



CUSTODIAL DEATHS IN NEPAL

Towards a Framework for
Investigation and Prevention



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FOREWORD

Each year, on 26 June, Advocacy Forum (AF) publishes its annual report on the occasion of the International Day in Support of Victims of Torture. Unlike previous years, when AF documented and analysed cases of torture, this year's report focuses on the patterns of deaths in police, prison, army and juvenile detention facilities since the new Penal Code came into force in 2018. In total, AF has documented 39 cases, including 16 in police custody, one at the hands of an army officer, 21 in prison, and one at a Child Correction Home (CCH).

In 9 out of 16 cases in police custody, the official cause of death was suicide; torture led to death in 5 cases, and in the remaining 2 cases, late or insufficient medical care was determined to be the cause of death. Suicide by hanging is sometimes used as a cover-up for torture or other inhuman treatment in police custody. Marginalised communities are most vulnerable to law enforcement officers' discrimination based on caste and social status. At least 11 out of 21 deaths in prison custody are associated with detainees from poor or Dalit communities. The authorities label custodial deaths as "natural" without post-mortem or any investigation,

preventing the due course of action and justice for the victims' families.

At least two prisoners are suspected of dying due to late or insufficient medical care during the COVID-19 pandemic. Yet, the pandemic has brought to the surface the routine problem of untimely and inadequate medical treatment in custody. In addition, a number of suicide cases also highlight the mental health challenges of detainees and the lack of safety in the places of detention.

The Penal Code includes a section criminalising torture. The law asserts that victims may receive compensation while perpetrators can be sentenced to up to five years in prison. Despite this positive change, there still has not been a single successful conviction of a perpetrator, regardless of the significant number of torture cases reported yearly to AF and other organisations. Even in cases of torture leading to death, the state fails to carry out prompt and impartial investigations.

The need for reform is wide-ranging. First and foremost, Nepal has to implement an effective prevention strategy for custodial deaths and torture, establish a proper independent monitoring mechanism and develop a comprehensive local legislative framework consistent with international standards and norms. Respective authorities are also recommended to review the detention management system and provide detainees with timely and comprehensive medical care. The state should develop long-term sustainable action plans to address the pressing issues of overcrowding and the unmet basic needs of detainees.

Pending the establishment of an independent investigative mechanism, there is a need for urgent reform of the current system, such as ensuring the proper registration of the First Information Reports (FIRs), guaranteeing ex officio investigations, and amending the Penal Code to hold police officers accountable for failing to register FIRs. Furthermore, the proper and immediate medico-legal examination must be conducted in all cases of custodial deaths.

AF wishes to acknowledge and express sincere thanks to all who were involved in the preparation of this report. First, we would like to show our gratitude to Kseniia Timoshchenko for her research and drafting of the report under the guidance of Ingrid Massage and Mandira Sharma. We would also like to thank Kumar Prasad Thapaliya for his collection of the cases and translation work. Finally, we commend all the AF lawyers and field officers for their tireless documentation of custodial deaths and torture cases, as well as legal support to the victims and their families.

Om Prakash Sen Thakuri

Executive Director
Advocacy Forum-Nepal

EXECUTIVE SUMMARY

Advocacy Forum (AF) has monitored and investigated incidents of suspicious deaths in custody since Nepal's new Penal Code came into force in 2018. It has documented 39 cases, including 16 in police custody, one at the hands of an army officer, 21 in prison, and one at a Child Correction Home (CCH).

This report summarizes the patterns of custodial deaths over this period. Key findings include:

- In 9 out of 16 deaths in police custody, the official cause of death was suicide; in 5 cases, torture is established to have led to death and in 2 cases late or insufficient medical care was determined to be the cause of death.
- Marginalized communities remain ever vulnerable to discrimination at the hands of police based on caste and social status. At least 11 out of 21 deaths in prisons concerned detainees from Dalit or other poor communities.
- Suicide by hanging is often used as a cover-up for torture or other inhuman treatment in police custody.

- The authorities label custodial deaths as “natural” without any post-mortem or investigation, preventing the due course of action and justice for the victims’ family.
- At least two prisoners are suspected to have died as a result of late or insufficient medical care during the COVID-19 pandemic. Yet, the pandemic has brought to the surface the routine problem of untimely and insufficient medical care in prisons.
- A number of cases of suicide in detention also highlight the mental health challenges of detainees and the lack of safety in custody.

AF’s investigations also reveal inadequate levels of independence and professionalism in the Nepal Police, the Office of the Attorney General, and the judiciary in addressing the problem of deaths in custody. Key findings in that respect include:

- Nepal’s custody management policy has fatally neglected and violated the UN Standard Minimum Rules for the Treatment of Prisoners, that require the detaining authority to ensure the safety and security of persons under their custody.
- Even in cases with strong evidence of torture (such as in the case of Khadga Bahadur Tamang) the existing system has failed to deliver justice, even after one year.
- Lack of transparency and investigation of health-related deaths reduces the chance of establishing the true causes of death.

- The case of death in a CCH could potentially have been prevented by the provision of timely and comprehensive medical care.
- When a detainee dies in custody, an impartial and independent investigation must be conducted regardless of the cause of death. Regardless, Morang Prison authorities maintain that no post-mortem is conducted if the deaths are deemed natural or suspicious.
- Despite torture being criminalized, the police routinely refuse to accept complaints and to register First Information Reports (FIRs, the initial complaints to police that formally initiate investigations); and when FIRs are registered, police and prosecutors routinely delay carrying out investigations, even when issued orders by their superiors or the Court of Appeal and Supreme Court.
- Nepal's laws are inadequate in respect of every single requirement under international law regarding prompt and independent investigation standards. The procedures that are outlined regarding FIR's are rarely implement in cases of human rights violations, and particularly torture, where the detention authorities are often alleged to be the ones committing the crime.
- Nepal's Penal Code has a limited and narrow definition of torture and cruel, inhuman or degrading treatment, prohibiting torture only in detention and setting restrictive objectives of torture. It has insufficient sanctions and penalties, inadequate reparations provisions, conviction-based compensation paid by perpetrators as opposed to the state.

- The right to reparation is not recognized in law.
- The most important part of the investigation procedures - the medico-legal examination and post-mortem - are often not carried out. Where carried out the family members are not informed about the outcome, let alone provided a copy of the post-mortem report.

The relentless persistence of impunity for those committing gross violations remains the main obstacle in ensuring victims' rights to effective remedies.

Based on Nepal's international obligations and Nepali law, every death in custody should be considered suspicious and therefore thoroughly investigated. This forms the basis from which AF is making detailed recommendations for urgent measures to be taken by the Government of Nepal to prevent death, conduct investigations, ensure justice, ensure the health of all detainees, and protect juveniles in custody. Key recommendations include:

- Set up an effective prevention mechanism for custodial deaths and torture, built on an effective detention management, a proper independent monitoring mechanism and a comprehensive local legislative framework compatible with international standards and norms.
- Ensure healthy detention conditions, educated personnel, essential requirements of basic needs, and a functional and modern operating equipment.

- Pass legislation, after consulting relevant stakeholders, to establish an independent investigative body for a fair, impartial, and effective investigation in cases of deaths in custody.
- Pass a new comprehensive law related to torture to ensure Nepal upholds all obligations under the Convention against Torture (CAT).
- Conduct an urgent reform to the current investigation system pending the establishment of an independent mechanism, including by ensuring the proper registering of FIRs, ensuring ex officio interventions, and amending the Penal Code to hold police officers accountable for failing to register FIRs.
- Fulfill the health needs of the detained by educating police and prison personnel, decrease stigmatization associated with detention, make medical supplies accessible, ensure equity in the delivery of health services, regular detention check-ups, and the adoption of a suicide prevention strategies.
- Ensure proper and immediate medico-legal examination in all cases of suspicious deaths.
- Develop long-term sustainable action plans to address the problems of overcrowding and basic needs.

CHAPTER 1

BACKGROUND

In Nepal, custodial deaths tend to receive a lot of attention from human rights advocates and the general public. Time and again, they have led to accusations from the victim's family and human rights organisations that the state has failed to protect its people from serious human rights violations. If a death is suspicious in any way, the state is required to determine the roles that different actors, including law enforcement personnel, medical personnel and forensic experts, may have played in these incidents. This action is necessary not only because the deaths could have been caused by torture, ill-treatment and inadequate medical assistance but also because it sets precedents for detention authorities, calling into question their competence in exercising proper control and professional management over places of detention.

More generally, these cases are informative for the investigation of the independence and professionalism of the police system, the Office of the Attorney General and the judiciary. It means that unnatural deaths in custody may serve as an indicator of the prevalence of torture and ill-treatment, the low professionalism of detention officers and unsatisfactory conditions of detention.

Documenting custodial deaths is difficult as they take place under the custody of the state in situations where relatives, human rights defenders and independent monitoring mechanisms may not have immediate access. It is therefore often complicated to prove that death was caused by ill-treatment or poor detention management and control.

In almost all cases documented by AF, the government maintains that the cause of custodial deaths are “natural” and due to specific physical or mental conditions. On that basis, the deaths are not investigated, therefore it remains unclear whether and how they could have been successfully prevented. Fundamentally, a successful prevention mechanism for custodial deaths and torture has to be built on effective detention management, an independent monitoring mechanism and a comprehensive local legislative framework compatible with international standards and norms.

Existing law and international guidelines define ‘death in custody’ differently.¹ First, a variety of interpretations exist in accordance with the places considered ‘custody’ in the particular country or context.² For the purposes of this report, death in custody includes not only the fact of deaths in certain places like prisons or police stations, but also deaths that occur in the process of any “interaction between an individual and law enforcement officers” because of apparent “consequences for law enforcement,

¹ Gaggioli, Gloria, and Bernice S. Elger. “Death in Custody: Towards an International Framework for Investigation and Prevention.” *Emerging Issues in Prison Health* edited by Bernice S. Elger, Catherine Ritter, Heino Stöver, Springer Netherlands, 2016, pp. 35–53, https://doi.org/10.1007/978-94-017-7558-8_3.

² *Ibid* p. 36

forensic, legal, and public health agencies”.³ General tendency is to include deaths that occur after arrest or apprehension and before release. However, this report also includes the deaths that occurred even without the official arrest or after the release because of the associated injuries or diseases while in the care of law enforcement personnel.

The term ‘custody’ could also be contested as there is no uniform definition for it. Neither the Penal Code nor the Torture Compensation Act, 1996 (TCA) defines ‘custody’, even though they both ban and punish torture in custody. Therefore, for the purpose of this report, we use the definition provided by the International Committee of the Red Cross (ICRC)’s Guidelines on Deaths in Custody. The ICRC defines “‘custody’ as beginning from the moment a person is apprehended, arrested or otherwise deprived of his or her liberty by agents of the State, or by agents of any other public or private entity or organisation, including in particular correctional or medical institutions or security companies, operating within the jurisdiction of that State. It includes, notably, detention or imprisonment, or any other placement of a person in a public or private custodial setting that he or she is not permitted to leave at will. “Custody” ends when a person is free to leave and is no longer under the effective control of State agents, or of agents of a public or private entity or organisation, including in particular correctional or

³ Koehler, Steven A., et al. “Deaths Among Criminal Suspects, Law Enforcement Officers, Civilians, and Prison Inmates: A Coroner-Based Study.” *The American Journal of Forensic Medicine and Pathology*, vol. 24, no. 4, Lippincott Williams & Wilkins, 2003, p. 337, <https://doi.org/10.1097/01.paf.0000097850.48559.86>

medical institutions, or security companies, operating within the jurisdiction of that State.”⁴

The detention authorities have a critical role to play in preserving and protecting the lives of the persons they guard, including measures to ensure the safety of detainees from external and internal threats in detention, such as violence from other prisoners, suicides, dangerous conditions of detention (fires, lack of ventilation, and unsanitary conditions dangerous to health) and others. International human rights standards as well as humanitarian law stipulate that detainees have the right to be treated humanely and not to be arbitrarily deprived of their life in peacetime and wartime situations. Summary executions of detainees are absolutely prohibited as well as torture or any other form of cruel, inhuman, or degrading treatment.⁵ Both States and the perpetrators themselves bear responsibility at the international level.⁶

⁴ International Committee of the Red Cross. “Guidelines for investigating deaths in custody.” <https://www.icrc.org/en/doc/assets/files/publications/icrc-002-4126.pdf>

⁵ See art. 6 of the International Covenant on Civil and Political Rights (ICCPR); art. 2 of the European Convention on Human Rights (ECHR); art. 3 common to the four Geneva Conventions (GC); art. 12 GCI, 12 GCII, 13 GCIII, 32 GCIV; art. 75(2) of Additional Protocol I to the Geneva Conventions (API); art. 4§2(a) Additional Protocol II to the Geneva Conventions (APII). For the prohibition of torture see art. 7 ICCPR; art. 3 ECHR; art. 3 common to the four GC; art. 12 GCI, 12 GCII, 17 GCIII, 32 GCIV; art. 75(2) of API; art. 4§2(a) APII.

⁶ See art. 6–8, UN General Assembly. “Rome Statute of the International Criminal Court.” (Last amended 2010), 17 July 1998, ISBN No. 92-9227-227-6, <https://www.refworld.org/docid/3ae6b3a84.html>; also art. 3-5, 20-22, UN General Assembly. “Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.” 10

Even though torture was criminalised in 2018, the culture of impunity still exists. Some relatives of the deceased do not believe they can obtain justice, especially when they come from poor backgrounds. The vulnerability of marginalised communities remained the same across the years, with caste and the resulting social group status still significant indicators of how police treat a person despite discrimination based on caste and race being illegal under Nepali law since 1963.⁷ 25 out of 39 death cases of detainees /prisoners were reported from marginalised groups. Out of 25, 12 cases were reported from Janajati, eight from Dalit community, three from Muslims, one from Indigenous and one from Newari community. This highlights marginalised groups' heightened vulnerability to unnatural deaths in detention.

