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European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

CPT standards

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About the CPT

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) was set up under the 1987 Council of Europe Convention of the same name (hereinafter "the Convention"). According to Article 1 of the Convention:

> "There shall be established a European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment... The Committee shall, by means of visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment."

The work of the CPT is designed to be an integrated part of the Council of Europe system for the protection of human rights, placing a proactive non-judicial mechanism alongside the existing reactive judicial mechanism of the European Court of Human Rights.

The CPT implements its essentially preventive function through two kinds of visits - periodic and ad hoc. Periodic visits are carried out to all Parties to the Convention on a regular basis. Ad hoc visits are organised in these States when they appear to the Committee "to be required in the circumstances".

When carrying out a visit, the CPT enjoys extensive powers under the Convention: access to the territory of the State concerned and the right to travel without restriction; unlimited access to any place where persons are deprived of their liberty, including the right to move inside such places without restriction; access to full information on places where persons deprived of their liberty are being held, as well as to other information available to the State which is necessary for the Committee to carry out its task.

The Committee is also entitled to interview in private persons deprived of their liberty and to communicate freely with anyone whom it believes can supply relevant information.

Visits may be carried out to any place "where persons are deprived of their liberty by a public authority". The CPT's mandate thus extends beyond prisons and police stations to encompass, for example, psychiatric institutions, detention areas at military barracks, holding centres for asylum seekers or other categories of foreigners, and places in which young persons may be deprived of their liberty by judicial or administrative order.

Two fundamental principles govern relations between the CPT and Parties to the Convention - co-operation and confidentiality. In this respect, it should be emphasised that the role of the Committee is not to condemn States, but rather to assist them to prevent the ill-treatment of persons deprived of their liberty.

After each visit, the CPT draws up a report which sets out its findings and includes, if necessary, recommendations and other advice, on the basis of which a dialogue is developed with the State concerned. The Committee's visit report is, in principle, confidential; however, almost all States have chosen to waive the rule of confidentiality and publish the report.

The CPT is required to draw up every year a General Report on its activities, which is published.

In a number of its General Reports the CPT has described some of the substantive issues which it pursues when carrying out visits to places of deprivation of liberty. The Committee hopes in this way to give a clear advance indication to national authorities of its views regarding the manner in which persons deprived of their liberty ought to be treated and, more generally, to stimulate discussion on such matters.

The "substantive" sections drawn up to date have been brought together in this document.

I. Law enforcement agencies

Detention by law enforcement officials

Extract from the 2nd General Report [CPT/Inf (92) 3]

36. The CPT attaches particular importance to three rights for persons detained by the police: the right of the person concerned to have the fact of his detention notified to a third party of his choice (family member, friend, consulate), the right of access to a lawyer, and the right to request a medical examination by a doctor of his choice (in addition to any medical examination carried out by a doctor called by the police authorities).[1] They are, in the CPT's opinion, three fundamental safeguards against the ill-treatment of detained persons which should apply as from the very outset of deprivation of liberty, regardless of how it may be described under the legal system concerned (apprehension, arrest, etc).

37. Persons taken into police custody should be expressly informed without delay of all their rights, including those referred to in paragraph 36. Further, any possibilities offered to the authorities to delay the exercise of one or other of the latter rights in order to protect the interests of justice should be clearly defined and their application strictly limited in time. As regards more particularly the rights of access to a lawyer and to request a medical examination by a doctor other than one called by the police, systems whereby, exceptionally, lawyers and doctors can be chosen from pre-established lists drawn up in agreement with the relevant professional organisations should remove any need to delay the exercise of these rights.

38. Access to a lawyer for persons in police custody should include the right to contact and to be visited by the lawyer (in both cases under conditions guaranteeing the confidentiality of their discussions) as well as, in principle, the right for the person concerned to have the lawyer present during interrogation.

As regards the medical examination of persons in police custody, all such examinations should be conducted out of the hearing, and preferably out of the sight, of police officers. Further, the results of every examination as well as relevant statements by the detainee and the doctor's conclusions should be formally recorded by the doctor and made available to the detainee and his lawyer.

[1] This right has subsequently been reformulated as follows: the right of access to a doctor, including the right to be examined, if the person detained so wishes, by a doctor of his own choice (in addition to any medical examination carried out by a doctor called by the police authorities).

39. Turning to the interrogation process, the CPT considers that clear rules or guidelines should exist on the way in which police interviews are to be conducted. They should address inter alia the following matters: the informing of the detainee of the identity (name and/or number) of those present at the interview; the permissible length of an interview; rest periods between interviews and breaks during an interview; places in which interviews may take place; whether the detainee may be required to stand while being questioned; the interviewing of persons who are under the influence of drugs, alcohol, etc. It should also be required that a record be systematically kept of the time at which interviews start and end, of any request made by a detainee during an interview, and of the persons present during each interview.

The CPT would add that the electronic recording of police interviews is another useful safeguard against the ill-treatment of detainees (as well as having significant advantages for the police).

40. The CPT considers that the fundamental safeguards granted to persons in police custody would be reinforced (and the work of police officers quite possibly facilitated) if a single and comprehensive custody record were to exist for each person detained, on which would be recorded all aspects of his custody and action taken regarding them (when deprived of liberty and reasons for that measure; when told of rights; signs of injury, mental illness, etc; when next of kin/consulate and lawyer contacted and when visited by them; when offered food; when interrogated; when transferred or released, etc.). For various matters (for example, items in the person's possession, the fact of being told of one's rights and of invoking or waiving them), the signature of the detainee should be obtained and, if necessary, the absence of a signature explained. Further, the detainee's lawyer should have access to such a custody record.

41. Further, the existence of an independent mechanism for examining complaints about treatment whilst in police custody is an essential safeguard.

42. Custody by the police is in principle of relatively short duration. Consequently, physical conditions of detention cannot be expected to be as good in police establishments as in other places of detention where persons may be held for lengthy periods. However, certain elementary material requirements should be met.

All police cells should be of a reasonable size for the number of persons they are used to accommodate, and have adequate lighting (i.e. sufficient to read by, sleeping periods excluded) and ventilation; preferably, cells should enjoy natural light. Further, cells should be equipped with a means of rest (eg. a fixed chair or bench), and persons obliged to stay overnight in custody should be provided with a clean mattress and blankets.

Persons in custody should be allowed to comply with the needs of nature when necessary in clean and decent conditions, and be offered adequate washing facilities. They should be given food at appropriate times, including at least one full meal (i.e. something more substantial than a sandwich) every day.[1]

[1] The CPT also advocates that persons kept in police custody for 24 hours or more should, as far as possible, be offered outdoor exercise every day.

43. The issue of what is a reasonable size for a police cell (or any other type of detainee/prisoner accommodation) is a difficult question. Many factors have to be taken into account when making such an assessment. However, CPT delegations felt the need for a rough guideline in this area. The following criterion (seen as a desirable level rather than a minimum standard) is currently being used when assessing police cells intended for single occupancy for stays in excess of a few hours: in the order of 7 square metres, 2 metres or more between walls, 2.5 metres between floor and ceiling.

Extract from the 6th General Report [CPT/Inf (96) 21]

14. The CPT welcomes the support for its work expressed in Parliamentary Assembly Recommendation 1257 (1995), on conditions of detention in Council of Europe member States. It was also most pleased to learn from the reply to Recommendation 1257 that the Committee of Ministers has invited the authorities of member States to comply with the guidelines on police custody as laid down in the 2nd General Report of the CPT (cf. CPT/Inf (92) 3, paragraphs 36 to 43).

In this connection, it should be noted that some Parties to the Convention are reluctant to implement fully certain of the CPT's recommendations concerning safeguards against ill-treatment for persons in police custody, and in particular the recommendation that such persons be accorded a right of access to a lawyer as from the very outset of their custody.

15. The CPT wishes to stress that, in its experience, the period immediately following deprivation of liberty is when the risk of intimidation and physical ill-treatment is greatest. Consequently, the possibility for persons taken into police custody to have access to a lawyer during that period is a fundamental safeguard against ill-treatment. The existence of that possibility will have a dissuasive effect upon those minded to ill treat detained persons; further, a lawyer is well placed to take appropriate action if ill-treatment actually occurs.

