

A prefabricated building in a quieter location within the prison compound for the Health, Probation and Welfare services in Prison is being considered as a cheaper option.

The planned reduction of the large population of prison inmates presently accommodated in the **Main Male Block** will obviously lead to better and more effective and efficient management. In my considered opinion, the present system allows the sellers and users of drugs to easily meet each other thus creating a situation where abuse of drugs is very difficult to manage.

The use of mobile phones, selling and injecting of drugs by inmates, would also be more effectively controlled when the known procurers of drugs are separated from the known users. The ideal "drug market" will thus be curbed or annihilated.

As opposed to the present Main Male Block housing over 300 inmates at any point in time, **Standard Accommodation Units** system proposed in the Plan is more relevant and appropriate.

The Units accommodating less than 50 inmates at any one time, will allow for better and more effective control of the movements of inmates among the Units. The planned system where each inmate is allocated a fixed bed and storage for their personal belongings, with

each Unit having small cells to segregate and lock up misbehaving inmates at night, would be more secured. These will also facilitate the effective management and control of inmates thus curbing their trading and misusing of drugs.

This planned approach will also assist in the classification, segregation and accommodation of adults separately from juveniles; males separately from females; the more compliant inmates separately from the so called hard ones; the drug addicts/users separately from drug suppliers etc. as well as by other classifications deemed appropriate by the Prison Authorities

The installation of better, more robust and appropriate **CCTV cameras** is planned. These will enable better monitoring by Prison Officers on a 24 hour basis, covering both inside and outside the entire prison compound.

The Plan may be well thought-out and geared towards the improvement of the administration of the Prisons but the essential factor that called for immediate consideration is the number and quality of **human resources** required to put the Plan in action.

Effective and efficient administration are difficult to achieve unless the human resources employed at the Prison are given better recognition in all its aspects, failing that, the hitherto high turnover of Seychellois prison staffs will continue, thus hampering the implementation of the Plan. Very few Seychellois will be attracted to take up jobs at the Prison in the future.

Appropriate and relevant **training** both locally and overseas, as planned, will assist in the control of contraband, correction and rehabilitation of prison inmates.

At present Prison Officers and other employees are comparatively not given due recognition when it comes to their **pay and conditions of employment.** They are not afforded attractive **perquisites**, such as home to office transport facilities; inducement for night work; allowance for the high risks involved; etc. to entice them to remain in their job at the Prison and to perform effectively and efficiently.

The present **financial package** afforded to all the employees at the Prison is not comparable to what other public servants are receiving when taking in consideration the working environment and risks involved. Even their uniforms are not that presentable and attractive!!

More Seychellois may be attracted to take up employment at the Prison, if the proper overall employment atmosphere is created and maintained.

Unless Prison Staff are appropriately rewarded, being human, their ethical and moral standard may be compromised, knowing that the drug businessmen can afford to otherwise influence them, thus undermining all attempts at stopping the misuse of drugs in Prison.

Chapter 9

Findings and Conclusions

- **Information to Steve's relatives**

On both occasions that Steve was admitted to Seychelles Hospital, the Prison Authorities indeed did not inform Steve's relatives.

It is neither a legal requirement nor is there any established procedure that relatives of prison inmates should be so informed. In such case it is only required of the Prison Officer accompanying the inmate to the Doctor to inform the Officer-in-Charge at the Prison Headquarters that the inmate has been admitted to Seychelles Hospital. The Officer-in-Charge will convey that information to the Duty Officer who decides what next step to take. He is also not required to inform any relative of such occurrence.

Names and other details of relatives of inmates are kept as part of an inmate's records so that they can be easily contacted if required. When an inmate is admitted at the Seychelles Hospital, the relatives are not informed about this, as a routine procedure. This is may not be done for good reasons. The Prison Authorities know from experience, that as soon as relatives of an inmate are informed, they turned up in large group to visit the inmate at the Hospital and this sometime made it difficult for the Prison Officer or even Hospital authorities to manage.

There is also the security element, both in the interest of the Prison as well as the inmate. Other reason being that inmates insist that their relatives are not informed of their situation in order not to cause them any worry. They may inform their relatives when they come to visit.

A Probation and Welfare Unit has been set up to deal with the rehabilitation and welfare of inmates. That Unit will henceforth be

responsible to inform the relatives of inmates when they are sick, admitted to hospital, met with an accident or even when deceased, unless that inmate has previously set in writing that his/her relatives are not to be informed. The Duty Officer will transmit such information to the Head of the Probation and Welfare Unit for appropriate action.