Ultimately, police, army and prison personnel abuses reflect a failure by Nepal's government to implement accountability mechanisms. Despite guidelines and human rights training,⁸ the law enforcement authorities and other directly involved actors routinely fail to conduct rigorous investigations and prosecute perpetrators implicated in torture and ill-treatment of detainees.

December 1984, United Nations, Treaty Series, vol. 1465, <https://www.refworld.org/docid/3ae6b3a94.html>

⁷ "In 1963, the New Civil Code declared that any practice of untouchability illegal and hence made it a punishable act."

Panday, Tulsi Ram et al. "Forms and patterns of social discrimination in Nepal.": Report (No. 8). UNESCO, Kathmandu Series of Monographs and Working papers, 2006, p. 86.

⁸ See Universal Periodic Review Report (3rd Cycle) of Nepal, submitted to Human Rights Council on 12 October 2020, p. 4, "Human Rights Education and Training", <https://www.opmcm.gov.np/en/download/universal-periodic-review-report-3rd-cycle-of-nepal/>

CHAPTER 2

PATTERN OF RECENT DEATHS IN CUSTODY

In this chapter, the patterns of deaths in custody in the last five years will be summarised. In total, AF documented 39 cases, including 16 in police custody, one at the hands of an army officer, 21 in prison and one at a Child Correction Home (CCH). An understanding of the patterns of deaths in custody is important for the development of recommendations to ensure more effective intervention protocols and to establish responsibility of all involved actors.

2.1 DEATHS IN POLICE CUSTODY

AF has documented 16 death cases in police custody. In 9 cases the official cause of death was suicide, in 5 cases torture is established to have led to death and in 2 cases late or insufficient medical care was determined to be the cause of death.

DEATHS AS THE ALLEGED RESULT OF TORTURE

Several cases of death in police custody documented by AF involved people from poor and marginalised communities.⁹ One of them is 19-year-old Bijay Mahara. Mr. Mahara belonged to the Dalit community and lived in Garuda Municipality 8, Rautahat district. He, along with 10 others, was arrested by police on 16 August 2020 on suspicion of involvement in a murder which took place the previous day. While in detention at the Area Police Office



of Garuda, police did not allow family members and local rights activists to meet him and other detainees despite their repeated requests. On 19 August 2020, Mr. Mahara was sent to a local hospital and was subsequently referred to the National Medical College in Birgunj, Parsa District, where he was admitted the following day. On 27 August 2020, Mr. Mahara died while

⁹ Binod Ghimire. “Custodial deaths continue with little being done towards investigation.” Kathmandu Post, 31 May 2022, <https://kathmandupost.com/national/2022/05/31/custodial-deaths-continue-with-little-being-done-towards-investigation#:~:text=And%20in%20September%2C%20Bhim%20Kamat,Kailali%20district%20police%20offices%2C%20respectively>

undergoing medical treatment. Only after his death was his family made aware that Mr. Mahara had been admitted to the hospital.¹⁰

However, moments before he died, Bijay Mahara made a declaration about how he was tortured. He explained that, “police tortured me every day demanding that I confess to my involvement in a murder I was never involved in.”¹¹ He stated that police kicked him, beat him with plastic pipes and wooden sticks



and gave him electroshocks. With visible injuries to his face, arms and legs, the video captures just how fragile Mr. Mahara condition was.¹²

After his death, the post-mortem conducted in the Teaching Hospital of Kathmandu attested to signs of torture on his body. This led to a First Information Report (FIR, complaint to the police) against three alleged perpetrators and three of their superiors. However, the family eventually stopped pursuing their quest for justice as they were allegedly threatened and offered money to stop raising the case. Birendra Ram, one of the Mahara's relatives, wondered “how a poor family can struggle for justice when they

¹⁰ See Joint Communication of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; the Special Rapporteur on extrajudicial, summary or arbitrary executions; the Special Rapporteur on the rights to freedom of peaceful assembly and of association and the Special Rapporteur on minority issues, 18 November 2020, <https://spcommreports.ohchr.org/TMResultsBase/DownloadPublicCommunicationFile?gId=25644>

¹¹ Ibid

¹² Ibid

feel unsafe even for raising the case and are offered money to keep quiet when you are starving from hunger?”

In its response to a joint communication of four UN Special Rapporteurs (see below), the Government of Nepal stressed that the current legislative framework ensures equality and prevents any form of discrimination, including against detainees, whose rights to justice are guaranteed by the Constitution, Penal Code, and Criminal Procedure Code, and other relevant laws. The Government stated that Bijay Mahara was “tortured and injured by three police personnel, namely, Inspector Nabin Kumar Singh, Police Constables Munna Singh and Firoj Miya Dhuniya. The Investigation Committee found them responsible and issued an arrest warrant against them. All three accused are absconding and at large.”¹³

Khadga Bahadur Tamang, a resident of Sindhupalchowk district, was arrested on 2 August 2021, on suspicion of theft of NPR 81,725 [Approximately USD 655]. On 3



¹³ See Response of the Government of Nepal on Joint Communication of Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, Special Rapporteur on Extra-judicial, Summary or Arbitrary Execution, Special Rapporteur on the Rights to Freedom of Peaceful Assembly and Association and Special Rapporteur on Minority Issues, 10 February 2021, <https://spcommreports.ohchr.org/TMResultsBase/DownloadFile?gId=35958>

August 2021, Khadga Bahadur made a declaration to his sister Nir Maya Tamang that he was tortured and requested her to sell his land and use the money to get him released as soon as possible. On 6 August 2021, the Sub-Inspector of the APO called Jit Bahadur Tamang (also called Prem Lopchan), the deceased's brother-in-law, and asked him to come to the local hospital. Jit Bahadur found the deceased Khadga Bahadur in an abnormal condition muttering about past and present incidents of his life. The doctor urged to take him to Dhulikhel Hospital immediately because an ambulance was not available. On the way, Khadga Bahadur made a dying declaration: "They will surely kill me, what will happen to my family and children? They are going to kill [me] by beating." Prem Lopchan also reported that he saw blue marks and bruises on his body. However, he could not make it to the hospital and died soon after these words.



The APO Chief Inspector Debendra Bahadur Shahi denied that the police tortured Tamang. The police reported that the FIR had

been registered on 15 August 2021, and that they were waiting for the post-mortem report for further investigation. On 7 August 2021, Tamang's body was taken to TUTH. It was kept there until 28 September 2021. According to the APO Chief, the post-mortem was done on 10 August 2021. However, the family members were not given a copy of the report, as of the time of writing this report. *The FIR registered at the APO Bahrabise regarding this incident does not include a reference to torture in detention.* As there were public protests demanding investigation and compensation, the police agreed to open an investigation by a committee. The police drafted the FIR for his father, Kaami Tamang, making no reference to torture and only asking for an investigation and to bring those responsible to justice.

The statements of the deceased, his dying declaration and the uncountable blue marks and wounds on his body suggest there are ample grounds to raise questions about police negligence or torture. Police officers were stating that Tamang was mentally ill despite there being no previous history. Even if that was the case, why did not the police take him to a proper place for treatment or get a doctor to examine him? However, as of the time of writing, almost a year has passed from his death and the investigation still has not progressed.

DEATH ALLEGEDLY AS A RESULT OF SUICIDE

The high occurrence of suicide in police custody highlights not only the mental health challenges of detainees but also the lack of safety in custody. AF has found that suicide by hanging can be

a cover up for torture or other inhuman treatment. This may have been the case for 19-year-old Roshan BK, who was found hanged in the detention cell of Kailali District Police Office (DPO) on 11 September 2020. Various photographs disseminated over social media show the victim's body with bruises on his face and limbs, and blood in his mouth and nose. A witness, who was in custody with Roshan BK confirmed that he saw Roshan BK being beaten by police on the same night.

Another man, Amar Bahadur Chand, died in the same Kailali DPO within a month of Roshan BK. He was found dead with a wound on his neck on 12 August 2020. Police stated that he used a razor blade to cut his neck as a blade was found at the place of death. He had been arrested the previous day after he allegedly threatened locals and his relatives while intoxicated.

In some cases, where detainees are said to have killed themselves, families believe that the deceased were arrested on false charges. This happened in the case of Mahomad Hakim Sah, who was arrested on suspicion of “indecent behaviour”. Mahomad, a Muslim from a poor family of farmers, fell in love with 18-year-old girl from the Hindu community and a wealthier family. They tried to get married and run away from their families twice before his arrest. Eventually, the girl's father registered a FIR on 19 July 2021, and the police arrested Mohamad Hakim Sah on 28 September 2021, and charged him with “indecent behaviour”. 13 days after his arrest, on 10 October 2021, he was found hanged in his cell. The police concluded that he committed suicide. However, according to his father, the police mentally tortured his son and threatened to charge him with serious crimes (abduction, rape, human trafficking, etc.). There were protests

outside the district police office and the residence of girl's family. It was also alleged that the crowd set fire to girl's father's house and hardware store, and according to preliminary data, destroyed property equivalent to NPR 40 million accusing the family for being responsible for his killing.

Shambhu Kumar Sada and Babulal Raidas, both from the Dalit community, died in police custody allegedly after committing suicide. In total, 12 of the 16 cases of deaths in custody are reported to concern people from poor or marginalised background.

Shambhu Kumar Sada, 23, was found dead in the toilet of the Sabaila Area Police Office, Janakpur town, Dhanusha district on 10 June 2020 after more than two weeks of pre-trial detention. He had surrendered to the police on 26 May after his tractor hit 42-year-old Sumindra Devi Sah and injured another person at Dhanusadham.¹⁴ Superintendent Ramesh Basnet, chief of the Dhanusha DPO concluded that Sada was the only detainee in custody on the night of the incident and had hung himself with his shirt while all police personnel were asleep. This statement points to the fatal negligence of the police and violates the UN Standard Minimum Rules for the Treatment of Prisoners, that require the detaining authority to ensure safety and security of persons under their custody.¹⁵

¹⁴ Ajit Tiwari. "In-custody death of a Musahar man sparks protests in Janakpur." Kathmandu Post, 14 June 2020, <https://kathmandupost.com/province-no-2/2020/06/14/in-custody-death-of-a-musahar-man-sparks-protests-in-janakpur>

¹⁵ For example, Rule 1 of the Nelson Mandela Rules states that "the safety and security of prisoners, staff, service providers and visitors shall be ensured at all times"; and rule 30(c) stipulates about "identifying any signs of psychological or other stress brought on by the

Members of Sada's Dalit community (Musahar caste) and his family refused to accept the official version of the detention authorities' conclusion that it was suicide by hanging and initiated protests demanding justice and a fair and impartial investigation. Some of them believe that the police murdered Sada, while others think that officers drove him to suicide through physical and emotional torture.¹⁶ Almost 2 years have passed since Shambhu Sada's death, the investigation has not moved off the ground. A writ of mandamus was filed on 29 April 2021, at the Janakpur High Court after the Dhanusha DPO and District Attorney Office denied registering a First Information Report. AF was informed that the public prosecutor has decided not to prosecute the case and the decision has been submitted for the AG's approval. As of May 2022, according to AF sources, the writ of mandamus had not been decided by the High Court.¹⁷

fact of imprisonment, including, but not limited to, the risk of suicide or self-harm and withdrawal symptoms resulting from the use of drugs, medication or alcohol; and undertaking all appropriate individualized measures or treatment."

UN General Assembly. "United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)." Resolution / adopted by the General Assembly, 8 January 2016, A/RES/70/175, <https://www.refworld.org/docid/5698a3a44.html>

¹⁶ Peter Gill and Abha Lal. "Nepal's Police Custodial Deaths: Patterns of Negligence, Alleged Abuse and Impunity." *The Wire*, 22 June 2020, <https://thewire.in/south-asia/deaths-in-custody-impunity-nepal-police>; also, Ajit Tiwari. "In-custody death of a Musahar man sparks protests in Janakpur." *Kathmandu Post*, 14 June 2020, <https://kathmandupost.com/province-no-2/2020/06/14/in-custody-death-of-a-musahar-man-sparks-protests-in-janakpur>

¹⁷ Bureau Of Democracy, Human Rights, And Labor. "Country Reports on Human Rights Practices: Nepal." 2021, <https://www.state.gov/reports/2021-country-reports-on-human-rights-practices/nepal/>

The first days (in some cases, weeks) in pre-trial detention are very critical for majority of detainees, particularly in alleged suicide cases. At that stage, detainees are unaware of what awaits them. Moreover, feelings of guilt and repentance can be exacerbated by the unprofessionalism of police officers, moral pressure or physical torture.

According to Rule 1 and 24 of the UN Standard Minimum Rules for the Treatment of Prisoners, when a detainee is in the custody of law enforcement agencies, they are responsible for their health and safety.¹⁸ It is therefore essential that such incidents are investigated to ensure any failure on the part of the state authorities.

This is why such cases should always be scrutinised by thorough forensic examination and a prompt and proficient investigation. Many deaths in custody, including alleged suicides, could be avoided if the detention conditions were improved to

¹⁸ “Rule 1. All prisoners shall be treated with the respect due to their inherent dignity and value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification. The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times. Rule 24 (1). The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.”

The UN General Assembly. “United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).” Resolution / adopted by the General Assembly, 8 January 2016, A/RES/70/175, <https://www.refworld.org/docid/5698a3a44.html>

create a healthy environment which meets the basic needs of detainees, and if appropriate material and human resources were made available to sufficiently screen mentally and physically ill detainees, as required by human rights law and conventions ratified by Nepal.¹⁹

2.2 DEATHS IN ARMY CUSTODY: THE CASE OF RAJ KUMAR CHEPANG

On 16 July 2020, during the festival of Makar Sankranti, Raj Kumar Chepang with seven friends (Santosh Chepang, 25, Bam Bahadur Magar, 32, Purna Chepang, 23, Santa Lal Praja, 32, Gopi Ram Praja, 32, Dil Maya Chepang, 25, and Maya Rai, 26) went on the territory of the Chitwan National Park in search of wild vegetables (fiddlehead fern) and *ghongi* (a species of snail considered to be a delicacy). They entered the area near the Jyudi river in the buffer zone (forests and private lands, near the Chitwan National Park, jointly managed by locals and park officials).