The CPT recognises that in order to protect the interests of justice, it may exceptionally be necessary to delay for a certain period a detained person's access to a particular lawyer chosen by him. However, this should not result in the right of access to a lawyer being totally denied during the period in question. In such cases, access to another independent lawyer who can be trusted not to jeopardise the legitimate interests of the police investigation should be arranged.

16. The CPT also emphasised in the 2nd General Report the importance of persons taken into police custody being expressly informed without delay of all their rights.

In order to ensure that this is done, the CPT considers that a form setting out those rights in a straightforward manner should be systematically given to persons detained by the police at the very outset of their custody. Further, the persons concerned should be asked to sign a statement attesting that they have been informed of their rights.

The above-mentioned measures would be easy to implement, inexpensive and effective.

Extract from the 12th General Report [CPT/Inf (2002) 15]

33. It is essential to the good functioning of society that the police have the powers to apprehend, temporarily detain and question criminal suspects and other categories of persons. However, these powers inherently bring with them a risk of intimidation and physical ill-treatment. The essence of the CPT's work is to seek ways of reducing that risk to the absolute minimum without unduly impeding the police in the proper exercise of their duties. Encouraging developments in the field of police custody have been noted in a number of countries; however, the CPT's findings also highlight all too often the need for continuing vigilance.

34. The **questioning of criminal suspects** is a specialist task which calls for specific training if it is to be performed in a satisfactory manner. First and foremost, *the precise aim of such questioning* must be made crystal clear: that aim should be to obtain accurate and reliable information in order to discover the truth about matters under investigation, not to obtain a confession from someone already presumed, in the eyes of the interviewing officers, to be guilty. In addition to the provision of appropriate training, ensuring adherence of law enforcement officials to the above-mentioned aim will be greatly facilitated by the drawing up of a code of conduct for the questioning of criminal suspects.

35. Over the years, CPT delegations have spoken to a considerable number of detained persons in various countries, who have made credible claims of having been physically ill-treated, or otherwise intimidated or threatened, by police officers trying to obtain confessions in the course of interrogations. It is self-evident that a criminal justice system which places a premium on *confession evidence* creates incentives for officials involved in the investigation of crime - and often under pressure to obtain results - to use physical or psychological coercion. In the context of the prevention of torture and other forms of ill-treatment, it is of fundamental importance to develop methods of crime investigation capable of reducing reliance on confessions, and other evidence and information obtained via interrogations, for the purpose of securing convictions.

36. The **electronic (i.e. audio and/or video) recording of police interviews** represents an important additional safeguard against the ill-treatment of detainees. The CPT is pleased to note that the introduction of such systems is under consideration in an increasing number of countries. Such a facility can provide a complete and authentic record of the interview process, thereby greatly facilitating the investigation of any allegations of ill-treatment. This is in the interest both of persons who have been ill-treated by the police and of police officers confronted with unfounded allegations that they have engaged in physical ill-treatment or psychological pressure. Electronic recording of police interviews also reduces the opportunity for defendants to later falsely deny that they have made certain admissions.

37. The CPT has on more than one occasion, in more than one country, discovered **interrogation rooms** of a highly intimidating nature: for example, rooms entirely decorated in black and equipped with spotlights directed at the seat used by the person undergoing interrogation. Facilities of this kind have no place in a police service.

In addition to being adequately lit, heated and ventilated, interview rooms should allow for all participants in the interview process to be seated on chairs of a similar style and standard of comfort. The interviewing officer should not be placed in a dominating (e.g. elevated) or remote position vis-à-vis the suspect. Further, colour schemes should be neutral.

38. In certain countries, the CPT has encountered the practice of **blindfolding** persons in police custody, in particular during periods of questioning. CPT delegations have received various - and often contradictory - explanations from police officers as regards the purpose of this practice. From the information gathered over the years, it is clear to the CPT that in many if not most cases, persons are blindfolded in order to prevent them from being able to identify law enforcement officials who inflict ill-treatment upon them. Even in cases when no physical ill-treatment occurs, to blindfold a person in custody - and in particular someone undergoing questioning - is a form of oppressive conduct, the effect of which on the person concerned will frequently amount to psychological ill-treatment. The CPT recommends that the blindfolding of persons who are in police custody be expressly prohibited.

39. It is not unusual for the CPT to find **suspicious objects** on police premises, such as wooden sticks, broom handles, baseball bats, metal rods, pieces of thick electric cable, imitation firearms or knives. The presence of such objects has on more than one occasion lent credence to allegations received by CPT delegations that the persons held in the establishments concerned have been threatened and/or struck with objects of this kind.

A common explanation received from police officers concerning such objects is that they have been confiscated from suspects and will be used as evidence. The fact that the objects concerned are invariably unlabelled, and frequently are found scattered around the premises (on occasion placed behind curtains or cupboards), can only invite scepticism as regards that explanation. In order to dispel speculation about improper conduct on the part of police officers and to remove potential sources of danger to staff and detained persons alike, items seized for the purpose of being used as evidence should always be properly labelled, recorded and kept in a dedicated property store. All other objects of the kind mentioned above should be removed from police premises.

40. As from the outset of its activities, the CPT has advocated a trinity of rights for persons detained by the police: **the rights of access to a lawyer and to a doctor and the right to have the fact of one's detention notified to a relative or another third party of one's choice**. In many States, steps have been taken to introduce or reinforce these rights, in the light of the CPT's recommendations. More specifically, the right of access to a lawyer during police custody is now widely recognised in countries visited by the CPT; in those few countries where the right does not yet exist, plans are afoot to introduce it.

41. However, in a number of countries, there is considerable reluctance to comply with the CPT's recommendation that the right of **access to a lawyer**[1] be guaranteed from the very outset of custody. In some countries, persons detained by the police enjoy this right only after a specified period of time spent in custody; in others, the right only becomes effective when the person detained is formally declared a "suspect".

The CPT has repeatedly stressed that, in its experience, the period immediately following deprivation of liberty is when the risk of intimidation and physical ill-treatment is greatest. Consequently, the possibility for persons taken into police custody to have access to a lawyer during that period is a fundamental safeguard against ill-treatment. The existence of that possibility will have a dissuasive effect upon those minded to ill treat detained persons; further, a lawyer is well placed to take appropriate action if ill-treatment actually occurs. The CPT recognises that in order to protect the legitimate interests of the police investigation, it may exceptionally be necessary to delay for a certain period a detained person's access to a lawyer of his choice. However, this should not result in the right of access to a lawyer being totally denied during the period in question. In such cases, access to another independent lawyer should be arranged.

The right of access to a lawyer must include the right to talk to him in private. The person concerned should also, in principle, be entitled to have a lawyer present during any interrogation conducted by the police. Naturally, this should not prevent the police from questioning a detained person on urgent matters, even in the absence of a lawyer (who may not be immediately available), nor rule out the replacement of a lawyer who impedes the proper conduct of an interrogation.

The CPT has also emphasised that the right of access to a lawyer should be enjoyed not only by criminal suspects but also by anyone who is under a legal obligation to attend - and stay at - a police establishment, e.g. as a "witness".

Further, for the right of access to a lawyer to be fully effective in practice, appropriate provision should be made for persons who are not in a position to pay for a lawyer.

42. Persons in police custody should have a formally recognised right of **access to a doctor**. In other words, a doctor should always be called without delay if a person requests a medical examination; police officers should not seek to filter such requests. Further, the right of access to a doctor should include the right of a person in custody to be examined, if the person concerned so wishes, by a doctor of his/her own choice (in addition to any medical examination carried out by a doctor called by the police).

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[1] The CPT has subsequently published a more detailed section on "access to a lawyer as a means of preventing ill-treatment"; see paragraphs 18-25 of the 21st General Report (CPT/Inf (2011) 28).

All medical examinations of persons in police custody must be conducted out of the hearing of law enforcement officials and, unless the doctor concerned requests otherwise in a particular case, out of the sight of such officials.

It is also important that persons who are released from police custody without being brought before a judge have the right to directly request a medical examination/certificate from a recognised forensic doctor.