Steve's Access to Drugs in Prison

Steve was a drug addict using hard drugs well before his admission in Prison in 2015. On the previous occasions when he was convicted, he did not have access to drug as this was not easily available in prison at that time.

However, on his last admission in prison in 2015, the situation was different in that Steve continued to readily have access to heroin to satisfy his addictions while he was in prison. He got the drugs by assisting drug dealers in prison to ply their illegal trades. His job was to take up a suitable position where he could observe the movements of Prison Officers and then alert the dealers when the Officers are approaching. For this service he was rewarded with his daily fixes.

When Steve was in Hospital he confessed to his sisters that he was indeed he using drugs intravenously for the period that he was in prison. When Steve was approaching his last days, he further confessed to his sister that even Prison Officers facilitated the entry of heroin in Prison. He even cited names.

- **Steve's Medical Treatment in Prison**

Inmates are afforded all possible medical attention in the present environment and circumstances prevailing at the Montagne Posee Prison.

Inmates at the Montagne Posee Prison are first seen by the PMO who either prescribed the appropriate medicine if available at the Prison or otherwise obtain the medicine from the Hospital Dispensary for the inmates.

When laboratory tests are required for diagnosis purposes, samples of blood, urine or stool etc. are obtained from the inmates, by the staff at the Prison Clinic and are then sent either to Anse Royale Health Centre or to the Laboratory at Victoria Hospital for analysis. The results of laboratory tests are then sent back to the PMO.

In general, the PMO refers appropriate cases, to the Anse Royale or Anse Boileau Health Centres. In certain cases he may even refer them to the Seychelles Hospital if the expertise of Medical Specialist is called for. Inmates are sometimes admitted at the Seychelles Hospital for further management as decided by the Specialist.

When an inmate is admitted at the Seychelles Hospital the accompanying Prison Guard informed the Officer-in-Charge at Montagne Prison and the latter informed the Duty Officer who record that information in the Occurrence Book. All information recorded in the Occurrence Book are shared during the daily briefings. The PMO or his representative attends such briefings and received information about an inmate who had been admitted.

Before the setting up of the Probation and Welfare Unit, it was the responsibility of the Duty Officer to decide whether to inform the relatives of the inmate about admission at the Seychelles Hospital.

This responsibility has now been allocated to the Probation and Welfare Unit.

There is no protocol that requires a Specialists at the Seychelles Hospital to keep the PMO informed of further developments regarding the diagnosis and treatment an inmate may be receiving at the Seychelles Hospital, unless the PMO called for such information. The PMO admitted that, at times, it had been very difficult for him to get such information, although he tried to.

In Steve's case, the PMO caused laboratory tests to be done at Anse Royale Heath Centre and did an initial diagnosis at the Prison Clinic. The PMO then decided to refer him to the Seychelles Hospital for further specialised attention, where he was admitted.

A day or two after his first admission at the Seychelles Hospital, the PMO was very surprised to find that Steve who was still very sick, back at the Montagne Posee Prison. The PMO had much difficulty establishing from the staff at the Seychelles Hospital as to why Steve was released in the health condition that he was in. That information was not easily forthcoming. The PMO eventually managed to establish contact late in the evening, with the CEO of the Health Care Agency who was busy earlier, in order to establish why Steve had been released.

The PMO was eventually informed that Steve had refused to stay at the Seychelles Hospital and had insisted that he wanted to go back to Montagne Posee Prison. Steve took it upon himself to ask for his discharge and signed his Release Form. He was transported back to the Prison accompanied by the Prison Guard. The PMO had to request for his re-admission. Steve was re-admitted soon thereafter, where he stayed until he passed away.

There is no protocol in place to facilitate communication between Seychelles Hospital and the PMO when inmates are admitted at the Seychelles Hospital. Inmates admitted at the Seychelles Hospital are supposed to be treated *at par* with any other sick person. However, in the case of a prison inmate, there are in fact certain essential legal dissimilarities. What is sometime overlooked is the fact that prison inmates are the 'wards' of the State who, by law, have in turn been entrusted to the care and control of Superintendent of Prisons. The latter, at all times has a legal duty of care towards those inmates.