Around two hours later, according to many in the group, they were approached by one soldier, who, before they could say anything, started verbally abusing them and kicking the men with his boots. He then talked to someone on the phone and repeated that he had caught people fishing illegally in the river and needed an extra team to get them to the camp office. Another

¹⁹ Birngruber, Christoph G., et al. “Sudden Deaths in Police Custody (and Other Detention Facilities) – Analysis of Causes and the Need for Prevention.” *Emerging Issues in Prison Health* edited by Bernice S. Elger, Catherine Ritter, Heino Stöver, Springer Netherlands, 2017, pp. 55–66, https://doi.org/10.1007/978-94-017-7558-8_4

five soldiers arrived. According to the statement made by Raj Kumar Chepang's friends, the army officer constantly beat them with sticks and kicked them with their boots. They also forced them to do over 100 press-ups and to carry heavy logs for long distances. Ultimately, the group was handed over to the National Park Administration Office which ordered to each pay a fine of NPR 1000 as fine, but they did not have the money. Before being released, their pictures were taken and they were told to return the next day to pay NPR 500.

After this, Raj Kumar was very weak and could not walk properly, so his friends carried him home. After returning home, the victims did not tell anyone for a few days that they were beaten by army personnel because they found it very embarrassing.

When Raj Kumar Chepang came home, he could not move or walk properly. There were bruises on his back. Day by day his condition worsened, and he began to cough up blood and eventually was taken to a local doctor who stressed the need for urgent hospitalisation. However, Chepang's family could not afford to pay for expensive hospital bills and returned home with the seriously ill Raj Kumar.

On 22 July 2020, his health condition deteriorated, and he was taken to Bharatpur Hospital after his family collected money from the neighbours in the village for an ambulance. But, by the time the ambulance reached halfway to the hospital, he had already died.

CHRONOLOGY OF FURTHER LEGAL STEPS

On 23 July 2020, Bishnu Lal Chepang, Raj Kumar Chepang's father, filed a First Information Report (FIR) at the DPO, Chitwan with the support of members from the Chepang Association. His body was taken to Kathmandu, where a post-mortem was conducted on 27 July 2020. On 31 July 2020, a meeting was held between the victim's family, local authorities and the administration of the Chitwan National Park, along with Nepal Army representatives. The meeting concluded with an agreement which committed the following:

- Impartial investigation of the incident and prosecution of the perpetrator according to the law.
- Support with the education expenses of Raj Kumar Chepang's daughter till high school.
- Provide support to build a house for Raj Kumar Chepang's family.
- Provide compensation of NPR 10 lakhs.
- Hand over the dead body of Raj Kumar Chepang to his family and solve the dispute.

Following an investigation by the Chitwan police and public prosecutor, on 12 October 2020, a charge sheet was filed against Chiran Kumar Budha at the Chitwan District Court accusing him of crimes under Penal Code Section 178 (2) that criminalises any acts likely to cause death and if a person dies in consequence

of any of such acts, then the offender is liable to a sentence of imprisonment for life. The prosecutor omitted the section on torture in the chargesheet and made no reference to it.

AF got information from family members of some witnesses saying that they were under pressure not to give statements against the army. On 7 December 2020, Balamram Chepang (member of the Chepang Association), with Bisnu Chepang (father of Raj Kumar Chepang) and other witnesses of the incident provided a witness statement at the Bharatpur District Court. But prior to this, they were approached by an Army Major who suggested they should not give any statement in the Court against the army personnel. He left his phone number but did not tell his name. But Balamram Chepang did not change his statement. However, some other witnesses retracted their statement stating that the inflicted torture was not so severe.

On 7 January 2021, an AF lawyer contacted one of the witnesses and victim of torture in the same incident), who informed that Raj Kumar Chepang's family received 10 lakhs NPR and that they were unwilling to go forward with the case. He stated: "we have received compensation; how long can we spend our time and effort for justice. It is better to move on."

On 24 January 2021, the AF lawyer received the results of further tests after the post-mortem, including a viscera test. The National Forensic Science Laboratory concluded that the blood sample had no alcohol in it. The Institute of Medicine-Maharajgunj Medical Campus, Department of Forensic Medicine stated the cause of Raj Kumar Chepang's death was a "Gross Pulmonary

Edema due to pulmonary contusion in the presence of Blunt Force Injury to the Upper Half of the Posterior Trunk”.

Chiran Kumar Budha was accused of violating section 178 (1) of the National Penal Code, according to the district attorney’s charge sheet. According to the charge sheet, he should be punished under sub section (2) of the same section.

These provisions of the Penal Code state:

Section 178. Prohibition of doing an act likely to cause death: (1) No person shall do any act, with the knowledge that, or having reason to believe that, such act is, in an ordinary course, likely to cause the death of another person. (2) If a person dies in consequence of any act referred to in sub-section (1), the offender shall be liable to the sentence of imprisonment for life.

However, on 13 July 2021, the Chitwan District Court, presided by Judge Gyatri Prasad Regmi, found Chiran Kumar Budha guilty of violating section 182 – Prohibition Causing Death by Negligence – and sentenced him to a jail term of nine months and a fine of NPR 9,000 (Approximately 72 USD) and to pay NPR 200,000 (Approximately 1600 USD) as financial compensation to Raj Kumar Chepang’s family.

The District Court decision was criticized as being too lenient for such serious human rights violations as torture leading to his death. The decision was later appealed.

On 20 February 2022, the Patan Appellate Court sentenced Chiran Kumar Budha, to lifetime imprisonment (25 years as per Penal Code 2018) for acts that resulted in the death of Raj Kumar Chepang.²⁰ Responding to the Court's decision, Bishnu Lal Chepang, Raj Kumar Chepang's father said, "I am happy to hear the decision of the High Court. Now, I want to see the implementation of Court's decision." However, Chiran Kumar Budha was not prosecuted for the torture of the other 5 men and the verbal abuse of the 2 women in the group with Rajkumar.²¹

At the time of writing, Chiran Kumar Budha was not in prison, as the period for him to appeal against the sentence of the Appellate Court had not expired. To AF's knowledge, an appeal has yet to be filed.

2.3 DEATHS IN PRISON

AF has conducted detailed investigations into four recent cases of death in prison, including two from Morang prison. Investigations into another 18 cases within 16 months in Morang prison were never investigated as the dead bodies were handed over to the family members without conducting post-mortem claiming that they died a natural death.

²⁰ Dev Kumar Sunuwar. "Rough Road to Justice in Nepal: The Case of Raj Kumar Chepang." Cultural Survival, 9 March 2022, <https://www.culturalsurvival.org/news/rough-road-justice-nepal-case-raj-kumar-chepang>

²¹ Ibid

At least two prisoners— Ram Lakhan Jaiswal held at the Central Jail in Kathmandu and Phurba Singh Tamang held in Morang prison— are suspected to have died as a result of late or insufficient medical care during the COVID-19 pandemic.

The family of Ram Lakhan Jaiswal, 63, accused the Kathmandu Central Jail authorities of killing Ram Lakhan and to have brought the dead body to the emergency ward of the hospital from the Central Jail to hide the real cause of death.²² The hospital did not allow the family to see the dead body citing a positive PCR test result. However, the daughter of the deceased prisoner had managed to record a video of his dead body which shows injuries, blood on the eyes, mouth, and head. This video footage compelled the family to claim custodial death. In a press conference organized by the Bir Hospital and Central Jail at the Ministry of Home Affairs in Kathmandu, the hospital and the jail's administrations claimed that Jaiswal had died a natural death on 19 September 2020. "He had Parkinson's disease and problems with high blood pressure. He was brought to the Central Jail's Hospital and later referred to the treatment in the Bir Hospital at 9:45 pm on September 19, during which he died", according to Sundhara prison's Jailer Laxmi Prasad Baskota. He also said that Jaiswal had tested positive for COVID-19 on the same day. Dr. Century explained that the blood containing foam leaking from the mouth and nose, shown in videos, are natural processes that

²² Purna Bahadur Pokhrel. "Bir Hospital Denies Allegations Over Rumors of Ram Lakhan Jaiswal's Dead Body." Review Nepal, 23 September 2020, <https://reviewnepal.com/national/bir-hospital-denies-allegations-over-rumors-of-ram-lakhan-jaiswal-s-dead-body.html>

begin with corpse decomposition in one to three days after death.²³ The fact remains that a prisoner with a severe chronic disease was not provided sufficient medical care. According to the law, when the health condition of a detainee is of serious concern, she or he should be transferred immediately to a hospital and the family should be informed accordingly.²⁴ However, in the case of Jaiswal, the family was informed only after he died.

The COVID -19 pandemic has further brought to the surface the problem of untimely or insufficient medical care in prisons. There have been media reports of 18 cases of suspicious deaths of inmates in Morang prison over 16 months.²⁵ AF is trying to find out the exact circumstances of these deaths, but the authorities are not cooperating.

Phurba Singh Tamang, 26, who was held at Morang prison, complained about sudden abdominal pain. He was taken to the

²³ Corporate Nepal. "Central Jail and Bir Hospital deny charges surrounding inmate's death." 23 September 2020, <https://english.corporatenepal.com/news/detail/19233/>

²⁴ Prisons Act (1963), art. 11 (2) states "If any Detainee or Prisoner becomes extremely sick and the government doctor makes his/her reasoned opinion in writing determining that it is necessary to keep the said Detainee or Prisoner in a hospital for better treatment, the handcuff and fetter, if put on the said Detainee or Prisoner, shall be taken off, and his/her treatment shall be done by keeping him/her in a hospital as prescribed."

Prisons Act, 2019 (1963), Nepal, adopted on 4 February 1963, <https://policehumanrightsresources.org/content/uploads/2016/07/Prisons-Act-Nepal-1963.pdf?x96812>

²⁵ Himal Sanchar. "Suspected death of 18 prisoners in the same jail in 16 months, 'post-mortem' did not happen." 13 December 2021, <https://himalsanchar.com/suspected-death-of-18-prisoners-in-the-same-jail-in-16-months-post-mortem-did-not-happen/>

Koshi Zonal Hospital on 29 August 2021, but the hospital denied him treatment citing symptoms of COVID-19. After the request of the Head of the Jail, he was treated but he died during treatment. The PCR test of the deceased prisoner came out negative.

Another prisoner in Morang prison, Nirajan Yadav (26), died 3 days before Phurba Singh Tamang in Morang prison. His cousin Shyam Sundar Yadav told AF: “On 26 August 2020, we were informed that Nirajan was sick and died on the way to the hospital at around 4:30 pm. We went to Koshi Zonal Hospital immediately, but the police refused to allow us to observe the dead body and instead transferred it to the COVID-19 Ward. When the PCR test of the deceased came out negative, we demanded to observe the dead body again. We raised several issues: the deceased was not sick, the family was not informed in advance, and the cause of death must be torture in the jail. We refused to collect the dead body and demanded a post-mortem. We also consulted with the ambulance people and knew that the death happened inside the jail. After the pressure of more than 100 people until the next day, the police authority agreed to a post-mortem on 27 August 2020.” However, family members have not received any updates since then.

The lack of transparency and investigation of these incidents has left little chance of establishing the true causes of these deaths. There are neither efforts to investigate the cases nor initiatives and directives to prevent repeating them in the future.²⁶ There are several potential causes mentioned in the media, though the truth

²⁶ Hari Adhikari. “Morang Prison: Where 18 deaths in 16 months go unprobed and unchecked.” Online Khabar, 20 December 2021, <https://english.onlinekhabar.com/morang-prison-deaths>.

is impossible to be determined in the absence of post-mortems and impartial investigations. There was information about violent showdowns between authoritative groups in Morang prison, which entailed physical violence against dissenters. Both cases of death as a result of insufficient and late medical care and due to fighting indicate that the prison management is so poor that it cannot guarantee the basic needs and safety of the prisoners.

Another case that shocked the public was the death of the juvenile Sundar Harijan, who was put behind bars in someone else's place and committed suicide by hanging in Rolpa jail in April 2022.²⁷ Harijan was 17 years old when he was convicted of theft. He was sent to prison instead of a CCH, which is quite common in Nepal. Harijan was supposed to be released on 12 January 2021 after paying 48,500 in lieu of imprisonment.²⁸

html#:~:text=According%20to%20Morang%20Prison%2C%2018,repeating%20them%20in%20the%20future

²⁷ Tika R Pradhan. "Panel to investigate youth's death in prison." Kathmandu Post, 29 May 2022, <https://kathmandupost.com/national/2022/05/29/panel-to-investigate-youth-s-death-in-prison>

²⁸ The National Criminal Procedure (Code) Act, 2017 Section 155 provides, "Payment of money in lieu of imprisonment: (1) If, in view of the age of the offender who is convicted, at the first instance, of any offence punishable by a sentence of imprisonment for a term of one year or less, gravity of the offence, manner of commission of the offence and his or her conduct, as well, the court does not consider it appropriate to confine the offender in prison and is of the view that there will be no threat to the public peace, law and order if he or she is released, and the court, for the reasons to be recorded, considers it appropriate to dispense with the requirement of undergoing imprisonment upon payment of a fine in lieu of imprisonment, the court may order that the offender be not liable to undergo imprisonment if he or she makes payment of money in lieu of imprisonment."

Instead one Bijaya Bikram Saha got released in his place by paying that money.