43. A detained person's **right to have the fact of his/her detention notified to a third party** should in principle be guaranteed from the very outset of police custody. Of course, the CPT recognises that the exercise of this right might have to be made subject to certain exceptions, in order to protect the legitimate interests of the police investigation. However, such exceptions should be clearly defined and strictly limited in time, and resort to them should be accompanied by appropriate safeguards (e.g. any delay in notification of custody to be recorded in writing with the reasons therefor, and to require the approval of a senior police officer unconnected with the case or a prosecutor).

44. Rights for persons deprived of their liberty will be of little value if the persons concerned are unaware of their existence. Consequently, it is imperative that persons taken into police custody are **expressly informed of their rights** without delay and in a language which they understand. In order to ensure that this is done, a form setting out those rights in a straightforward manner should be systematically given to persons detained by the police at the very outset of their custody. Further, the persons concerned should be asked to sign a statement attesting that they have been informed of their rights.

45. The CPT has stressed on several occasions **the role of judicial and prosecuting authorities** as regards combatting ill-treatment by the police.

For example, all persons detained by the police whom it is proposed to remand to prison should be physically brought before the judge who must decide that issue ; there are still certain countries visited by the CPT where this does not occur. Bringing the person before the judge will provide a timely opportunity for a criminal suspect who has been ill-treated to lodge a complaint. Further, even in the absence of an express complaint, the judge will be able to take action in good time if there are other indications of ill-treatment (e.g. visible injuries; a person's general appearance or demeanour).

Naturally, the judge must take appropriate steps when there are indications that ill-treatment by the police may have occurred. In this regard, whenever criminal suspects brought before a judge at the end of police custody allege ill-treatment, the judge should record the allegations in writing, order immediately a forensic medical examination and take the necessary steps to ensure that the allegations are properly investigated. Such an approach should be followed whether or not the person concerned bears visible external injuries. Further, even in the absence of an express allegation of ill-treatment, the judge should request a forensic medical examination whenever there are other grounds to believe that a person brought before him could have been the victim of ill-treatment.

The diligent examination by judicial and other relevant authorities of all complaints of ill-treatment by law enforcement officials and, where appropriate, the imposition of a suitable penalty will have a strong deterrent effect. Conversely, if those authorities do not take effective action upon complaints referred to them, law enforcement officials minded to ill-treat persons in their custody will quickly come to believe that they can do so with impunity.

46. **Additional questioning by the police of persons remanded to prison** may on occasion be necessary. The CPT is of the opinion that from the standpoint of the prevention of ill-treatment, it would be far preferable for such questioning to take place within the prison establishment concerned rather than on police premises. The return of remand prisoners to police custody for further questioning should only be sought and authorised when it is absolutely unavoidable. It is also axiomatic that in those exceptional circumstances where a remand prisoner is returned to the custody of the police, he/she should enjoy the three rights referred to in paragraphs 40 to 43.

47. Police custody is (or at least should be) of relatively short duration. Nevertheless, **conditions of detention in police cells** must meet certain *basic requirements*.

All police cells should be clean and of a reasonable size[1] for the number of persons they are used to accommodate, and have adequate lighting (i.e. sufficient to read by, sleeping periods excluded) ; preferably cells should enjoy natural light. Further, cells should be equipped with a means of rest (e.g. a fixed chair or bench), and persons obliged to stay overnight in custody should be provided with a clean mattress and clean blankets. Persons in police custody should have access to a proper toilet facility under decent conditions, and be offered adequate means to wash themselves. They should have ready access to drinking water and be given food at appropriate times , including at least one full meal (i.e. something more substantial than a sandwich) every day. Persons held in police custody for 24 hours or more should, as far as possible , be offered outdoor exercise every day.

Many police detention facilities visited by CPT delegations do not comply with these minimal standards. This is particularly detrimental for persons who subsequently appear before a judicial authority ; all too frequently persons are brought before a judge after spending one or more days in substandard and filthy cells, without having been offered appropriate rest and food and an opportunity to wash.

48. The duty of care which is owed by the police to persons in their custody includes the responsibility to ensure their *safety and physical integrity*. It follows that the proper monitoring of custody areas is an integral component of the duty of care assumed by the police. Appropriate steps must be taken to ensure that persons in police custody are always in a position to readily enter into contact with custodial staff.

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[1] As regards the size of police cells, see also paragraph 43 of the 2nd General Report (CPT/Inf (92) 3).

On a number of occasions CPT delegations have found that police cells were far removed from the offices or desks where police officers are normally present, and were also devoid of any means (e.g. a call system) enabling detained persons to attract the attention of a police officer. Under such conditions, there is considerable risk that incidents of various kinds (violence among detainees; suicide attempts; fires etc.) will not be responded to in good time.

49. The CPT has also expressed misgivings as regards the practice observed in certain countries of each operational department (narcotics, organised crime, anti-terrorism) in a police establishment having its own detention facility staffed by officers from that department. The Committee considers that such an approach should be discarded in favour of a *central detention facility*, staffed by a distinct corps of officers specifically trained for such a custodial function. This would almost certainly prove beneficial from the standpoint of the prevention of ill-treatment. Further, relieving individual operational departments of custodial duties might well prove advantageous from the management and logistical perspectives.

50. Finally, the **inspection of police establishments by an independent authority** can make an important contribution towards the prevention of ill-treatment of persons held by the police and, more generally, help to ensure satisfactory conditions of detention. To be fully effective, visits by such an authority should be both regular and unannounced, and the authority concerned should be empowered to interview detained persons in private. Further, it should examine all issues related to the treatment of persons in custody: the recording of detention; information provided to detained persons on their rights and the actual exercise of those rights (in particular the three rights referred to in paragraphs 40 to 43); compliance with rules governing the questioning of criminal suspects; and material conditions of detention.

The findings of the above-mentioned authority should be forwarded not only to the police but also to another authority which is independent of the police.

Access to a lawyer as a means of preventing ill-treatment

Extract from the 21st General Report [CPT/Inf (2011) 28]

18. The possibility for persons taken into police custody to have access to a lawyer is a fundamental safeguard against ill-treatment. The existence of that possibility will have a dissuasive effect upon those minded to ill-treat detained persons. Further, a lawyer is well placed to take appropriate action if ill-treatment actually occurs.

19. To be fully effective, the right of access to a lawyer should be guaranteed as from the very outset of a person's deprivation of liberty[1]. Indeed, the CPT has repeatedly found that the period immediately following deprivation of liberty is when the risk of intimidation and physical ill-treatment is greatest. Further, the right of access to a lawyer should apply as of the moment of deprivation of liberty, irrespective of the precise legal status of the person concerned; more specifically, enjoyment of the right should not be made dependent on the person having been formally declared to be a "suspect". For example, under many legal systems in Europe, persons can be obliged to attend – and stay at – a law enforcement establishment for a certain period of time in the capacity of a "witness" or for "informative talks"; the CPT knows from experience that the persons concerned can be at serious risk of ill-treatment.

20. The right of access to a lawyer should be enjoyed by everyone who is deprived of their liberty, no matter how "minor" the offence of which they are suspected. In numerous countries visited by the CPT, persons can be deprived of their liberty for several weeks for so-called "administrative" offences. The Committee can see no justification for depriving such persons of the right of access to a lawyer. Further, the Committee has frequently encountered the practice of persons who are in reality suspected of a criminal offence being formally detained in relation to an administrative offence, so as to avoid the application of the safeguards that apply to criminal suspects; to exclude certain offences from the scope of the right of access to a lawyer inevitably brings with it the risk of loopholes of this kind developing.

21. Similarly, the right of access to a lawyer should apply, no matter how "serious" the offence of which the person detained is suspected. Indeed, persons suspected of particularly serious offences can be among those most at risk of ill-treatment, and therefore most in need of access to a lawyer. Consequently, the CPT opposes measures which provide for the systematic denial for a given period of access to a lawyer for detained persons who are suspected of certain categories of offences (e.g. offences under anti-terrorism legislation). The question whether restrictions on the right of access to a lawyer are justified should be assessed on a case-by-case basis, not determined by the category of offence involved.[2]

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[1] Of course, depending on the circumstances of the case concerned, the right of access to a lawyer may become operative at an even earlier stage.