The PMO, is by law, administratively answerable to the Superintendent with regards to health aspects of prison inmates and must, at all material times, be in the know as to what is medically happening to inmates wherever they are receiving medical treatment so that the PMO could brief the Superintendent accordingly. If this is aspect is neglected, legal consequences may arise, if anything wrong happened to a prison inmate.

- **Steve's Medical Treatment at Seychelles Hospital**

Steve's relatives agree that he received all available medical treatment when he was admitted at the Seychelles Hospital, until he passed away. They are satisfied that Steve's case was diligently and professionally dealt with by all medical personnel concerned. They also accepted that they received from the Health Authorities, good cooperation and assistance available in the circumstances. They are satisfied with the way Steve was treated at the Seychelles Hospital until he passed away. They expressed their appreciation and their gratefulness for that.

The testimonies of the CEO of the Health Care Agency lead me to reach the same conclusion expressed by Steve's relatives.

There is however, the issue of smooth communication between the Seychelles Hospital and the PMO where it concerns the management of prison inmates admitted to the Seychelles Hospital. When the PMO refers a prison inmate to the Seychelles Hospital, the PMO must be allowed to follow a different procedure from that in place for the referral of a patient who is at liberty, done by a Doctor at a Health Centre. There must be constant direct communication between the PMO and the Medical Specialist who is managing a prison who is in the Hospital Ward.

Presently, there is no existing written protocol as to how these two institutions ought to collaborate and communicate so that the Prison Authorities are kept informed at all times about the management of inmates when they are admitted at the Seychelles Hospital.

There is also no established procedure whereby the PMO has access to confidential information about, or is made aware of, a particular inmate who is suffering from any communicable disease. That was the situation in Steve's case.

- **Steve's Cause of Death**

The results of a post-mortem examination performed by Dr. Mirna Batista Santos on Steve's body on 22nd January, 2018 are contained the Post Mortem Report **(Document N).**

The examination reveals that there was focal subarachnoid hemorrhage of the right parietal and left occipital region. His brain was of moderate size weighing 1360 grams with edema, with small intra-parenchimal hemorrhage (ICM) right parietal lobe. There was mucous secretion in the lumen of trachea, thymus glands and bronchis. His **lungs** were heavy with congestion, consolidation areas and edema. The right lung weighed 1150 grams and the left one weighed 1100 grams.

Heart weighed 350 grams, with yellowish areas of the myocardium (possibility of myocarditis). Aorta, pulmonary and major blood vessels showed moderate aortic and coronary atherosclerosis.

The **liver** including gall bladder weighed 1700 grams, revealed hepatomegaly and chronic passive congestion.

The **spleen** weighed 250 grams and showed reactive splenitis.

The **kidneys,** each weighing 160 grams**,** had congestion of the medulla and abscess on the surface.

The **causes of death** according to the post mortem examination are as a result of diseases or conditions directly leading the septic shock. The antecedent causes or morbid conditions, giving rise to the above causes, are ***infective endocarditis***. The conclusion reached was that Steve died due to ***septic shock and infective endocarditis.***

Other findings were ***severe bilateral bronchopneumonia***, ***pulmonary distress, reactive splenitis***, ***right-side kidney infarction***, ***moderate brain edema with focal subarachnoid and intra-parenchimal hemorrhage.***

The findings only means that the diseases and/or injuries are the complications causing the death. Tissue sample was taken for histopathological evaluation.

My layman's conclusion, based on the findings of the post mortem examination, as well as testimonies of medical experts, is that Steve died as a result of having constantly injecting himself with drugs and using dirty syringes and/or needles to do so, over a long period, prior to and during his incarceration in Prison at Montagne Posee. The heroin he was using might have contained other impurities. The dirty syringes he used caused impurities or debris to enter his blood streams leading to his eventual death.

Chapter 10

Recommendations

Information to Relatives

1. It is recommended that a procedure should be put in place, whereby Probation and Welfare Unit will inform an inmate' s relatives, when he or she is taken ill, injured or admitted to Seychelles Hospital, subject to his or her consent having first been obtained.

Medical Treatment in Prison

2. It is recommended that a medium of communication should be established between the Prison through the Prison Medical Officer and the Seychelles Hospital. In that regard it is also recommended that a Protocol should be drawn up between them setting the terms for effective communication.

3. It is recommended that prison inmates and detainees should receive medical treatment at the Prison Clinic, subject to their rights, under the written laws, being properly observed by the State.