This case clearly depicts the urgent need for reforms in the existing prison management and strengthening legal aid system. Unlike adult prisoners, self-harm and suicide by children are less likely to be characteristic of a psychiatric disorder and far more likely to represent a reaction to the existential problems of life in detention.²⁹ There are many internationally accepted rules and standards regarding juvenile justice and the protection of juveniles deprived of their liberty, which guarantee special attention to detention conditions. Among them is the responsibility of the detention institutions to provide care, protection and all necessary assistance – social, educational, vocational, psychological, medical and physical – which juveniles may require because of their age, sex, and personality and in the interest of their wholesome development.³⁰

Overall, unhealthy conditions such as overcrowding, malnutrition and poor hygiene are common in many prisons. For example, the Morang prison has the capacity for 250 men and 50 women, while in reality there are more than 950 prisoners.³¹ A man

The National Criminal Procedure (Code) Act, 2017, Nepal, adopted on 16 October 2017 <https://www.moljpa.gov.np/en/wp-content/uploads/2018/12/Criminal-procedure-code-Revised.pdf>

²⁹ Liebling, Alison. "Suicides in Prison." Routledge, 1992, <https://doi.org/10.4324/9780203218365>

³⁰ See art. 26 (20), UN General Assembly. "United Nations Standard Minimum Rules for the Administration of Juvenile Justice ("The Beijing Rules")." Resolution / adopted by the General Assembly, 29 November 1985, A/RES/40/33, <https://www.refworld.org/docid/3b00f2203c.html>

³¹ Hari Adhikari. "Morang Prison: Where 18 deaths in 16 months go unprobed and unchecked." Online Khabar, 20 December

who had recently been released from Morang Prison described the conditions of detention as follows:

“You have to sleep on the floor, in a row of prisoners, in awkward positions. Because there is no room inside, some sleep in the corridor too. If you want to turn to the other side, you have to turn everyone in the line ... It is inconvenient even in the daytime as prisoners are not allowed to walk freely inside the jail. Many prisoners have developed leg problems as they are not able to walk properly.”³²

AF has previously reported that along with the lack of health check-ups, some detainees had access only to unfiltered and dirty water and inadequate food, and that many detention centres had poor ventilation, lighting, heating, and bedding.³³ AF monitoring visits always emphasise that basic needs and facilities should be ensured at all prisons and detention facilities in accordance with international standards as well as national legislation.³⁴ Every state has a special, sovereign **duty of care for detainees** and is fully accountable for “all avoidable health impairments to prisoners caused by inadequate health care measures or inadequate prison

2021, <https://english.onlinekhabar.com/morang-prison-deaths.html#:~:text=According%20to%20Morang%20Prison%2C%2018,repeating%20them%20in%20the%20future>

³² Ibid

³³ Advocacy Forum. “COVID-19 and Human Rights Situation in detention Centres and Prison of Banke.” 28 May 2021, <http://www.advocacyforum.org/news/2021/06/covid-19-and-human-rights-situation-in-detention-centres-and-prison-of-banke.php>

³⁴ Ibid

conditions with regard to hygiene, catering, space, heating, lighting, ventilation, physical activity and social contacts.”³⁵ One of the necessary steps for the Government authorities is to develop long-term sustainable action plans to address the problems of overcrowding and basic needs. Moreover, it should always be stressed through specialised capacity-building training of law enforcement agencies and raising awareness of the general public that detainees retain all human rights other than their freedom and the fundamental right to health is in no way diminished by the fact of detention.³⁶

When a detainee dies in custody, an impartial and independent investigation must be conducted regardless of the supposed cause of death, which may be natural or accidental, because it may also have been an unlawful killing as well as the result of inhumane treatment or inadequate conditions of detention. An immediate, transparent, and effective investigation is essential for establishing the real cause of death and preventing identical cases in the future while guaranteeing the safety and security of other prisoners and reassuring the relatives of the deceased and general public of the detention authorities’ responsibility to fulfil their national and international obligations.

³⁵ WHO. “Prisons and Health.” Edited by: Stefan Enggist, Lars Møller, Gauden Galea and Caroline Udesen, 2014, ISBN: 978 92 890 5059 3, https://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

³⁶ WHO Regional Office for Europe. “Good governance for prison health in the 21st century. A policy brief on the organization of prison health.” Copenhagen, 2013, https://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf

However, Morang Prison authorities comment that no post-mortem is conducted, notwithstanding if the deaths are natural or suspicious. The Nayab Subba of the jail (a non-gazetted officer³⁷) Ram Prasad Pokharel informed the media that the relatives of the deceased do not want to conduct a post-mortem examination as it is a complicated process. According to him, no legal requirement dictates the necessity of a post-mortem for those who have died in prisons, leaving this decision to the family and not to the prison administration or other state authorities.³⁸ This is based on Article 13 of the Prison Act 1963 on the Action to be done in the event of death of Detainee or Prisoner which does not contain a clause on obligatory post-mortem.³⁹ Moreover, it has no mention of a

³⁷ Nayab Subba is a non-gazetted permanent employee of the Government of Nepal who has been selected by the Public Service Commission.

³⁸ Hari Adhikari. "Morang Prison: Where 18 deaths in 16 months go unprobed and unchecked." Online Khabar, 20 December 2021, <https://english.onlinekhabar.com/morang-prison-deaths.html#:~:text=According%20to%20Morang%20Prison%2C%2018,repeating%20them%20in%20the%20future>

³⁹ "Article 13. Action to be done in the event of death of Detainee or Prisoner:

(1) If any Detainee or Prisoner dies and the government doctor certifies his/her death after examination, the Jailer shall execute a deed to that effect, as well as a deed on inventory of his/her entire property, witnessed by the guard soldier who is on duty at that time and by at least Four Detainees or Prisoners, if available, credit the property of the deceased Detainee or Prisoner to the security deposit and give information thereof to the Office or Court through which he/she has been detained or imprisoned and to the heir to the deceased Detainee or Prisoner.

(2) If the heir applies for the property of the deceased Detainee or Prisoner within Thirty Five days, except the time required for journey, after the service of the information as referred to in Subsection (1), the said heir shall be provided with the said property by fulfilling the

protocol to follow in situations of torture or suicide in detention, thus making it completely obsolete and not in line with currently accepted norms and standards of prison detention.

Above all, investigating death in detention cases may reveal the patterns and practices directly or indirectly linked to it. It is not enough to ensure that appropriate measures have been taken to react to a single case under investigation. The state should adopt sustainable measures to prevent such incidents while addressing possible root causes such as inadequate conditions of detention, insufficient access to health care, insufficient contact with the family, inadequate safeguards against suicide, arbitrary deprivation of life, torture and other forms of ill-treatment.⁴⁰ The Government of Nepal has already made promises in its Policies and Programs for the Fiscal Year 2079/80, Para 129 to develop a solution to overcrowding in prisons, namely “A Prison Reform Plan will be implemented to improve the current situation of high number of prisoners/inmates in excess of the capacity, while developing the prison as a correctional facility. An alternative concept of the open prison will be brought into implementation.”⁴¹

prescribed procedures. If no heir applies within the said time-limit, such property shall be auctioned and proceeds of the sale shall be credited to the cash revenue and paid to the government fund.

(3) If the heir to a deceased Detainee or Prisoner wishes to take away the dead body, the dead body shall be handed over to the heir unless it is necessary to do otherwise. If the heir does not so take away the dead body or there is no heir, action shall be taken as prescribed.”

⁴⁰ International Committee of the Red Cross. “Guidelines for investigating deaths in custody.” <https://www.icrc.org/en/doc/assets/files/publications/icrc-002-4126.pdf>

⁴¹ Policies and Programs of Government of Nepal for the Fiscal Year 2079/80 <https://www.opmcm.gov.np/en/download/policies-and->

2.4 DEATH OF A JUVENILE IN A CHILD CORRECTION HOME (CCH)

AF has documented 4 cases of death in custody that could have been prevented by the provision of timely and comprehensive medical care. One of which happened in the CCH in Biratnagar. 17-year-old Vinaya Limbu was transferred from the CCH to the Model Hospital in Biratnagar and died there during treatment on 21 May 2020. It was reported that around 100 juveniles, including Vinaya, were facing diarrhoea problems in the CCH. During treatment he was also diagnosed as having kidney problems. However, no investigation was conducted to find the depth of the problem in the CCH in Biratnagar leading up to the death of a juvenile.

The UN Rules for the Protection of Juveniles Deprived of their Liberty, Article 57 state: “Upon the death of a juvenile in detention, there should be an independent inquiry into the causes of death, the report of which should be made accessible to the nearest relative.”⁴² However, in the case of Vinaya Limbu no investigation was made and no post-mortem was done.

Above all, as a State party to the UN Convention on the Rights of the Child (CRC) and its two Optional Protocols, Nepal is bound to protect the rights of juveniles deprived of their liberty and to uphold internationally accepted standards and norms relating to the treatment of young prisoners. The state introduced

programs-of-the-government-of-nepal-2079-80/

⁴² UN General Assembly. “United Nations Rules for the Protection of Juveniles Deprived of Their Liberty.” Resolution / adopted by the General Assembly, 2 April 1991, A/RES/45/113, <https://www.refworld.org/docid/3b00f18628.html>

a comprehensive Children's Act in 1992,⁴³ which was amended in 2018. It ensures the rights, equality, inclusion, development and other needs of children.⁴⁴ However, the legal framework administering the conditions of imprisonment of juveniles does not yet measure up to the country's international commitments. There are no mentions of juvenile prisoners in the Prisons Act (1963). The Children's Act, 2075 (2018)⁴⁵ was criticized by human rights defenders as it needs to be amended in order to make it compatible with international practices.⁴⁶ It does not even provide guarantees for minors to be incarcerated separately from adults in police detention. Furthermore, the annual report of the National Human Rights Commission stated that in reality this rule is violated even in prison custody.⁴⁷

Several recommendations can be derived from the cases of juvenile deaths both in CCHs and prisons, as with the above-mentioned case of 17-year-old Sundar Harijan, who was sent to prison despite his age. First of all, decent conditions of imprisonment should be created for juveniles to be separately detained from adult offenders. CCHs should be supported by

⁴³ Children's Act, 2048 (1992), Nepal, adopted on 20 May 1992, https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=30034&p_country=NPL&p_count=117

⁴⁴ The Act Relating to Children, 2075 (2018), Nepal, adopted on 18 September 2018, <https://www.lawcommission.gov.np/en/wp-content/uploads/2019/07/The-Act-Relating-to-Children-2075-2018.pdf>

⁴⁵ Ibid

⁴⁶ Ram Kumar Kamat. "Juvenile justice laws need to change." *The Himalayan*. 14 July 2019, <https://thehimalayantimes.com/nepal/juvenile-justice-laws-need-to-change>

⁴⁷ National Human Rights Commission. "Annual Report Synopsis 2020-2021 A.D." Nepal, p. 20, https://www.nhrcnepal.org/uploads/publication/Annual_Report_Synopsis_2020-21_compressed.pdf

both the government and non-government organisations, not as places of detention and punishment, but as spaces of new hope and rehabilitation for children who have most likely already been subjected to severe trials in their lives. The Children's Act should be amended in consultation with civil society and child rights defenders, and moreover, it is necessary to create a coordinating mechanism capable of thorough implementation monitoring of the national juvenile legislation provisions and international recommendations. Sensitisation to juvenile offenders' challenges should be extended among both detention personnel and the general public in order to stress vulnerability of children in custody and create an environment for eliminating stigmatisation that can ruin the rest of their lives.

It should be noted that during the third cycle of the Universal Period Review (UPR), Nepal has supported the recommendation of Liechtenstein to strengthen its efforts to put an end to torture and ill-treatment of children in all settings, including by ensuring that children are detained as a measure of last resort only, as well as Cuba's recommendation to continue to improve the prison infrastructure and the living conditions of persons deprived of liberty.⁴⁸ And though Child Rights and Juvenile Justice were included into the Fifth National Human Rights Action Plan (2020-2025),⁴⁹ little progress has so far been made. According to AF monitoring in recent years, the incidents of torture among juveniles

⁴⁸ Universal Periodic Review of Nepal (3rd Cycle - 37th Session). "Matrix of recommendations." Date of consideration: Thursday 21 January 2021 - 09:00 - 12:30, <https://www.ohchr.org/en/hr-bodies/upr/np-index>

⁴⁹ Fifth National Human Rights Action Plan (Fiscal Year 2077-78 to 2081/82) (2020 - 2025)

is higher than in adults— 19.8% of all detainees reported torture in 2019, with 24.5% for juveniles.⁵⁰ These findings only strengthen the argument about the need to reform the criminal justice system, taking into account the special needs and characteristics of more vulnerable population groups, including juveniles.

Recently published Policies and Programs of Government of Nepal for the Fiscal Year 2079/80⁵¹ address some aspects of juvenile justice. For example, para 97 states that “while making the juvenile justice system effective, additional juvenile correction homes will be constructed and the physical infrastructure of the existing juvenile correction home will be upgraded.” However, no exact action plans have been released yet.

⁵⁰ Advocacy Forum. “Torture in Nepal in 2019. The Need for New Policies and Legal Reforms.” Annual Report, 2020, <http://www.advocacyforum.org/downloads/pdf/publications/torture/26-june-2020.pdf>

⁵¹ Policies and Programs of Government of Nepal for the Fiscal Year 2079/80 <https://www.opmcm.gov.np/en/download/policies-and-programs-of-the-government-of-nepal-2079-80/>

CHAPTER 3

ACCOUNTABILITY/THE STATE FAILURE TO PROVIDE JUSTICE

By guaranteeing the right to life in the Constitution and by ratifying different human rights treaties, Nepal has an obligation to protect the right to life. This obligation requires the State, 1) to respect the right to life and refrain from depriving anyone from their right to life arbitrarily; 2) to protect and fulfil the right to life and 3) to investigate potentially unlawful deaths, ensure accountability and provide an effective remedy for victims.

This chapter will set out the failings of the state in relation to accountability for deaths in custody and the role of the various actors involved.

Over the years, UN bodies have repeatedly raised concern with the Government of Nepal regarding torture and deaths in custody, calling for independent investigation and effective remedies for victims. On 18 November 2020, in correspondence addressed to the Ministry of Foreign Affairs, four UN Special Rapporteurs⁵² requested the Nepal government to provide further details of

⁵² Those included the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; the Special Rapporteur on extrajudicial, summary or arbitrary executions; the Special Rapporteur

investigations and actions taken against perpetrators in several cases, including three of deaths in police detention: Sambhu Sada Musahar, Bijay Mahara, and Durgesh Yadav.⁵³ The UN Special Rapporteurs wrote: “It is reported that police routinely refuse to accept complaints and to register First Information Reports (FIRs, the initial complaints to police that formally initiate investigations); and when FIRs are registered, police and prosecutors routinely delay in carrying out investigations, even when issued orders and legal rulings are made by the Courts of Appeal and Supreme Court.”⁵⁴

The State’s not entertaining FIRs and the lack of investigation are longstanding problems in Nepal. Under international law, the State’s duty to investigate is triggered when it knows or should have known of any potentially unlawful death, including where reasonable allegations of a potentially unlawful death are made.⁵⁵ The duty to investigate does not apply only where the State is in

on the rights to freedom of peaceful assembly and of association and the Special Rapporteur on Minority Issues.