[2] Reference might be made here to the judgment of the European Court of Human Rights in the

22. The CPT fully recognises that it may exceptionally be necessary to delay for a certain period a detained person's access to a lawyer of his choice. However, this should not result in the right of access to a lawyer being totally denied during the period in question. In such cases, access to another independent lawyer who can be trusted not to jeopardise the legitimate interests of the investigation should be organised. It is perfectly feasible to make satisfactory arrangements in advance for this type of situation, in consultation with the local Bar Association or Law Society.

23. The right of access to a lawyer during police custody must include the right to meet him, and in private. Seen as a safeguard against ill-treatment (as distinct from a means of ensuring a fair trial), it is clearly essential for the lawyer to be in the direct physical presence of the detained person. This is the only way of being able to make an accurate assessment of the physical and psychological state of the person concerned. Likewise, if the meeting with the lawyer is not in private, the detained person may well not feel free to disclose the manner in which he is being treated. Once it has been accepted that exceptionally the lawyer in question may not be a lawyer chosen by the detained person but instead a replacement lawyer chosen following a procedure agreed upon in advance, the CPT fails to see any need for derogations to the confidentiality of meetings between the lawyer and the person concerned.

24. The right of access to a lawyer should also include the right to have the lawyer present during any questioning conducted by the police and the lawyer should be able to intervene in the course of the questioning. Naturally, this should not prevent the police from immediately starting to question a detained person who has exercised his right of access to a lawyer, even before the lawyer arrives, if this is warranted by the extreme urgency of the matter in hand; nor should it rule out the replacement of a lawyer who impedes the proper conduct of an interrogation. That said, if such situations arise, the police should subsequently be accountable for their action.

25. Finally, in order for the right of access to a lawyer during police custody to be fully effective in practice, appropriate provision should be made already at this early stage of the criminal procedure for persons who are not in a position to pay for a lawyer.

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case of *Salduz v.Turkey* (27 November 2008), in which the Court found that "… Article 6§1 [of the European Convention on Human Rights] requires that, as a rule, access to a lawyer should be provided…, unless it is demonstrated in the light of the particular circumstances of each case that there are compelling reasons to restrict this right." (paragraph 55).

II. Prisons

Imprisonment

Extract from the 2nd General Report [CPT/Inf (92) 3]

44. In introduction, it should be emphasised that the CPT must examine many questions when visiting a prison. Of course, it pays special attention to any allegations of ill-treatment of prisoners by staff. However, all aspects of the conditions of detention in a prison are of relevance to the CPT's mandate. Ill-treatment can take numerous forms, many of which may not be deliberate but rather the result of organisational failings or inadequate resources. The overall quality of life in an establishment is therefore of considerable importance to the CPT. That quality of life will depend to a very large extent upon the activities offered to prisoners and the general state of relations between prisoners and staff.

45. The CPT observes carefully the prevailing climate within an establishment. The promotion of constructive as opposed to confrontational relations between prisoners and staff will serve to lower the tension inherent in any prison environment and by the same token significantly reduce the likelihood of violent incidents and associated ill-treatment. In short, the CPT wishes to see a spirit of communication and care accompany measures of control and containment. Such an approach, far from undermining security in the establishment, might well enhance it.

46. Overcrowding is an issue of direct relevance to the CPT's mandate. All the services and activities within a prison will be adversely affected if it is required to cater for more prisoners than it was designed to accommodate; the overall quality of life in the establishment will be lowered, perhaps significantly. Moreover, the level of overcrowding in a prison, or in a particular part of it, might be such as to be in itself inhuman or degrading from a physical standpoint.

47. A satisfactory programme of activities (work, education, sport, etc.) is of crucial importance for the well-being of prisoners. This holds true for all establishments, whether for sentenced prisoners or those awaiting trial. The CPT has observed that activities in many remand prisons are extremely limited. The organisation of regime activities in such establishments - which have a fairly rapid turnover of inmates - is not a straightforward matter. Clearly, there can be no question of individualised treatment programmes of the sort which might be aspired to in an establishment for sentenced prisoners. However, prisoners cannot simply be left to languish for weeks, possibly months, locked up in their cells, and this regardless of how good material conditions might be within the cells. The CPT considers that one should aim at ensuring that prisoners in remand establishments are able to spend a reasonable part of the day (8 hours or more) outside their cells, engaged in purposeful activity of a varied nature. Of course, regimes in establishments for sentenced prisoners should be even more favourable.

48. Specific mention should be made of outdoor exercise. The requirement that prisoners be allowed at least one hour of exercise in the open air every day is widely accepted as a basic safeguard (preferably it should form part of a broader programme of activities). The CPT wishes to emphasise that **all prisoners without exception** (including those undergoing cellular confinement as a punishment) should be offered the possibility to take outdoor exercise daily. It is also axiomatic that outdoor exercise facilities should be reasonably spacious and whenever possible offer shelter from inclement weather.

49. Ready access to proper toilet facilities and the maintenance of good standards of hygiene are essential components of a humane environment.

In this connection, the CPT must state that it does not like the practice found in certain countries of prisoners discharging human waste in buckets in their cells (which are subsequently "slopped out" at appointed times). Either a toilet facility should be located in cellular accommodation (preferably in a sanitary annex) or means should exist enabling prisoners who need to use a toilet facility to be released from their cells without undue delay at all times (including at night).

Further, prisoners should have adequate access to shower or bathing facilities. It is also desirable for running water to be available within cellular accommodation.

50. The CPT would add that it is particularly concerned when it finds a combination of overcrowding, poor regime activities and inadequate access to toilet/washing facilities in the same establishment. The cumulative effect of such conditions can prove extremely detrimental to prisoners.

51. It is also very important for prisoners to maintain reasonably good contact with the outside world. Above all, a prisoner must be given the means of safeguarding his relationships with his family and close friends. The guiding principle should be the promotion of contact with the outside world; any limitations upon such contact should be based exclusively on security concerns of an appreciable nature or resource considerations.

The CPT wishes to emphasise in this context the need for some flexibility as regards the application of rules on visits and telephone contacts vis-à-vis prisoners whose families live far away (thereby rendering regular visits impracticable). For example, such prisoners could be allowed to accumulate visiting time and/or be offered improved possibilities for telephone contacts with their families.

52. Naturally, the CPT is also attentive to the particular problems that might be encountered by certain specific categories of prisoners, for example: women, juveniles and foreigners.

53. Prison staff will on occasion have to use force to control violent prisoners and, exceptionally, may even need to resort to instruments of physical restraint. These are clearly high risk situations insofar as the possible ill-treatment of prisoners is concerned, and as such call for specific safeguards.

A prisoner against whom any means of force have been used should have the right to be immediately examined and, if necessary, treated by a medical doctor. This examination should be conducted out of the hearing and preferably out of the sight of non-medical staff, and the results of the examination (including any relevant statements by the prisoner and the doctor's conclusions) should be formally recorded and made available to the prisoner. In those rare cases when resort to instruments of physical restraint is required, the prisoner concerned should be kept under constant and adequate supervision. Further, instruments of restraint should be removed at the earliest possible opportunity; they should never be applied, or their application prolonged, as a punishment. Finally, a record should be kept of every instance of the use of force against prisoners.

54. Effective grievance and inspection procedures are fundamental safeguards against ill-treatment in prisons. Prisoners should have avenues of complaint open to them both within and outside the context of the prison system, including the possibility to have confidential access to an appropriate authority. The CPT attaches particular importance to regular visits to each prison establishment by an independent body (eg. a Board of visitors or supervisory judge) possessing powers to hear (and if necessary take action upon) complaints from prisoners and to inspect the establishment's premises. Such bodies can inter alia play an important role in bridging differences that arise between prison management and a given prisoner or prisoners in general.

55. It is also in the interests of both prisoners and prison staff that clear disciplinary procedures be both formally established and applied in practice; any grey zones in this area involve the risk of seeing unofficial (and uncontrolled) systems developing. Disciplinary procedures should provide prisoners with a right to be heard on the subject of the offences it is alleged they have committed, and to appeal to a higher authority against any sanctions imposed.

Other procedures often exist, alongside the formal disciplinary procedure, under which a prisoner may be involuntarily separated from other inmates for discipline-related/security reasons (eg. in the interests of "good order" within an establishment). These procedures should also be accompanied by effective safeguards. The prisoner should be informed of the reasons for the measure taken against him, unless security requirements dictate otherwise[1], be given an opportunity to present his views on the matter, and be able to contest the measure before an appropriate authority.