Medical Treatment in Hospital

4. Where prison inmates and detainees were to receive medical treatment at the Seychelles Hospital, it is recommended that their rights, under the written laws, should be properly observed by the State.

Access to Illegal Drugs by inmates

5. That the holistic approaches set out in the "Prison Master Plan" be given utmost consideration as the issue of access to drugs by

inmates cannot be considered, and properly and adequately addressed in isolation of the other major prison matters.

Avoiding Entry of Drugs in Prison

6. It is recommended that the State should give utmost consideration to putting in place the necessary infrastructures, systems, equipment and facilities, as well as providing the required human resources called for in order to address the other findings and conclusions highlighted in **Chapter 8** of this Report.

Other recommendations

7. It is recommended that the State should consider renaming "Prison Services" as "Correctional Services" and "Prison Officers/Wardens/Wardresses/Guards etc." be named "Correctional Officers" and should be provided with proper uniforms. Their attire and appearance should be professional and appropriate.

8. The State should re-visit the terms and conditions of employment and the welfare of all the staff employed at the Prison with a view to improving them.

9. The State should consider the present facilities at the Bois de Rose Remand Centre to bring it in conformity with the provisions of Article 18(11), (12) and (13) of our Constitution. These provisions read as follows:

   Article 18 (11) - A person who has not been convicted of an offence, if kept or confined in a prison or place of detention, shall not be treated as a convicted person and ***shall be kept away from*** *any convicted person."*

Article 18 (12) – An offender or a suspect who is a minor and who is kept in lawful custody or detention ***shall be kept separately*** *from any adult offender or suspect.*

Article 18 (13) – A female offender or suspect who is kept in lawful custody or detention ***shall be kept separately*** *from any male offender or suspect.*

Chapter 11

Expenses

No special budget was allocated to me for the carrying out of this Inquiry. I carried out the Inquiry *pro bono* and have kept all expenses to the minimum. Expenses incurred and invoiced so far, are as follows:

(a)	TV Advertisements	-	SR 6,500.00
(b)	Nation Advertisements	-	SR ?
(c)	Secretary	-	SR15,000.00
(d)	Court Orderly	-	SR 6,000.00

By prior arrangements, invoices are certified by me and forwarded to the Ministry of Finance for payment. Duly signed and certified Contracts for Services in respect of items (c) and (d) were forwarded to the Ministry of Finance for payment.

Chapter 12

Acknowledgements

I would like to place on record my appreciation to the President of the Court of Appeal who permitted the use of the Court and its facilities to hold the public hearings. I also received support from the staff of the Court.

My sincere appreciation also to the Chief Justice who allowed me the use of the services of certain staff members of the Supreme Court to assist me.

Both the President of the Court of Appeal and the Chief Justice have been very cooperative and supportive, thus facilitating my tasks. I am indeed grateful to them.

I recognize and appreciate the kind support services of the staff of the Supreme Court, namely, the Secretary of the Commission Ms. Cecile Boniface, Commission Orderly Mrs. Jacqueline Port-Louis, Translator Ms. Dina Vidot and Ms. Louisianne Leveau who did the binding.

I likewise record my appreciation for the kind support and services of the staff of the Seychelles Court of Appeal, namely, Mrs. Vivienne Vadivello, Ms. Marie-Claire Julie and Ms. Bernardette Pompe.

Chapter 13

List of Documents

Documents relating to this Report are marked as A to T and have been bound in the Volume attached. These are:

A Letter of Appointment dated 25 January 2018

B Gazette Publication dated 21 February 2018

C Oath of Commissioner dated 28th February 2018

D Advertisement in "NATION" newspaper

E Letter to Commissioner of Police

F Letter to Ag. SOP date 19th March 2018

G Letter to Dr. D. Louange – CEO Health Care Agency

H Police Case Docket of Steve Khan

I Reply of Ag. SOP dated 23 March 2018

J Report of Ag. SOP date 22 March 2018

K First Medical Report of PMO Dr. F. Arissol

L Second Medical Report of PMO Dr. F. Arissol

M Medical Report of Dr. D. Louange - 22 March 2018

N Post Mortem Examination Report

O Birth Certificate of Steve Khan

P Death Certificate of Steve Khan

Q IT Gadgets – Photo-copy

R Article in 'NATION" by Ag. SOP

S Prison Action Plan

T Verbatim of Proceedings