⁵³ Kathmandu Post. “Four UN special rapporteurs on human rights seek details on investigations into deaths in custody and police actions.” 28 January 2021, <https://kathmandupost.com/national/2021/01/28/four-un-special-rapporteurs-on-human-rights-seek-details-on-investigations-into-deaths-in-custody-and-police-actions>

⁵⁴ See Joint Communication of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; the Special Rapporteur on extrajudicial, summary or arbitrary executions; the Special Rapporteur on the rights to freedom of peaceful assembly and of association and the Special Rapporteur on minority issues, 18 November 2020, <https://spcommreports.ohchr.org/TMResultsBase/DownloadPublicCommunicationFile?gId=25644>

⁵⁵ ECtHR, *Ergi v. Turkey*, Judgment, 28 July 1998, para. 82; *Isayeva, Yusopva and Bazayeva v. Russia*, Judgment, 24 February 2005, paras. 208–09; IACtHR, *Montero-Aranguren and others v. Venezuela*,

receipt of a formal complaint.⁵⁶ Given the particular context of custody and based on the international obligations of the State to protect the detainees, **every death in custody should be considered suspicious** and should be thoroughly investigated.

International law also lays down principles and procedures on how an investigation in a suspicious death should take place, giving practical effect to the duties to respect and protect the right to life, and promoting accountability and remedy where the substantive right may have been violated. In order to be effective, any investigation should fulfil the fundamental criteria:

- It should be *thorough*. It should extensively document and prove all the facts related to the death, including the identity of the deceased, the cause, manner, place and time of the death, the extent of involvement of other individuals, as well as any pattern or practice, including torture or ill-treatment, that may have caused the death. It should also specify whether the death was natural or accidental or a case of suicide or homicide. Thorough and exhaustive investigations also require that States make an effort to investigate and clarify *patterns of violations* and operational structures that allowed violations to commence in such a pattern, identify the causes driving them as well as

Judgment, 5 July 2006, para. 79. 44 See the Nelson Mandela Rules, Rule 71(1).

⁵⁶ See Rule 71(1), UN General Assembly. “United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).” Resolution / adopted by the General Assembly, 8 January 2016, A/RES/70/175, <https://www.refworld.org/docid/5698a3a44.html>

their consequences and beneficiaries such that an applicable punishment can be imposed.⁵⁷

- It should be *conducted ex officio*, i.e., of the authorities' own will, as soon as the custodial death case has come to their attention, whether or not a formal complaint has been made, and undertaken *as promptly as possible*. Prompt investigation is found to be important not only to protect life, prevent torture and enforced disappearances but also to maintain public confidence in the authorities and adherence to the rule of law.⁵⁸ It is also important to prevent any collusion in, or tolerance of, unlawful acts.⁵⁹
- The authorities responsible for the investigation must be *independent and impartial*. They must have no institutional or hierarchical relationship with individuals or agencies whose conduct has to be investigated in due course. In addition, their conclusions must be based on objective and established standards and must not be influenced by any bias. Similarly, an autopsy must be carried out by independent and impartial medical personnel.
- The investigation should possess some degree of *public scrutiny*. Its findings should be made public. In addition, the victim's *next of kin* should be involved in the process. They should receive appropriate legal aid, have free access to the

⁵⁷ Manuel Cepeda Vargas v Colombia (Preliminary Objections, Merits, Reparations and Costs) IACtHR Series C No 213 (26 May 2010) paras. 118-19.

⁵⁸ Ramsahai and Others v The Netherlands App no 52391/99 (ECtHR, 15 May 2007) para. 326.

⁵⁹ Ibid

case details, and participate in the proceedings. They should also be allowed the presence of a medical or other qualified representatives at the autopsy.

Soft law and international jurisprudence provide further guidance for collecting and analysing necessary evidence.⁶⁰ The investigation should include the following, especially in suspected cases of arbitrary deprivation of life or torture:

- ***All relevant physical and documentary evidence.*** The death scene should be preserved in order to protect evidence and investigating authorities should make their way to it promptly. Ballistic testing should be conducted whenever a firearm has been used.
- ***Statements from witnesses.*** All key witnesses, including eyewitnesses and suspects, should be identified and thoroughly interviewed. Testimonies must be carefully recorded and analysed by the authorities in charge of the investigation. Failure to interview and seek evidence from key witnesses may be sufficient to regard the investigation as seriously inadequate.
- ***A proper autopsy.*** A certified medical officer should perform the autopsy. It should recognise any injury suffered by the deceased, including evidence of physical torture.

⁶⁰ Ibid

Nepal legislative framework shortcoming for the investigation of deaths in custody, especially associated with torture and ill-treatment

Nepal's laws are inadequate in respect of nearly every single requirement for the prompt and independent investigation standards as set out above.

Torture is a criminal offence under the Penal Code. It is listed under Schedule-1 in the Code, meaning that Nepal Police is obligated to investigate any allegations of torture. At least five cases of custodial death documented by AF were the result of alleged torture. Article 4 of Criminal Procedure Code requires that a FIR, either written or communicated orally or through electronic means, be filed at the nearest police station. However, in many cases the nearest police station is the place of offence, so due to the conflict of interests, many FIRs are not accepted by the local police. In other words, the onus is put on the family of the deceased to file a complaint, rather than the authorities being obliged to initiate investigations *ex officio*.

In the FIR, the complainant should provide evidence (to the greatest extent possible) that the alleged incident occurred.⁶¹ This implies that the onus of proving the crime is put on the

⁶¹ See Section 4 (1) of the National Criminal Procedure Code, 2074 (2017): "(1) A person who knows that any offence set forth in Schedule-1 has been committed or is being committed or is likely to be committed shall, as soon as possible, make a first information report in writing or give information verbally or through electronic means, on such offence, along with whatever proof or evidence which is in his or her possession or which he or she has seen or known, to the nearby police office in the form set forth in Schedule-5."

complainant, who rarely, if ever, will have been a witness to the death due to the simple fact that it occurred in detention.

Once the FIR is registered or the police are informed about the incident, the concerned police office must, as soon as possible, designate an investigating officer to investigate the incident and collect evidence.⁶² The investigating officer is endowed with the power to arrest the perpetrator when given permission from the judicial authority.⁶³ Once police collect all the evidence, they then present the dossier to the prosecutor, who will decide whether to prosecute or not after assessing the evidence provided by the police.

Inadequate as they may be, the police have rarely implemented even these legal provisions when they come to investigate a case of human rights violations and, particularly, in cases of torture, ill-treatment and suspicious custodial deaths, where detention authorities are often alleged to have committed the crime. AF has documented several cases where police have outrightly refused to register the FIR and initiate an investigation even when the evidence is strong and convincing.

An impartial, independent and effective investigation includes several components such as the assurance that there is ***no influence of any alleged perpetrators in the investigation***;⁶⁴ and investigators

The National Criminal Procedure (Code) Act, 2017, Nepal, adopted on 16 October 2017 <https://www.moljpa.gov.np/en/wp-content/uploads/2018/12/Criminal-procedure-code-Revised.pdf>

⁶² Ibid, Section 8.

⁶³ Ibid, Section 9.

⁶⁴ Philip Leach, Rachel Murray and Clara Sandoval. "The Duty to Investigate Right to Life Violations across Three Regional Systems: Harmonisation or Fragmentation of International Human Rights Law?" in Carla M Buckley, Alice Donald and Philip Leach (eds), Towards

have no records of being involved in violations.⁶⁵ However, in Nepal, investigation committees formed for examining custodial deaths cases can hardly be considered independent. For example, though a 5-member panel has been formed to investigate the death of Sundar Harijan (the minor who was sent to the prison instead of a CCH, and committed suicide by hanging in Rolpa jail – see above), there was a conflict of interests from the very beginning since the panel is led by the director of the Prison Department, and not by an impartial former judge and a forensic specialist and independent lawyers.⁶⁶

The Supreme Court has also recognized the inadequacy of investigations by police in cases where they are alleged perpetrators. On 6 January 2020, when ruling on a writ petition, it reiterated the need to have an independent investigative mechanism in respect of cases of extrajudicial killings (EJKs). In its decision, the Court has interpreted that, “the investigation, in order to be considered independent, requires that the investigating body and investigators have no subordination, hierarchy or functional dependency with the alleged or the body the alleged are involved.”⁶⁷ The Court also

Convergence in International Human Rights Law Approaches of Regional and International Systems. Approaches of Regional and International Systems, Brill-Nijhoff, 2017, p. 38.

⁶⁵ Güleç v Turkey App no 54/1997/838/1044 (ECtHR, 27 July 1998) paras. 81-82.

⁶⁶ Binod Ghimire. “Custodial deaths continue with little being done towards investigation.” Kathmandu Post, 31 May 2022, <https://kathmandupost.com/national/2022/05/31/custodial-deaths-continue-with-little-being-done-towards-investigation#:~:text=And%20in%20September%2C%20Bhim%20Kamat,Kailali%20district%20police%20offices%2C%20respectively>

⁶⁷ Sunil Ranjan Singh and Others v. Government of Nepal & Others, 6 January 2020 (067-WO-1043).

ruled that the authorities, including the Government of Nepal, must constitute an independent investigation mechanism for a fair, impartial and effective investigation of EJKs committed by security officials.

There are further shortcomings in Nepal's legislative framework that impede the thorough and proper investigations of deaths in custody, especially associated with torture or other ill-treatment. AF's analysis of the Penal Code revealed the following problems: 1) limited and narrow definition of torture and inhuman and degrading treatment, prohibiting torture only in detention; 2) restrictive objectives of torture; 3) insufficient sanctions and penalties; 4) inadequate reparations provisions; 5) conviction-based compensation; 6) compensation paid by perpetrators as opposed to the state; 7) notion of reparation not recognized; 8) problematic provision related to interim relief and unclear definition of victims.⁶⁸

For those cases associated with torture, including psychological pressure that has a potential to trigger self-harming behaviour, as well as other degrading or inhuman treatment which logically includes non-provision or fatal delay of medical care,⁶⁹ which are criminalised by Articles 167 and 168 of Penal Code respectively,⁷⁰

⁶⁸ Advocacy Forum. "Countering impunity in torture." Annual Report, 2021, <http://advocacyforum.org/downloads/pdf/publications/torture/countering-impunityin-torture.pdf>, pp. 23-30.

⁶⁹ See art. 168 (1) (d), The National Penal (Code) Act, 2017, Nepal, adopted on 16 October 2017, <http://www.moljpa.gov.np/en/wp-content/uploads/2018/12/Penal-Code-English-Revised-1.pdf>

⁷⁰ The National Penal (Code) Act, 2017, Article 167. Prohibition of torture: (1) No authority who is competent under the law in force to investigate or prosecute any offence, implement law, take any one into control, or hold any one in custody or detention in accordance with law

Article 170 (2) however envisages a statute of limitation. It says:
 “No complaint shall lie after the expiry of six months from the date

shall subject, or cause to be subjected, any one to physical or mental torture or to cruel, brutal, inhuman or degrading treatment.

Explanation: For the purposes of this Section, intentional inflicting of physical or mental pain or suffering on any person who is arrested, taken into control, held in custody, detention or imprisonment or under preventive detention or security or any other person interested in such person or subjecting such person to cruel, brutal, inhuman or degrading treatment or punishment for the following purpose shall be considered to constitute torture or cruel, brutal, inhuman or degrading treatment or punishment against or to such person:

- (a) To get information on any matter,
- (b) To extort confession of any offence,
- (c) To punish for any act,
- (d) To show fear, intimidation or coercion, or
- (e) To do any other act contrary to law.

(2) A person who commits the offence referred to in subsection

(1) shall be liable to a sentence of imprisonment for a term not exceeding five years or a fine not exceeding fifty thousand rupees or both the sentences, according to the gravity of the offence.

(3) A person who orders the commission of the offence referred to in sub-section (1) or an accomplice who aids in the commission of the offence referred to in this Section shall be liable to the same sentence as is imposable on the principal offender.

(4) No person who commits the offence referred to in subsection (1) shall be allowed to plea that he or she has committed the offence in pursuance of an order by the authority superior to him or her; and, on such ground, he or she shall not be exempted from the sentence imposable on him or her for the commission of such offence.

168. Prohibition of degrading or inhuman treatment: (1) No person shall subject, or cause to be subjected, any one to degrading or inhuman treatment.

of commission of the offence referred to in Section 167 or from the date of release of the concerned person from arrest, control, custody, detention, imprisonment or preventive detention and from the date of knowledge of commission of any of the other offences referred to in this Chapter.”

Moreover, Section 201 prohibits authorities who are competent by law from holding anyone in detention without providing minimum humane facilities.⁷¹ However, complaints regarding the

Explanation: For the purposes of this Section, the following act shall be deemed to constitute a degrading or inhumane treatment:

- (a) To accuse one of being a witch,
- (b) To expel one from his or her place of residence in accusation of being a witch,
- (c) To ex-communicate one from the society, or
- (d) To make cruel, inhuman or degrading treatment by doing any other act whatsoever.

(2) A person who commits the offence referred to in subsection (1) shall be liable to a sentence of imprisonment for a term not exceeding five years and a fine not exceeding fifty thousand rupees.

(3) Banishing a woman to a shed (Chhaupadi) during menstruation or delivery, or subjecting, causing to be subjected, her to similar other discrimination, untouchability or inhuman treatment of any kind is prohibited.