[1] This requirement has subsequently been reformulated as follows: the prisoner should be informed in writing of the reasons for the measure taken against him (it being understood that the reasons given might not include details which security requirements justify withholding from the prisoner).

56. The CPT pays particular attention to prisoners held, for whatever reason (for disciplinary purposes; as a result of their "dangerousness" or their "troublesome" behaviour; in the interests of a criminal investigation; at their own request), under conditions akin to solitary confinement.

The principle of proportionality requires that a balance be struck between the requirements of the case and the application of a solitary confinement-type regime, which is a step that can have very harmful consequences for the person concerned. Solitary confinement can, in certain circumstances, amount to inhuman and degrading treatment; in any event, all forms of solitary confinement should be as short as possible.

In the event of such a regime being imposed or applied on request, an essential safeguard is that whenever the prisoner concerned, or a prison officer on the prisoner's behalf, requests a medical doctor, such a doctor should be called without delay with a view to carrying out a medical examination of the prisoner. The results of this examination, including an account of the prisoner's physical and mental condition as well as, if need be, the foreseeable consequences of continued isolation, should be set out in a written statement to be forwarded to the competent authorities.

57. The transfer of troublesome prisoners is another practice of interest to the CPT. Certain prisoners are extremely difficult to handle, and the transfer of such a prisoner to another establishment can sometimes prove necessary. However, the continuous moving of a prisoner from one establishment to another can have very harmful effects on his psychological and physical well being. Moreover, a prisoner in such a position will have difficulty in maintaining appropriate contacts with his family and lawyer. The overall effect on the prisoner of successive transfers could under certain circumstances amount to inhuman and degrading treatment.

* * *

59. Finally, the CPT wishes to emphasise the great importance it attaches to the training of law enforcement personnel[1] (which should include education on human rights matters - cf. also Article 10 of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment). There is arguably no better guarantee against the ill-treatment of a person deprived of his liberty than a properly trained police or prison officer. Skilled officers will be able to carry out successfully their duties without having recourse to ill-treatment and to cope with the presence of fundamental safeguards for detainees and prisoners.

[1] The expression "law enforcement personnel" in this report includes both police and prison officers.

60. In this connection, the CPT believes that aptitude for interpersonal communication should be a major factor in the process of recruiting law enforcement personnel and that, during training, considerable emphasis should be placed on developing interpersonal communication skills, based on respect for human dignity. The possession of such skills will often enable a police or prison officer to defuse a situation which could otherwise turn into violence, and more generally, will lead to a lowering of tension, and raising of the quality of life, in police and prison establishments, to the benefit of all concerned.[1]

Extract from the 7th General Report [CPT/Inf (97) 10]

12. In the course of several of its visits during 1996, the CPT once again encountered the evils of **prison overcrowding**, a phenomenon which blights penitentiary systems across Europe. Overcrowding is often particularly acute in prisons used to accommodate remand prisoners (i.e. persons awaiting trial); however, the CPT has found that in some countries the problem has spread throughout the prison system.

13. As the CPT pointed out in its 2nd General Report, prison overcrowding is an issue of direct relevance to the Committee's mandate (cf. CPT/Inf (92) 3, paragraph 46).

An overcrowded prison entails cramped and unhygienic accommodation; a constant lack of privacy (even when performing such basic tasks as using a sanitary facility); reduced out-of-cell activities, due to demand outstripping the staff and facilities available; overburdened health-care services; increased tension and hence more violence between prisoners and between prisoners and staff. This list is far from exhaustive.

The CPT has been led to conclude on more than one occasion that the adverse effects of overcrowding have resulted in inhuman and degrading conditions of detention.

14. To address the problem of overcrowding, some countries have taken the route of increasing the number of prison places. For its part, the CPT is far from convinced that providing additional accommodation will alone offer a lasting solution. Indeed, a number of European States have embarked on extensive programmes of prison building, only to find their prison populations rising in tandem with the increased capacity acquired by their prison estates. By contrast, the existence of policies to limit or modulate the number of persons being sent to prison has in certain States made an important contribution to maintaining the prison population at a manageable level.

[1] The CPT also encourages national authorities to seek to integrate human rights concepts into practical professional training for handling high-risk situations such as the apprehension and interrogation of criminal suspects; this will prove more effective than seperate courses on human rights.

15. The problem of prison overcrowding is sufficiently serious as to call for cooperation at European level, with a view to devising counter strategies. Consequently, the CPT was most pleased to learn that work on this subject has recently begun within the framework of the European Committee on Crime Problems (CDPC). The CPT hopes that the successful conclusion of that work will be treated as a priority.[1]

Extract from the 11th General Report [CPT/Inf (2001) 16]

Staff-prisoner relations

26. The cornerstone of a humane prison system will always be properly recruited and trained prison staff who know how to adopt the appropriate attitude in their relations with prisoners and see their work more as a vocation than as a mere job. Building positive relations with prisoners should be recognised as a key feature of that vocation.

Regrettably, the CPT often finds that relations between staff and prisoners are of a formal and distant nature, with staff adopting a regimented attitude towards prisoners and regarding verbal communication with them as a marginal aspect of their work. The following practices frequently witnessed by the CPT are symptomatic of such an approach: obliging prisoners to stand facing a wall whilst waiting for prison staff to attend to them or for visitors to pass by; requiring prisoners to bow their heads and keep their hands clasped behind their back when moving within the establishment; custodial staff carrying their truncheons in a visible and even provocative manner. Such practices are unnecessary from a security standpoint and will do nothing to promote positive relations between staff and prisoners.

The real professionalism of prison staff requires that they should be able to deal with prisoners in a decent and humane manner while paying attention to matters of security and good order. In this regard prison management should encourage staff to have a reasonable sense of trust and expectation that prisoners are willing to behave themselves properly. The development of constructive and positive relations between prison staff and prisoners will not only reduce the risk of ill-treatment but also enhance control and security. In turn, it will render the work of prison staff far more rewarding.

Ensuring positive staff-inmate relations will also depend greatly on having an adequate number of staff present at any given time in detention areas and in facilities used by prisoners for activities. CPT delegations often find that this is not the case. An overall low staff complement and/or specific staff attendance systems which diminish the possibilities of direct contact with prisoners, will certainly impede the development of positive relations; more generally, they will generate an insecure environment for both staff and prisoners.

[1] On 30 September 1999, the Committee of Ministers of the Council of Europe adopted Recommendation No. R (99) 22 concerning prison overcrowding and prison population inflation.

It should also be noted that, where staff complements are inadequate, significant amounts of overtime can prove necessary in order to maintain a basic level of security and regime delivery in the establishment. This state of affairs can easily result in high levels of stress in staff and their premature burnout, a situation which is likely to exacerbate the tension inherent in any prison environment.

Inter-prisoner violence

27. The duty of care which is owed by custodial staff to those in their charge includes the responsibility to protect them from other inmates who wish to cause them harm. In fact, violent incidents among prisoners are a regular occurrence in all prison systems; they involve a wide range of phenomena, from subtle forms of harassment to unconcealed intimidation and serious physical attacks.

Tackling the phenomenon of inter-prisoner violence requires that prison staff be placed in a position, including in terms of staffing levels, to exercise their authority and their supervisory tasks in an appropriate manner. Prison staff must be alert to signs of trouble and be both resolved and properly trained to intervene when necessary. The existence of positive relations between staff and prisoners, based on the notions of secure custody and care, is a decisive factor in this context; this will depend in large measure on staff possessing appropriate interpersonal communication skills. Further, management must be prepared fully to support staff in the exercise of their authority. Specific security measures adapted to the particular characteristics of the situation encountered (including effective search procedures) may well be required; however, such measures can never be more than an adjunct to the above-mentioned basic imperatives. In addition, the prison system needs to address the issue of the appropriate classification and distribution of prisoners.