(4) A person who commits the offence referred to in subsection (3) shall be liable to a sentence of imprisonment for a term not exceeding three months or a fine not exceeding three thousand rupees or both the sentences.

(5) Where a public servant commits the offence referred to in this Section, he or she shall be liable to an additional sentence of imprisonment for a term not exceeding three months.

⁷¹ The National Penal (Code) Act, 2017, art. 201. Prohibition of holding in detention without providing minimum humane facilities: (1)

same cannot be filed after the expiry of three months from the date of the release of the detained person from such detention.⁷² It should be noted that not a single representative of the authorities of places of detention was convicted under these sections.

Finally, although the law prevents the authorities from pardoning, suspending, altering or reducing the sentences imposed on offenders of torture and murder in a cruel and inhumane way or by taking control, as there have not been any investigations and prosecution in these cases, these provisions remain moot to date.⁷³

3.1 EXAMPLES OF FAILINGS DURING INVESTIGATIONS

As discussed, filing FIRs and initiating an investigation is difficult. Even if there are investigations opened through court interventions, they are stalled due to a number of reasons. The

No authority who is competent by law to make detention shall detain, or cause to be detained, any person by depriving him or her of such facilities as required to be provided in accordance with law or of such minimum humane facilities as are available in the place of his or her detention.

(2) A person who commits the offence referred to in subsection (1) shall be liable to a sentence of imprisonment for a term not exceeding one and half years and a fine not exceeding fifteen thousand rupees.

⁷² The National Penal (Code) Act, 2017, art. 205. Statute of limitation: No complaint shall lie, in the case of an offence under sub-section (3) of Section 200, after the expiry of three months from the date of commission of such offence, and in the case of any of the other offences under this Chapter, after the expiry of three months from the date of release of the detained person from such detention.

⁷³ Section 159 (4) of the Criminal Procedure Code, 2074 (2017) (3).

following three cases illustrate the challenges of striving for justice in the cases of custodial deaths.

Ram Manohar Yadav, a resident of Banke district, died in police custody several days after being detained for waving a black flag to then Deputy Prime Minister Upendra Yadav. Ram Manohar's family members refused to receive the body for months because they believed he had died after torture. While detention authorities argued that the deceased died during treatment at a local hospital, the family demanded an impartial investigation into his death, arguing that there was no reason why Ram Manohar would have died suddenly. The Yadav family also accused the police of conducting an autopsy without their consent. They also receive a copy of the concluding report, nor has it been made public. In an interview with the Kathmandu Post, the brother of the deceased, Bishnu Yadav, stated that the family received several phone calls from the police asking them to collect the body in Kathmandu as well as threatening calls after their refusal.

It was also stated that Yadav was in ongoing medical treatment for hypertension. However, he was denied his medicines in detention despite family members requesting police to provide them. Family members were also not allowed to meet him. On 30 August 2018, Yadav complained about a severe headache, and the police took him first to Gulariya District Hospital and later to the Nepalgunj-based Bheri Zonal Hospital. There, the doctors referred Yadav to Kathmandu for immediate treatment, suggesting Yadav required treatment in an Intensive Care Unit, which was not available at Nepalgunj. *The police delayed the process because of paperwork.*

On 31 August 2018, Yadav was transported to Kathmandu. Doctors declared him dead upon arrival at Tribhuvan University Teaching Hospital (TUTH). Family members demanded the FIR be registered in Kathmandu to initiate an open investigation into Yadav's suspicious death. However, police in Kathmandu denied registering an FIR and suggested they return to their district. Local human rights activists termed Yadav's death an extra-judicial killing.⁷⁴ Resistance to the investigation led to much public scrutiny. Many organisations expressed concern over the refusal of the Nepal Police to register the FIR.⁷⁵ The family agreed to accept his body five months after the incident in February 2019,⁷⁶ and the family was offered one million NPR by the Home Ministry as monetary compensation which also committed to investigate the case. However, to date, to AF's knowledge, no investigation has been conducted.

The case of Khadga Bahadur Tamang, 32, resident of Bahrabise, Sindhupalchok district, Bagmati Province, who was arrested on 2 August 2021 on suspicion of theft, is another example of the stalled investigation associated with torture in police detention. As

⁷⁴ Setopati. "Death of CK Raut's cadre under police detention sparks controversy." 2 September 2018, <https://en.setopati.com/political/129500>

⁷⁵ Terai Human Rights Defenders Alliance (THRD Alliance). "Situation Update on Ram Manohar Yadav's custodial death." 7 September 2018, <https://www.thrda.org/situation-update/situation-update-ram-manohar-yadavs-custodial-death/>

⁷⁶ Chandan Kumar Mandal. "Family receives body of Ram Manohar Yadav five months after he died in police custody." Kathmandu Post, 3 February 2019, <https://kathmandupost.com/national/2019/02/03/family-receives-body-of-ram-manohar-yadav-five-months-after-he-died-in-police-custody>

discussed in Chapter 2, Khadga complained of torture in detention to his family members but died on the way to hospital.

In response to public protest against the killing of Khadga, police and local administration agreed to open an investigation, bring those responsible to justice and offer reparation to victims. However, as time passed, no investigation was conducted. AF received information from the police in-charge inspector Mukesh Neupane of the APO Barhabise that they have decided to close the case as there were no evidence of police inflicting torture resulting in his death. When AF asked the inspector of Barabise police in May 2022, he reported that the case has been “solved” and the police have closed the case and sent the file to the higher authority. In response to the question as to how the case was “solved”, he stated that as “the investigation showed Khadga had been beaten up by the villagers before he was brought to detention where police had no role”. However, AF did not find any evidence of him being beaten up by the villagers. Even in that case, the police still have an obligation to investigate and bring those who beat him to justice.

Stalled investigations are also typical of all 9 cases of alleged suicides in police custody documented by AF. These cases provide further evidence supporting the growing concern and recognition that suicide in detention is a complex problem covering prison management, health care issues and professionalism of the detention staff. Considering that all 9 deceased had not been officially indicted with any crime, they were undergoing complex psychological experiences and it was a grave mistake of police personnel to pay insufficient attention and lack of control.

This was the case for Durgesh Yadav, 24, a resident of Siraha district in Province 2, who was alone in detention during the COVID-19 lockdown and is alleged to have committed suicide by hanging in the toilet of the Lalitpur police station.⁷⁷

Yadav's death is another example of police negligence which did not receive proper attention from the relevant authorities nor a thorough investigation. In his case, his family members could not visit him. His complete isolation could have caused mental suffering and triggered suicide. However, the family members do not believe that Durgesh committed suicide. They alleged the police were responsible for his death and applied for legal support at AF on 16 July 2020. Family members tried to register an FIR at the Metropolitan Police Division on 28 September 2020, but the police refused to register the case. On the same day, the text of the FIR was sent to the District Attorney General's Office, Lalitpur. After several months of uncertainty, Metropolitan Police Division, Jawalakhel, Lalitpur, informed the family members on 16 December 2020 that the case was kept on hold. According to the Government's response to the UN Rapporteurs of February 2021 (see above), based on CCTV evidence, an investigation committee concluded that it was suicide. The letter also states that disciplinary action was taken against Assistant Sub-Inspector Ram Kumar Mahato, Head Constable Deepak Jung Thakuri and

⁷⁷ Shuvam Dhungana. "Suicide by youth in police custody raises concern over mental health of inmates." Kathmandu Post, 2 July 2020, <https://kathmandupost.com/national/2020/07/02/suicide-by-youth-in-police-custody-raises-concern-over-mental-health-of-inmates>

police constable Deepak Thapa for “not giving proper attention in their respective line of duty”.⁷⁸

All three cases demonstrate the problems with registering the FIR: police refuse to register it; or, when filed, there is no investigation, and police allegedly do not include relevant information in the FIR when they prepare the FIR by themselves. The longer the investigation process drags on, the more the public suspects that the real cause of the detainee’s death is ill-treatment or torture. One of the most important investigation procedures is a medico-legal examination. In Nepal, these are often carried out without the consent of the family, and the family is never informed about the outcome, let alone provided a copy of the post-mortem report.

3.2 ROLE OF MEDICAL PROFESSION: WHAT ARE THE WEAKNESSES AND WHAT NEEDS CHANGING

The fundamental right to be treated humanely when detained is universally guaranteed in international law and jurisprudence.⁷⁹

⁷⁸ See Response of the Government of Nepal on Joint Communication of Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, Special Rapporteur on Extra-judicial, Summary or Arbitrary Execution, Special Rapporteur on the Rights to Freedom of Peaceful Assembly and Association and Special Rapporteur on Minority Issues, 10 February 2021, <https://spcommreports.ohchr.org/TMResultsBase/DownloadFile?gId=35958>

⁷⁹ The right to life as well as the right to be treated humanely in detention are recognized by several international binding and non-binding instruments, applicable during peace time and war, from which a State Party cannot derogate. For Nepal, see art. 3 and 5 of the Universal Declaration of Human Rights (December 10, 1948); art. 4, 6, 7, and 10 of the International Covenant on Civil and Political Rights, 999 UNTS

Deficiencies in detention conditions as well as any form of torture or ill-treatment, however, continue to subvert this right, including in Nepal.

Proper medico-legal examinations are crucial, and irrespective of the nature of a death in detention should be mandatory. In Nepal, they are not always held and if held, there are often delays in conducting them and the results are kept secret from the families of the deceased. This raises serious concerns over the effectiveness and fairness of medico-legal investigations.

AF has identified practical and ethical difficulties encountered in the medico-legal investigation following deaths in custody. The role of forensic experts is essential in the criminal justice

171; art. 1, 2, and 11 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1465 UNTS 85; art. 3, 13, 14, 15, 22, 25, 26, 29, and 30 of the Geneva Convention (III) relative to the Treatment of Prisoners of War, 75 UNTS 135; art. 32 and 37 of the Geneva Convention (IV) relative to the Protection of Civilian Persons During Time of War, 75 UNTS 287. Moreover, see the UN Standard Minimum Rules for the Treatment of Prisoners, adopted by the first UN Congress on the Prevention of Crime and the Treatment of Offenders, 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV), July 31, 1957, and 2076 (LXII), May 13, 1977. In addition, see the Human Rights Committee, General Comment No. 6: The Right to Life, 1982; General Comment No. 20: art. 7, 1992: Prohibition of torture or other cruel, inhuman or degrading treatment or punishment; General Comment No. 21: art. 10, 1992: Treating all persons deprived of their liberty with humanity and with respect for their dignity; Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 (2003), 127, 151, and 153, respectively. See also art. 22 of the Constitution of Nepal (2015) that guarantees the right to be free from physical or mental torture and cruel, inhuman or degrading treatment when arrested or detained.

process as they can provide strong evidence for subsequent investigations, prosecutions and punishments of perpetrators. Their professionalism and impartiality when investigating custodial deaths are considered critical and, lack thereof, problematic. When medico-legal expertise is not independent, concerns arise with conflicts of interest, biased conclusions, and low-quality and uninformative post-mortem reports, which in turn impede the further development of investigation and prosecution within the judicial system and the execution of punishment.

The role of medical personnel is also of utmost importance during detention check-ups, which are supposed to be carried out regularly to detect the physical and psychological problems of detainees in a timely manner and provide sufficient medical care to prevent deaths in places of detention. Moreover, the Compensation Relating to Torture Act, 2053 (1996), Article 3.2 requires detaining authorities to have a thorough medical check-up of detainees before taking them into custody and while releasing them. However, in many death cases documented by AF, no medical examinations were done while taking those detainees into custody.⁸⁰

LACK OF POST-MORTEM INVESTIGATIONS AND INCIDENT REPORTS

Section 20 of the Criminal Procedural Code 2017 requires police officers that have responsibility of investigation to first prepare an

⁸⁰ Compensation Relating to Torture Act, 2053 (1996), Nepal, adopted on 18 December 1996, https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=45831&p_country=NPL&p_count=128&p_classification=01.05&p_classcount=4

incident report, visiting the place where the dead body is found. Such reports should contain the identification of the dead body, the place and the location of the dead body, any marks, abrasion, wounds and any other signs or symptoms that would help to understand the cause of death. If anything indicates that the death might be suspicious or unnatural then the body has to be sent for a post-mortem.⁸¹ Although no detailed rules and guidelines have been provided for the implementation of this, Section 20 provision, Rule 18 of the Prison Management Procedural Guidelines also requires the prison authority to have a body checked by a medical professional in cases of death of prisoners. However, in many instances, those limited rules are not observed by the prison officials in cases relating to death in prisons and police custody and a post-mortem investigation is not conducted.

PREVENTION OF LATE/INSUFFICIENT MEDICAL HELP

While in custody, the detainees lose the freedom to choose the provider and timing of medical care along with their freedom of movement. It means they are entirely dependent on prison or police authorities as well as the judiciary and the state's government to ensure proper and timely medical care. The Torture Compensation Act requires the detaining authority to have a thorough medical check of detainees before taking them into custody and also while releasing them from custody. However, in many of the cases of

⁸¹ Section 20 of the National Criminal Procedure Code, 2074 (2017), Nepal, adopted on 16 October 2017, <https://www.moljpa.gov.np/en/wp-content/uploads/2018/12/Criminal-procedure-code-Revised.pdf>

death in custody that AF documented, no medical examinations were done while taking those detainees into custody. Section 11 of the Health and Treatment of the Prisons Act, 2019 (1963) contains general assumptions on the provision of medical care by a public doctor on a free basis or by a personal doctor at the expense of the prisoner. But it does not contain clauses related to the non-provision of medical care or its fatal delay.⁸² The Consumer Protection Act of Nepal also contains some provisions to prevent harms by medical practitioners,⁸³ but no laws provide guidelines for holding medical professionals accountable for insufficient or late medical care for detainees. However, constitutional guarantees on the right relating to health state that “every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services.”⁸⁴ It is very important to consider that both physical and mental health should remain under constant review and is the responsibility of the detention authorities and medical staff designated for detention places.

⁸² Prisons Act, 2019 (1963), Nepal, adopted on 4 February 1963, <https://policehumanrightsresources.org/content/uploads/2016/07/Prisons-Act-Nepal-1963.pdf?x96812>

⁸³ See section 3(2) (e) of The Consumer Protection Act, 2075 (2018), Nepal, adopted on 18 September 2018, <https://www.lawcommission.gov.np/en/wp-content/uploads/2019/09/The-Consumer-Protection-Act-2075-2018.pdf>

⁸⁴ See art. 35(1) of the Constitution of Nepal, adopted on 20 September 2015, https://www.mohp.gov.np/downloads/Constitution%20of%20Nepal%202072_full_english.pdf

PREVENTION OF SUICIDES

According to AF's analysis, *all suicides occurred while in police custody*, within the first 24 hours to the first month of detention. This means that ensuring proper conditions of detention and humane treatment of prisoners, access to medical staff (including professional psychologists and psychiatrists), trained prison and police staff to identify vulnerable prisoners and provide them with appropriate support, as well as contact with the outside world— with relatives, with other prisoners— are all important components of any policy to prevent harm to oneself while confined.⁸⁵ Detention authorities should put in place special procedures that will enable them to identify detainees who are at risk of suicide, such as assessing the risk of suicide during the initial pre-imprisonment medical examination. If a risk has been identified, then a specialized team consisting of prison administration and medical staff should be established to decide where prisoners at high risk of suicide should be held, and to ensure their safety through constant monitoring. Thus a protocol should be followed according to Article 11(2) on Health and Treatment of the Prison Act (1963), which states: "If any Detainee or Prisoner becomes extremely sick and the government doctor makes his or her reasoned opinion in writing determining that it is necessary to keep the said detainee or prisoner in a hospital for better treatment, the handcuff and fetter, if put on the said detainee or prisoner, shall

⁸⁵ International Committee of the Red Cross. "Guidelines for investigating deaths in custody." <https://www.icrc.org/en/doc/assets/files/publications/icrc-002-4126.pdf>

be taken off, and his or her treatment shall be done by keeping him/her in a hospital as prescribed.”⁸⁶

All prison and police officers who have daily contact with detainees should also be trained to recognize the risk of suicide. Detention authorities must carefully record suicides and determine the causes through independent and transparent investigations.

In line with the recommendations of the 3rd Asian and Pacific Conference on Prison Health held in November 2019,⁸⁷ and the UNODC Good Governance Guidance for Prison Health in the 21st Century,⁸⁸ strategic deployment of human resources for adequate health services in any state detention facility should be a whole-government approach if there is an apparent lack of medical personnel across the country’s detention facilities. Detention health services should be an integral part of the national health policies and systems, including the specific training and professional development of health care staff.

Overall strengthening of the public dialogue to fight against the stigma associated with detention is important to promote a vision of detention facilities firstly as places for rehabilitation rather than

⁸⁶ Prisons Act, 2019 (1963), Nepal, adopted on 4 February 1963, <https://policehumanrightsresources.org/content/uploads/2016/07/Prisons-Act-Nepal-1963.pdf?x96812>

⁸⁷ Recommendations of the 3rd Asian and Pacific conference on prison health held on 13 to 15 November 2019, <https://apcph.ircr.org/wp-content/themes/ircr/includes/resources/Recommendations-APCPH-2019-final.pdf>.

⁸⁸ WHO Regional Office for Europe. “Good governance for prison health in the 21st century. A policy brief on the organization of prison health.” Copenhagen, 2013, https://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf

punishment. The latter should be especially so while working with juveniles coming into conflict with the law. Essential medical supplies and technologies should be accessible free of charge to all detainees in order to prevent deaths caused by insufficient and late medical assistance. They should be of the same professional, ethical, and technical standards as those available for the general population.⁸⁹ Equity and continuity in delivery of health services to detainees must be ensured by the detention authorities without any exclusion or discrimination.

It is important to include the medico-legal documentation in the medical education and conduct extensive training of medical personnel involved in detainees' check-ups after arrest, upon release or in case of death. In particular, the guidance provided in the Minnesota Protocol⁹⁰ dealing with investigations of potentially unlawful deaths, and Istanbul Protocol⁹¹ as the Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment should form the basis for the training.

⁸⁹ Ibid

⁹⁰ Office of the United Nations High Commissioner for Human Rights (OHCHR). "The Minnesota Protocol on the Investigation of Potentially Unlawful Death." New York/Geneva, 2017, <https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf>

⁹¹ UN Office of the High Commissioner for Human Rights (OHCHR). "Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Istanbul Protocol")." 2004, HR/P/PT/8/Rev.1, <https://www.refworld.org/docid/4638aca62.html>

3.3 ROLE OF PUBLIC PROSECUTORS

The Constitution of Nepal and also the Regulations relating to the job responsibility of public prosecutors identify the Attorney General and public prosecutors under his office as the authority responsible for monitoring of places of detention. Article 158 (6) c of the Constitution states that “if a complaint is made alleging that any person held in custody has not been treated humanely subject to this Constitution or such person has not been allowed to meet his or her relative or through his or her legal practitioner or if the information of such matter is received, to inquire thereinto and give necessary directive to the concerned authority to prevent such act’. This is further elaborated in the Regulations relating to the power and responsibility of the public prosecutors. A similar provision can be found in respect of the role, responsibility and benefits of the provincial Chief Attorneys.

While the Office of the Attorney General brings out a report (generally once a year) highlighting its monitoring work in detention, the frequency of visits to places of detention is low and the implementation of necessary measures recommended is non-existent to prevent arbitrary detention, torture, ill-treatment and deaths in custody. Chief Attorneys of the provincial governments are still working out the modality of their detention monitoring mandate.

According to the Minnesota Protocol,⁹² the state’s duty to investigate deaths in custody is an essential part of upholding

⁹² Office of the United Nations High Commissioner for Human Rights (OHCHR). “The Minnesota Protocol on the Investigation of Potentially

the right to life.⁹³ This duty promotes accountability as well as a remedy where a fundamental right may have been violated. Where an investigation reveals evidence of unlawful death, the state must ensure that the perpetrators are prosecuted and, where appropriate, punished through a judicial process.⁹⁴ Impunity emanating from unreasonably short statutes of limitations or blanket amnesties (*de jure impunity*), or from prosecutorial inaction to file the cases or political interference (*de facto impunity*), is incompatible with this duty.⁹⁵ A failure to respect the state's duty to investigate is a violation of the fundamental right to life. Proper investigations and prosecutions are crucial to prevent future violations and to

Unlawful Death." New York/Geneva, 2017, <https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf>

⁹³ See, e.g., ECtHR, *McCann and others v. United Kingdom*, Judgment (Grand Chamber), 27 September 1995, para. 161; IACtHR, *Montero-Aranguren and others (Detention Center of Catia) v. Venezuela*, Judgment, 5 July 2006, para. 66; African Commission on Human and Peoples' Rights (ACHPR), General Comment No. 3 on the Right to Life, November 2015, paras. 2, 15; Human Rights Committee, General Comment No. 31, paras. 15 and 18.

⁹⁴ See Principle 1, Orentlicher, Diane, UN. Independent Expert to Update the Set of Principles for the Protection and Promotion of Human Rights through Action to Combat Impunity. "Impunity : report of the Independent Expert to Update the Set of Principles to Combat Impunity, Diane Orentlicher : addendum." UN doc. E/CN.4/2005/102/Add.1, 8 February 2005, https://undocs.org/Home/Mobile?Final_Symbol=E%2FCN.4%2F2005%2F102%2FAdd.1&Language=E&DeviceType=Desktop&LangRequested=False

⁹⁵ See, for example, Human Rights Committee, General Comment No. 31, para. 18.

UN Human Rights Committee (HRC), General comment no. 31 [80], The nature of the general legal obligation imposed on States Parties to the Covenant, 26 May 2004, CCPR/C/21/Rev.1/Add.13, <https://www.refworld.org/docid/478b26ae2.html>.

- (k) The relevant laws to be applied, and the reasons therefor,
- (l) The demand for punishment to be imposed on the accused, and the reasons therefor,
- (m) The amount of compensation, if any, required to be awarded to the person who has sustained injury from the offence.

A copy of the decision should be given by the government attorney to the concerned investigating authority and the accused, if any, made by him or her not to institute the case or a copy of the charge sheet if he or she has made a decision to institute the case.⁹⁹ In the cases of suspicious custodial deaths that fall under Schedule 1 of the National Criminal Procedure Code, 2074 (2017) in cases under Penal Code Article 167 on torture and 168 on ill-treatment, the concerned government attorney makes decision to the effect that the evidence is not sufficient enough to institute the case and he or she shall give information of such decision to the concerned investigating authority and the authority or office higher in level than such investigating authority.¹⁰⁰ Notice of the decision should also be given to informants or victims.¹⁰¹

The Minnesota Protocol also states the following: “Particular circumstances in which the State will be held responsible for the death, unless it is proven to the contrary, include, for example, *cases where the person suffered injury while in custody or where*

⁹⁹ See art. 40 (1) of the National Criminal Procedure Code, 2074 (2017).

¹⁰⁰ See art. 40 (2) of the National Criminal Procedure Code, 2074 (2017).

¹⁰¹ See art. 41 of the National Criminal Procedure Code, 2074 (2017).

the deceased was, prior to his or her death, a political opponent of the government or a human rights defender; was known to be suffering from mental health issues; *or committed suicide in unexplained circumstances.*”¹⁰²

¹⁰² Office of the United Nations High Commissioner for Human Rights (OHCHR). “The Minnesota Protocol on the Investigation of Potentially Unlawful Death” New York/Geneva, 2017, p. 6, <https://www.ohchr.org/sites/default/files/Documents/Publications/MinnesotaProtocol.pdf>

CHAPTER 4

RECOMMENDATIONS

Based on Nepal's international obligations and Nepali law to protect detainees, *every death in custody should be considered suspicious and should be thoroughly investigated* as imprisoned persons constitute a vulnerable group, and authorities have a special duty to protect their lives and safety.

AF is **recommending for the Government of Nepal** to take the following measures for the prevention of deaths in custody; their impartial investigation; wider legislative reform and measures in respect of CCHs:

PREVENTION

1. Take all necessary measures to improve *detention conditions and create a healthy environment which meets the basic needs of detainees*. This should include the allocation of appropriate material and human resources to sufficiently screen mentally and physically ill detainees, as required by human rights law and treaties ratified by Nepal.

2. *Health care personnel, detention officers, and legal professionals should be thoroughly educated about international standards as well as the State's commitments on the rights of detainees in order to prevent self-harm behaviour and other causes of unnatural deaths in custody.*
3. *Ensure basic needs are met at all prisons and detention facilities in accordance with standard minimum rules prescribed by international law as well as national legislation.*
4. *To ensure the effective prevention of custodial deaths and torture, put in place more effective detention management, a proper independent monitoring mechanism and a comprehensive local legislative framework that is compatible with international standards.*
5. *Reform the criminal justice system, taking into account the special needs and characteristics of more vulnerable population groups, including juveniles.*
6. *Bring the conditions of detention to generally accepted safety standards and norms, such as modern and fully operating CCTV equipment, safe detention cells (doors that cannot be locked from the inside, specialised furniture and system of plumbing, avoidance of piercing objects and surfaces in cells), a system of thorough screening of visitors for the carrying of prohibited substances and items, etc.*

LEGISLATION

1. *Pass legislation to establish an independent investigative body for a fair, impartial, and effective investigation in cases of deaths in custody.*
2. After meaningful consultation with relevant stakeholders, table legislation harmonising the many different rules and procedures in monitoring of places of detention and handling of death in custody, taking into account the work of the Law and Human Rights Committee of the House of Representatives.
3. *Pass a new comprehensive law related to torture to ensure Nepal upholds all obligations under the Convention against Torture (CAT).* This includes a definition of torture and cruel, inhuman or degrading treatment in line with the CAT, adequate sanctions and penalties, adequate reparations provisions, and compensation paid by the state.
4. Ensure unreasonably short statutes of limitations or blanket amnesties (*de jure impunity*), or prosecutorial inaction to file cases or political interference (*de facto impunity*), are eliminated through an effective legal framework.

INVESTIGATION

GENERAL RECOMMENDATIONS ON INVESTIGATION

1. Set up an *independent monitoring and investigation mechanism* to properly investigate any incidents of deaths in custody to establish the cause of death and any failures on the part of the authorities involved, and hold those responsible to account. The mechanism should be impartial, independent and effective, ensuring *alleged perpetrators have no influence on the investigation* and *investigators have no records of being involved in violations*.

In order to be effective, any investigation should fulfil the fundamental criteria:

- It should be *thorough*.
 - It should be conducted *ex officio*.
 - The authorities responsible for the investigation must be *independent and impartial*.
 - The investigation should possess some degree of *public scrutiny*.
 - The investigation should collect all relevant physical and documentary evidence, statements from witnesses and ensure a proper autopsy
2. The mechanism should not only be mandated to investigate individual incidents of deaths in detention, but must also analyse the patterns and practices directly or indirectly linked

to them and make recommendations for the state to adopt sustainable measures to prevent such incidents, including by addressing possible root causes identified during the investigations.

URGENT REFORMS TO CURRENT INVESTIGATION SYSTEM PENDING THE ESTABLISHMENT OF AN INDEPENDENT MECHANISM

1. *Ensure proper registering of FIRs* and resolve many related issues such as police refusing to register; or, when filed, the FIR not having sufficient information about the actual allegations.
2. *Ensuring ex officio investigations.* Amend the Criminal Procedure Code to ensure that FIRs can be filed at a police station of the complainant's choice rather than the nearest one, which is likely to be the place of the offence. Also, review the requirement for the complainant to provide evidence (to the greatest extent possible) that the alleged incident occurred, thereby removing the onus of proving the crime from the family.
3. Ensure ex-officio investigation of allegation of torture and custodial death to prevent any undue pressure on victims and witnesses to prevent them filing FIRs.
4. Amend the Penal Code to hold police officers accountable for not registering FIR to avoid the persistent problem of police creating obstruction at the preliminary stage of the justice process.