Prisoners suspected or convicted of sexual offences are at a particularly high risk of being assaulted by other prisoners. Preventing such acts will always pose a difficult challenge. The solution that is often adopted is to separate such prisoners from the rest of the prison population. However, the prisoners concerned may pay a heavy price for their – relative – security, in terms of much more limited activities programmes than those available under the normal prison regime. Another approach is to disperse prisoners suspected or convicted of sexual offences throughout the prison concerned. If such an approach is to succeed, the necessary environment for the proper integration of such prisoners into ordinary cell blocks must be guaranteed; in particular, the prison staff must be sincerely committed to dealing firmly with any signs of hostility or persecution. A third approach can consist of transferring prisoners to another establishment, accompanied by measures aimed at concealing the nature of their offence. Each of these policies has its advantages and disadvantages, and the CPT does not seek to promote a given approach as opposed to another. Indeed, the decision on which policy to apply will mainly depend on the particular circumstances of each case.

Prison overcrowding

28. The phenomenon of prison overcrowding continues to blight penitentiary systems across Europe and seriously undermines attempts to improve conditions of detention. The negative effects of prison overcrowding have already been highlighted in previous General Reports.[1] As the CPT's field of operations has extended throughout the European continent, the Committee has encountered huge incarceration rates and resultant severe prison overcrowding. The fact that a State locks up so many of its citizens cannot be convincingly explained away by a high crime rate; the general outlook of members of the law enforcement agencies and the judiciary must, in part, be responsible.

In such circumstances, throwing increasing amounts of money at the prison estate will not offer a solution. Instead, current law and practice in relation to custody pending trial and sentencing as well as the range of non-custodial sentences available need to be reviewed. This is precisely the approach advocated in Committee of Ministers Recommendation N° R (99) 22 on prison overcrowding and prison population inflation. The CPT very much hopes that the principles set out in that important text will indeed be applied by member States; the implementation of this Recommendation deserves to be closely monitored by the Council of Europe.

Large capacity dormitories

29. In a number of countries visited by the CPT, particularly in central and eastern Europe, inmate accommodation often consists of large capacity dormitories which contain all or most of the facilities used by prisoners on a daily basis, such as sleeping and living areas as well as sanitary facilities. The CPT has objections to the very principle of such accommodation arrangements in closed prisons and those objections are reinforced when, as is frequently the case, the dormitories in question are found to hold prisoners under extremely cramped and insalubrious conditions. No doubt, various factors - including those of a cultural nature - can make it preferable in certain countries to provide multi-occupancy accommodation for prisoners rather than individual cells. However, there is little to be said in favour of - and a lot to be said against - arrangements under which tens of prisoners live and sleep together in the same dormitory.

Large-capacity dormitories inevitably imply a lack of privacy for prisoners in their everyday lives. Moreover, the risk of intimidation and violence is high. Such accommodation arrangements are prone to foster the development of offender subcultures and to facilitate the maintenance of the cohesion of criminal organisations. They can also render proper staff control extremely difficult, if not impossible; more specifically, in case of prison disturbances, outside interventions involving the use of considerable force are difficult to avoid. With such accommodation, the appropriate allocation of individual prisoners, based on a case by case risk and needs assessment, also becomes an almost impossible exercise. All these problems

[1] 2nd General Report - CPT/Inf (92) 3, paragraph 4, and 7th General Report - CPT/Inf (97) 10, paragraphs 12-15.

are exacerbated when the numbers held go beyond a reasonable occupancy level; further, in such a situation the excessive burden on communal facilities such as washbasins or lavatories and the insufficient ventilation for so many persons will often lead to deplorable conditions.

The CPT must nevertheless stress that moves away from large-capacity dormitories towards smaller living units have to be accompanied by measures to ensure that prisoners spend a reasonable part of the day engaged in purposeful activities of a varied nature outside their living unit.

Access to natural light and fresh air

30. The CPT frequently encounters devices, such as metal shutters, slats, or plates fitted to cell windows, which deprive prisoners of access to natural light and prevent fresh air from entering the accommodation. They are a particularly common feature of establishments holding pre-trial prisoners. The CPT fully accepts that specific security measures designed to prevent the risk of collusion and/or criminal activities may well be required in respect of certain prisoners. However, the imposition of measures of this kind should be the exception rather than the rule. This implies that the relevant authorities must examine the case of each prisoner in order to ascertain whether specific security measures are really justified in his/her case. Further, even when such measures are required, they should never involve depriving the prisoners concerned of natural light and fresh air. The latter are basic elements of life which every prisoner is entitled to enjoy; moreover, the absence of these elements generates conditions favourable to the spread of diseases and in particular tuberculosis.

The CPT recognises that the delivery of decent living conditions in penitentiary establishments can be very costly and improvements are hampered in many countries by lack of funds. However, removing devices blocking the windows of prisoner accommodation (and fitting, in those exceptional cases where this is necessary, alternative security devices of an appropriate design) should not involve considerable investment and, at the same time, would be of great benefit for all concerned.

Transmissible diseases

31. The spread of transmissible diseases and, in particular, of tuberculosis, hepatitis and HIV/AIDS has become a major public health concern in a number of European countries. Although affecting the population at large, these diseases have emerged as a dramatic problem in certain prison systems. In this connection the CPT has, on a number of occasions, been obliged to express serious concerns about the inadequacy of the measures taken to tackle this problem. Further, material conditions under which prisoners are held have often been found to be such that they can only favour the spread of these diseases.

The CPT is aware that in periods of economic difficulties - such as those encountered today in many countries visited by the CPT - sacrifices have to be made, including in penitentiary establishments. However, regardless of the difficulties faced at any given time, the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment. Compliance with this duty by public authorities is all the more important when it is a question of care required to treat life-threatening diseases.

The use of up-to date methods for screening, the regular supply of medication and related materials, the availability of staff ensuring that prisoners take the prescribed medicines in the right doses and at the right intervals, and the provision when appropriate of special diets, constitute essential elements of an effective strategy to combat the above-mentioned diseases and to provide appropriate care to the prisoners concerned. Similarly, material conditions in accommodation for prisoners with transmissible diseases must be conducive to the improvement of their health; in addition to natural light and good ventilation, there must be satisfactory hygiene as well as an absence of overcrowding.

Further, the prisoners concerned should not be segregated from the rest of the prison population unless this is strictly necessary on medical or other grounds. In this connection, the CPT wishes to stress in particular that there is no medical justification for the segregation of prisoners solely on the grounds that they are HIV-positive.

In order to dispel misconceptions on these matters, it is incumbent on national authorities to ensure that there is a full educational programme about transmissible diseases for both prisoners and prison staff. Such a programme should address methods of transmission and means of protection as well as the application of adequate preventive measures. More particularly, the risks of HIV or hepatitis B/C infection through sexual contacts and intravenous drug use should be highlighted and the role of body fluids as the carriers of HIV and hepatitis viruses explained.

It must also be stressed that appropriate information and counselling should be provided before and - in the case of a positive result - after any screening test. Further, it is axiomatic that patient-related information should be protected by medical confidentiality. As a matter of principle, any interventions in this area should be based on the informed consent of the persons concerned.

Moreover, for control of the above-mentioned diseases to be effective, all the ministries and agencies working in this field in a given country must ensure that they co-ordinate their efforts in the best possible way. In this respect the CPT wishes to stress that the continuation of treatment after release from prison must be guaranteed. [1]

[1] See also "Health care services in prisons", section "transmittable diseases".

High security units

32. In every country there will be a certain number of prisoners considered to present a particularly high security risk and hence to require special conditions of detention. The perceived high security risk of such prisoners may result from the nature of the offences they have committed, the manner in which they react to the constraints of life in prison, or their psychological/psychiatric profile. This group of prisoners will (or at least should, if the classification system is operating satisfactorily) represent a very small proportion of the overall prison population. However, it is a group that is of particular concern to the CPT, as the need to take exceptional measures vis-à-vis such prisoners brings with it a greater risk of inhuman treatment.

Prisoners who present a particularly high security risk should, within the confines of their detention units, enjoy a relatively relaxed regime by way of compensation for their severe custodial situation. In particular, they should be able to meet their fellow prisoners in the unit and be granted a good deal of choice about activities. Special efforts should be made to develop a good internal atmosphere within high-security units. The aim should be to build positive relations between staff and prisoners. This is in the interests not only of the humane treatment of the unit's occupants but also of the maintenance of effective control and security and of staff safety.