AUTOPSY

1. *Ensure proper and immediate medico-legal examinations are mandatory in all cases of suspicious deaths in police, army, prison or other places of confinement to establish the nature of death in detention and that the results are shared with the families of the deceased and their legal representatives.*
2. *Put in place Obligatory autopsy and action protocol in the situations of torture or suicide in detention.* In terms of prisons, this means amending Section 13 of the Prison Act 1963 to insert a clause on obligatory post-mortems.

HEALTH IN DETENTION

1. Include substantive hours of teaching/training in the medical education to equip medical professionals to conduct detainees' check-ups after arrest, upon release or in case of death. In particular, the guidance provided in the *Minnesota Protocol* dealing with investigations of potentially unlawful deaths, and *Istanbul Protocol* as the Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment should form the basis for the course and training.
2. *Start a public information campaign to fight against the stigma associated with detention* and promote a vision of detention facilities firstly as places for rehabilitation rather than

punishment. The latter should be especially so while working with juvenile offenders.

3. *Essential medical supplies and technologies* should be accessible free of charge to all detainees in order to prevent deaths caused by insufficient and late medical assistance. They should be of the same professional, ethical, and technical standards as those available for the general population.
4. *Equity and continuity in delivery of health services* to detainees must be ensured by the detention authorities without any exclusion or discrimination.
5. *Strategic deployment of human resources* for adequate health services in any state detention should be a whole-government approach if there is an apparent lack of medical personnel across the country's detention facilities. *Detention health services should be an integral part of the national health policies and systems*, including the specific training and professional development of health care staff.
6. Ensure that *both physical and mental health should remain under constant control* and responsibility of the detention authorities and medical staff.
7. *Detention check-ups should be carried out regularly* to detect the physical and psychological problems of detainees in a timely manner and to provide sufficient medical care to prevent deaths in places of detention. It should be guaranteed in law that when the health condition of a detainee is of serious concern, she or he should be transferred immediately to a hospital and the family should be informed accordingly.

8. *Adopt a suicide prevention strategy that includes the following components: ensuring proper conditions of detention and humane treatment of prisoners, access to medical staff (including professional psychologists and psychiatrists), training prison and police staff to identify vulnerable prisoners and provide them with appropriate support, as well as contact with the outside world.*
9. Detention authorities should put in place special procedures that will enable them to identify detainees who are at risk of suicide, such as assessing the risk of suicide during the initial pre-imprisonment medical examination. If a risk has been identified, then a specialized team consisting of prison administration and medical staff should be established to decide both where prisoners at high risk of suicide should be held and to ensure their safety through constant monitoring. Thus, a protocol should be followed according to Article 11(2) on Health and Treatment of the Prison Act (1963).
10. Detention authorities must carefully record suicides and determine the causes through independent and transparent investigations.

JUVENILES

1. Implement all internationally accepted rules and standards regarding juvenile justice and the protection of juveniles deprived of their liberty, which guarantee *special attention to detention conditions*. Among them is the responsibility of the detention institutions to provide care, protection and

all necessary assistance— social, educational, vocational, psychological, medical and physical— that juveniles may require because of their age, sex, and personality and in the interest of their wholesome development.

2. *Create sufficient CCHs throughout the country, to ensure separate detention of juveniles from adult offenders with adequate infrastructure for the rehabilitation and correction of juveniles.*
3. CCHs should be supported by both the government and non-government organisations *not as places of detention and punishment, but as the space of new hope and rehabilitation for children* who have most likely already been subjected to severe trials in their lives.
4. *Sensitisation to juvenile offenders' challenges should be extended among both detention personnel and the general public* in order to stress vulnerability of children in custody and create an environment for eliminating stigmatisation that can ruin the rest of their lives.
5. Revise secondary level education textbook to inform children regarding laws and policies on juvenile justice.

ANNEXES

Annex 1: Distribution of cases by type of custody and cause of death

	Suicides	Torture	Late/Insufficient medical care	No information	Total
Prison	1	1	2	17	21
Police	9	5	2	0	16
Army	0	1	0	0	1
CCH	0	0	1	0	1
	10	7	5	17	39

Annex 2: Distribution of cases by year

	2018	2019	2020	2021	2022
Prison	0	0	12	8	1
Police	1	1	7	5	2
Army	0	0	1	0	0
CCH	0	0	1	0	0
Total	1	1	21	13	3

Annex 3: Distribution of cases by caste

Caste	Army	CCH	Police	Prison	Total	Remarks
Bhramin/Chhetri/Thakuri	0	0	3	4	7	So-called upper caste
Dalit	0	0	5	3	8	So-called untouchable
Ethic groups/Minorities	1	1	8	14	24	So-called middle/lower caste
	1	1	16	21	39	

Annex 4: List of cases

SN	Name of Detainee	Age	Ethnicity	Address	District	Place of detention	Type of custody	Cause of death	Date of Death
1	Narayan Khadka		Chhetri	Itahari - 8, Morang	Morang	Morang Prison	Prison	No Information	11 November 2021
2	Gopal Sharma	53	Bhramin	Biratnagar metropolitan city-10	Morang	Morang Prison	Prison	No Information	20 November 2021

SN	Name of Detainee	Age	Ethnicity	Address	District	Place of detention	Type of custody	Cause of death	Date of Death
3	Subash Limbu	30	Janajati	Dharan sub-metropolitan city-8	Sunsari	Morang Prison	Prison	No Information	14 August 2021
4	Ramesh Magar	28	Janajati	Kerabari rural municipality-4, Morang	Morang	Morang Prison	Prison	No Information	30 July 2020
5	Bidyananda Mandal		Tarai Origin	Biratnagar metropolitan city-16	Morang	Morang Prison	Prison	No Information	3 August 2020
6	Dhan Bahadur Gurung	52	Janajati	Ratuwamai municipality-5	Morang	Morang Prison	Prison	No Information	17 August 2020
7	Ram Bahadur Rai	59	Janajati	Urlabari municipality-4, Morang	Morang	Morang Prison	Prison	No Information	26 November 2021
8	Som Pariyar	20	Dalit	Ramdhungi municipality-2	Sunsari	Morang Prison	Prison	No Information	20 July 2021

SN	Name of Detainee	Age	Ethnicity	Address	District	Place of detention	Type of custody	Cause of death	Date of Death
9	Bhim Lal Subba	60	Janajati	Pathari Shanishchare municipality-10	Morang	Morang Prison	Prison	No Information	9 September 2021
10	Muhammad Yusuf	56	Muslim	Shambhunath rural municipality-12	Saptari	Morang Prison	Prison	No Information	13 September 2021
11	Ashok Rai	28	Janajati	Letang Municipality-1, Morang	Morang	Morang Prison	Prison	No Information	30 September 2020
12	Dipesh Mahara	20	Dalit	Itahari Sub-Metropolis-11, Sunsari	Sunsari	Morang Prison	Prison	No Information	9 October 2020
13	Shivahang Rai	26	Janajati	Bhojpur Municipality-11	Bhojpur	Morang Prison	Prison	No Information	15 October 2020
14	Kewal Karki	32	Chhetri	Dharan sub-metropolitan city-6	Sunsari	Morang Prison	Prison	No Information	30 October 2020

SN	Name of Detainee	Age	Ethnicity	Address	District	Place of detention	Type of custody	Cause of death	Date of Death
15	Suman Danuwar	25	Tarai Origin	Sundar Haraicha municipality-9	Morang	Morang Prison	Prison	No Information	4 November 2020
16	Rishi Ram Bhattarai	24	Bhramin	Sundar Haraicha municipality-4	Morang	Morang Prison	Prison	No Information	16 November 2020
17	Mohammad Aslam		Muslim			Morang Prison	Prison	No Information	22 November 2020
18	Sundar Harijan	20	Tarai Origin (Dalit)	Nepalgunj-2, Gharbari Tole	Banke	Prison Office, Rolpa	Prison	Suicide by hanging	18 May 2022
19	Nirajan Yadav	26	Tarai Origin	Biratnagar metropolitan city-4	Morang	Morang Prison	Prison	Suspicion of torture leading to death	26 August 2020
20	Ram Laxhan Jaiswal	63	Tarai Origin	Bank Road, Bhairahawa, Siddhartha Municipality-5	Rupandehi	Kathmandu Prison	Prison	Late/ Insufficient medical care	19 September 2020

SN	Name of Detainee	Age	Ethnicity	Address	District	Place of detention	Type of custody	Cause of death	Date of Death
21	Suvarna Singh Tamang (Phurba Singh Tamang)	26	Janajati	Sundar Haraucha Municipality-5	Morang	Morang Prison	Prison	Late/ Insufficient medical care	29 August 2021
22	Raj Kumar Chepang	24	Indigenous	Chitwan	Chitwan	Chitwan National Park, Army Camp	Army Custody	Torture leading to death	22 July 2020
36	Vinaya Limbu	17	Janajati	Shiva Satashi Municipality, Dudhe, Jhapa	Jhapa	District Police Office, Taplejung	Child Correction Home	Late/ Insufficient medical care	31 May 2020
23	Krishna Hamal	31	Thakuri	Tilagufa Municipality, Ward No. 3, Kalikot, Karnali Province	Kalikot	Subbakuna Police Station under District Police Office, Surkhet	Police Custody	Torture leading to death	5 March 2022

SN	Name of Detainee	Age	Ethnicity	Address	District	Place of detention	Type of custody	Cause of death	Date of Death
24	Shambhu Kumar Sada	23	Tarai Origin (Dalit)	Sabaila, Dhanusha	Dhanusha	Area Police Office (APO) Sabaila's detention center	Police Custody	Suicide by hanging	10 June 2020
25	Durgesh Yadav	24	Tarai Origin	Aurahi Rural Municipality-3, Siraha district of Province 2	Siraha	Metropolitan Police Circle, Satdobato, Lalitpur	Police Custody	Suicide by hanging	1 July 2020
26	Bijay Mahara	19	Tarai Origin (Dalit)	Garuda Municipality, Rautahat District	Rautahat	Garuda Police, Rautahat	Police Custody	Torture leading to death	26 August 2020
27	Roshan BK	19	Dalit	Kailali District, Dhangadhi Sub-Metropolitan, Ward no. 5	Kailali	Kailali District Police	Police Custody	Suicide by hanging	11 September 2020

SN	Name of Detainee	Age	Ethnicity	Address	District	Place of detention	Type of custody	Cause of death	Date of Death
28	Amar Bahadur Chand	47	Thakuri	Kailali district, Dhangadi Sub Metropolitan, Ward no 14	Kailali	Fulbari Area Police Office, Kailali	Police Custody	Suicide (was found dead with a wound on his neck caused by a blade)	12 August 2020
29	Babulal Raidas	35	Tarai Origin (Dalit)	Duduwa Rural Municipality, Banke district, Bankatti, Lumbini Province	Banke	District Police Station, Banke	Police Custody	Suicide by hanging	20 November 2020
30	Khadga Bahadur Tamang	32	Janajati	Barhabise Municipality, Ward No 7, Thagam Street, Sindhupalchok, Bagmati Province	Sindhupalchok	Area Police Office (APO), Barhabise Municipality, Ward No. 7, Barhabise Bazar, Sindhupalchok	Police Custody	Torture leading to death	6 August 2021

SN	Name of Detainee	Age	Ethnicity	Address	District	Place of detention	Type of custody	Cause of death	Date of Death
31	Mahomad Hakim Sah	24	Muslim	Bhokraha Narsingh Rural Municipality, Ward No 5, Tapara Village, Sunsari District, Province No. 1	Sunsari	District Police Office (DPO), Inaruwa, Sunsari, Province No. 1	Police Custody	Suicide by hanging	10 October 2021
32	Bhim Kamat	37	Tarai Origin	Biratnagar Metropolitan City, Ward No. 11, Janpath Tole	Morang	Ward Police Office, Biratnagar Metropolitan, Morang	Police Custody	Suspicion of torture leading to death	5 September 2021
33	Ram Manohar Yadav	30	Tarai Origin	Janaki Rural Municipality, Banke	Banke	District Police Office (DPO), Bardiya	Police Custody	Late/ Insufficient medical care	31 August 2018

SN	Name of Detainee	Age	Ethnicity	Address	District	Place of detention	Type of custody	Cause of death	Date of Death
34	Shyam Thapa Magar	20	Janajati	Ghodaghodi Municipality, Ward No 1, Sukhad Kailali, Sudurpashchim Province	Kailali	Prison Office, Kailali	Police Custody	Late/ Insufficient medical care	4 March 2022
35	Paltu Ravidas	40	Tarai Origin (Dalit)	Dhanusha District, Ward no. 2, Sigarjoda Village, Madhesh Province	Dhanusha	District Police Office (DPO), Dhanusha District, Janakpur Municipality	Police Custody	Suicide by hanging	30 July 2021
37	Kishmat Shrestha	34	Newar	Kapilvastu District, Baadganga, Ward No. 1, Dhode Tole	Kapilvastu	Area Police Office (APO), Pipra, Kapilvastu	Police Custody	Suicide by hanging	2 April 2020

SN	Name of Detainee	Age	Ethnicity	Address	District	Place of detention	Type of custody	Cause of death	Date of Death
38	Kamalakanta Panta	71	Bhramin	Patan Municipality Ward No. 6, Bhukuda (Letada), Baitadi District	Baitadi	Area Police Office (APO), Patan	Police Custody	Torture leading to death	13 May 2019
39	Dhan Bahadur Rana Magar	35	Janajati	Chaukune Rural Municipality, Ward No. 3	Surkhet	Area Police Office (APO), Tikapur, Kailali District	Police Custody	Suicide by hanging	11 October 2021



26 June 2022

This report documents patterns of suspicious deaths in custody since Nepal's new Penal Code came into force in 2018 as monitored and investigated by Advocacy Forum. It has documented 39 cases, including 16 in police custody, one at the hands of an army officer, 21 in prison, and one at a Child Correction Home (CCH). The report makes the case for a wide range of measures to be taken by the Government of Nepal to prevent deaths in custody, ensure impartial investigations, deliver justice and ensure the health of all detainees and the protection of all juveniles in custody.