The existence of a satisfactory programme of activities is just as important - if not more so - in a high security unit than on normal location. It can do much to counter the deleterious effects upon a prisoner's personality of living in the bubble-like atmosphere of such a unit. The activities provided should be as diverse as possible (education, sport, work of vocational value, etc.). As regards, in particular, work activities, it is clear that security considerations may preclude many types of work which are found on normal prison location. Nevertheless, this should not mean that only work of a tedious nature is provided for prisoners.

It is axiomatic that prisoners should not be subject to a special security regime any longer than the risk they present makes necessary. This calls for regular reviews of placement decisions. Such reviews should always be based on the continuous assessment of the individual prisoner by staff specially trained to carry out such assessment. Moreover, prisoners should as far as possible be kept fully informed of the reasons for their placement and, if necessary, its renewal; this will inter alia enable them to make effective use of avenues for challenging that measure.

Life-sentenced and other long-term prisoners

33. In many European countries the number of life-sentenced and other long-term prisoners is on the increase. During some of its visits, the CPT has found that the situation of such prisoners left much to be desired in terms of material conditions, activities and possibilities for human contact. Further, many such prisoners were subject to special restrictions likely to exacerbate the deleterious effects inherent in long-term imprisonment; examples of such restrictions are permanent separation from the rest of the prison population, handcuffing whenever the prisoner is taken out of his cell, prohibition of communication with other prisoners, and limited visit entitlements. The CPT can see no justification for indiscriminately applying restrictions to all prisoners subject to a specific type of sentence, without giving due consideration to the individual risk they may (or may not) present.

Long-term imprisonment can have a number of desocialising effects upon inmates. In addition to becoming institutionalised, long-term prisoners may experience a range of psychological problems (including loss of self-esteem and impairment of social skills) and have a tendency to become increasingly detached from society; to which almost all of them will eventually return. In the view of the CPT, the regimes which are offered to prisoners serving long sentences should seek to compensate for these effects in a positive and proactive way.

The prisoners concerned should have access to a wide range of purposeful activities of a varied nature (work, preferably with vocational value; education; sport; recreation/association). Moreover, they should be able to exercise a degree of choice over the manner in which their time is spent, thus fostering a sense of autonomy and personal responsibility. Additional steps should be taken to lend meaning to their period of imprisonment; in particular, the provision of individualised custody plans and appropriate psycho-social support are important elements in assisting such prisoners to come to terms with their period of incarceration and, when the time comes, to prepare for release. Further, the negative effects of institutionalisation upon prisoners serving long sentences will be less pronounced, and they will be better equipped for release, if they are able effectively to maintain contact with the outside world.

Solitary confinement of prisoners

Extract from the 21st General Report [CPT/Inf (2011) 28]

Introduction

53. Solitary confinement of prisoners is found, in some shape or form, in every prison system. The CPT has always paid particular attention to prisoners undergoing solitary confinement, because it can have an extremely damaging effect on the mental, somatic and social health of those concerned.[1]

This damaging effect can be immediate and increases the longer the measure lasts and the more indeterminate it is. The most significant indicator of the damage which solitary confinement can inflict is the considerably higher rate of suicide among prisoners subjected to it than that among the general prison population. Clearly, therefore, solitary confinement on its own potentially raises issues in relation to the prohibition of torture and inhuman or degrading treatment or punishment. In addition, it can create an opportunity for deliberate ill-treatment of prisoners, away from the attention of other prisoners and staff. Accordingly, it is central to the concerns of the CPT and, on each visit, delegations make a point of interviewing prisoners in solitary confinement in order to examine their conditions of detention and treatment and to check the procedures for deciding on such placements and reviewing them. In this section of its General Report, the CPT sets out the criteria it uses when assessing solitary confinement. The Committee believes that if these criteria are followed, it should be possible to reduce resort to solitary confinement to an absolute minimum, to ensure that when it is used it is for the shortest necessary period of time, to make each of the solitary confinement regimes as positive as possible, and to guarantee that procedures are in place to render the use of this measure fully accountable.

54. The CPT understands the term "solitary confinement" as meaning whenever a prisoner is ordered to be held separately from other prisoners, for example, as a result of a court decision, as a disciplinary sanction imposed within the prison system, as a preventative administrative measure or for the protection of the prisoner concerned. A prisoner subject to such a measure will usually be held on his/her own; however, in some States he/she may be accommodated together with one or two other prisoners, and this section applies equally to such situations.

As regards more specifically the solitary confinement of juveniles, a practice concerning which the CPT has particularly strong reservations, reference should also be made to the comments made by the Committee in its 18th General Report.[2]

This section does not apply to the isolation of prisoners for medical reasons, as the grounds for such a measure are of a fundamentally different nature.

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[1] The research evidence for this is well summarised in Sharon Shalev's "A Sourcebook on Solitary Confinement" (Mannheim Centre for Criminology, London, 2008), available electronically at www.solitaryconfinement.org

[2] See CPT/Inf (2008) 25, paragraph 26.

The principles involved

55. Solitary confinement further restricts the already highly limited rights of people deprived of their liberty. The extra restrictions involved are not inherent in the fact of imprisonment and thus have to be separately justified. In order to test whether any particular imposition of the measure is justified, it is appropriate to apply the traditional tests enshrined in the provisions of the European Convention on Human Rights and developed by the case-law of the European Court of Human Rights. The simple mnemonic **PLANN** summarises these tests.

(a) Proportionate: any further restriction of a prisoner's rights must be linked to the actual or potential harm the prisoner has caused or will cause by his or her actions (or the potential harm to which he/she is exposed) in the prison setting. Given that solitary confinement is a serious restriction of a prisoner's rights which involves inherent risks to the prisoner, the level of actual or potential harm must be at least equally serious and uniquely capable of being addressed by this means. This is reflected, for example, in most countries having solitary confinement as a sanction only for the most serious disciplinary offences, but the principle must be respected in all uses of the measure. The longer the measure is continued, the stronger must be the reason for it and the more must be done to ensure that it achieves its purpose.

(b) Lawful: provision must be made in domestic law for each kind of solitary confinement which is permitted in a country, and this provision must be reasonable. It must be communicated in a comprehensible form to everyone who may be subject to it. The law should specify the precise circumstances in which each form of solitary confinement can be imposed, the persons who may impose it, the procedures to be followed by those persons, the right of the prisoner affected to make representations as part of the procedure, the requirement to give the prisoner the fullest possible reasons for the decision (it being understood that there might in certain cases be reasonable justification for withholding specific details on security-related grounds or in order to protect the interests of third parties), the frequency and procedure of reviews of the decision and the procedures for appealing against the decision. The regime for each type of solitary confinement should be established by law, with each of the regimes clearly differentiated from each other.

(c) Accountable: full records should be maintained of all decisions to impose solitary confinement and of all reviews of the decisions. These records should evidence all the factors which have been taken into account and the information on which they were based. There should also be a record of the prisoner's input or refusal to contribute to the decision-making process. Further, full records should be kept of all interactions with staff while the prisoner is in solitary confinement, including attempts by staff to engage with the prisoner and the prisoner's response.

(d) Necessary: the rule that only restrictions necessary for the safe and orderly confinement of the prisoner and the requirements of justice are permitted applies equally to prisoners undergoing solitary confinement. Accordingly, during solitary confinement there should, for example, be no automatic withdrawal of rights to visits, telephone calls and correspondence or of access to resources normally available to prisoners (such as reading materials). Equally, the regime should be flexible enough to permit relaxation of any restriction which is not necessary in individual cases.

(e) Non-discriminatory: not only must all relevant matters be taken into account in deciding to impose solitary confinement, but care must also be taken to ensure that irrelevant matters are not taken into account. Authorities should monitor the use of all forms of solitary confinement to ensure that they are not used disproportionately, without an objective and reasonable justification, against a particular prisoner or particular groups of prisoners.

Types of solitary confinement and their legitimacy

56. There are four main situations in which solitary confinement is used. Each has its own rationale and each should be viewed differently:

(a) Solitary confinement as the result of a court decision

In most countries, courts have the power to order that a person remanded in custody (i.e. placed in pre-trial detention) be held for a certain period in solitary confinement, in the interests of the criminal investigation. Further, in a few countries, a period of solitary confinement is an automatic part of some sentences established by legislation or can be ordered by a court as part of a sentence.

In relation to solitary confinement ordered by a court as part of remand conditions, it is axiomatic that there may be justification, in an individual case and based on sufficient evidence, for keeping a given remand prisoner apart from other particular prisoners or, in even more exceptional circumstances, prisoners in general, and in restricting his/her contact with the outside world. This should only be done to guard against a real risk to the administration of justice and must be subject to the safeguards outlined in paragraph 57 below.

The CPT considers that solitary confinement should never be imposed – or be imposable at the discretion of the court concerned – as part of a sentence. The generally accepted principle that offenders are sent to prison as a punishment, not to receive punishment, should be recalled in this context. Imprisonment is a punishment in its own right and potentially dangerous aggravations of a prison sentence as part of the punishment are not acceptable. It may be necessary for a sentenced prisoner to be subject, for a certain period of time, to a solitary confinement regime; however, the imposition of such a regime should lie with the prison authorities and not be made part of the catalogue of criminal sanctions.

(b) Solitary confinement as a disciplinary sanction

Withdrawal of a prisoner from contact with other prisoners may be imposed under the normal disciplinary procedures specified by the law, as the most severe disciplinary punishment. Recognising the inherent dangers of this sanction, countries specify a maximum period for which it may be imposed. This can vary from as little as a few days to as much as a month or more. Some countries allow prison directors to impose a given maximum period, with the possibility for a judicial body to impose a longer period. Most countries – but not all – prohibit sequential sentences of solitary confinement.

Given the potentially very damaging effects of solitary confinement, the CPT considers that the principle of proportionality requires that it be used as a disciplinary punishment only in exceptional cases and as a last resort, and for the shortest possible period of time. The trend in many member States of the Council of Europe is towards lowering the maximum possible period of solitary confinement as a punishment. The CPT considers that the maximum period should be no higher than 14 days for a given offence, and preferably lower.[1] Further, there should be a prohibition of sequential disciplinary sentences resulting in an uninterrupted period of solitary confinement in excess of the maximum period. Any offences committed by a prisoner which it is felt call for more severe sanctions should be dealt with through the criminal justice system.

(c) Administrative solitary confinement for preventative purposes

The law in most European countries allows for an administrative decision to place into solitary confinement prisoners who have caused, or are judged likely to cause, serious harm to others or who present a very serious risk to the safety or security of the prison. This may be for as short as a few hours, in the case of an isolated incident, or for as long as a period of years in cases involving prisoners who are considered as particularly dangerous and to continue to pose an imminent threat.

This is potentially the longest lasting type of solitary confinement and often the one with the fewest procedural safeguards. It is therefore crucial that there be rules to ensure that it is not used too readily (e.g. as an immediate response to every disciplinary infraction pending adjudication), too extensively or for too lengthy periods. Accordingly, the safeguards described in paragraph 57 below must be rigorously followed.

[1] The maximum period should certainly be lower in respect of juveniles.

(d) Solitary confinement for protection purposes

Every prison system has prisoners who may require protection from other prisoners. This may be because of the nature of their offence, their co-operation with the criminal justice authorities, inter-gang rivalry, debts outside or inside the prison or the general vulnerability of the person. While many prisoners can be managed in the general prison population in these circumstances, the risk to some is such that the prison can only discharge its duty of care to the individuals by keeping them apart from all other prisoners. This may be done at the prisoner's own request or at the instigation of management when it is deemed necessary. Whatever the process, the fact is that it can be very difficult for a prisoner to come off protection for the rest of the sentence – and maybe even for subsequent sentences.

States have an obligation to provide a safe environment for those confined to prison and should attempt to fulfil this obligation by allowing as much social interaction as possible among prisoners, consistent with the maintenance of good order. Resort should be had to solitary confinement for protection purposes only when there is absolutely no other way of ensuring the safety of the prisoner concerned.

The decision of placement in solitary confinement: procedures and safeguards

57. In order to ensure that solitary confinement is only imposed in exceptional circumstances and for the shortest time necessary, each type of solitary confinement should have its own distinct process for applying and reviewing it. The CPT outlines here what it considers to be the appropriate processes:

(a) Solitary confinement as part of remand conditions

As already indicated, solitary confinement of persons remanded in custody should only be used sparingly and where there is direct evidence in an individual case that there is a serious risk to the administration of justice if the prisoner concerned associates with particular inmates or others in general. Such decisions should be made in open court, with as fully reasoned a judgment as possible, and be separately appealable. They should also be reviewed by the competent court on a frequent basis to ensure that there is a continuing need for solitary confinement.

(b) Solitary confinement as a disciplinary sanction

The reason for the imposition of solitary confinement as a punishment, and the length of time for which it is imposed, should be fully documented in the record of the disciplinary hearing. Such records should be available to senior managers and oversight bodies. There should also be an effective appeal process which can reexamine the finding of guilt and/or the sentence in time to make a difference to them in practice. A necessary concomitant of this is the ready availability of legal advice for prisoners in this situation.

Prisoners undergoing this punishment should be visited on a daily basis by the prison director or another member of senior management, and the order given to terminate solitary confinement when this step is called for on account of the prisoner's condition or behaviour. Records should be kept of such visits and of related decisions.

(c) Administrative solitary confinement for preventative purposes

This can result in very long-term placements under solitary confinement and the administrative decisions involved are often indeterminate; both these elements aggravate the negative effects of the measure. Consequently, there is a need for stringent controls. The CPT considers that placement in administrative solitary confinement should only be authorised by the most senior member of staff in the prison; any imposition of this measure as an emergency should be reported to the most senior member of staff on duty immediately and brought to the attention of the prison director as soon as possible. A full written report should be drawn up before the member of staff who makes the decision goes off-duty. This should record the reasons for the decision and the precise time the measure was adopted as well as the views of the prisoner as far as these can be ascertained. There should be constant, logged, monitoring of all cases for the first few hours and the person should be released from solitary confinement as soon as the reason for the imposition of the measure has been resolved. In all cases where the measure continues for longer than 24 hours, there should be a full review of all aspects of the case with a view to withdrawing the measure at the earliest possible time.

If it becomes clear that solitary confinement is likely to be required for a longer period of time, a body external to the prison holding the prisoner, for example, a senior member of headquarters staff, should become involved. A right of appeal to an independent authority should also be in place. When an order is confirmed, a full interdisciplinary case conference should be convened and the prisoner invited to make representations to this body. A major task for the review team is to establish a plan for the prisoner with a view to addressing the issues which require the prisoner to be kept in solitary confinement. Among other things, the review should also look at whether some of the restrictions imposed on the prisoner are strictly necessary – thus it may be possible to allow some limited association with selected other prisoners. The prisoner should receive a written, reasoned decision from the review body and an indication of how the decision may be appealed. After an initial decision, there should be a further review at least after the first month and thereafter at least every three months, at which progress against the agreed plan can be assessed and if appropriate a new plan developed. The longer a person remains in this situation, the more thorough the review should be and the more resources, including resources external to the prison, made available to attempt to (re)integrate the prisoner into the main prison community. The prisoner should be entitled to require a review at any time and to obtain independent reports for such a review. The prison director or senior members of staff should make a point of visiting such prisoners daily and familiarise themselves with the individual plans. Medical staff should also pay particular attention to prisoners held under these conditions.

(d) Solitary confinement for protection purposes

"Own request" protection cases raise fewer questions than those ordered to go on protection by staff, but they still need some consideration. The CPT considers that all the alternatives, including transferring to another prison either the individual prisoner in need of protection or the prisoners causing the problem, mediation and assertiveness training, should be tried first and the full consequences of a decision to go on protection explained to the prisoner. Of course, a request from any prisoner on voluntary protection to return to the mainstream should be considered and granted if this can be safely done.

Those who are placed on protection against their will should have the right to play a full part in the discussion of the decision and to proffer alternative solutions. They should be given a full explanation of the decision and the opportunity to challenge it at a higher level. The decision should be reviewed on a regular basis so that solitary confinement can be ended as soon as it is no longer necessary.

Material conditions in solitary confinement

58. The cells used for solitary confinement should meet the same minimum standards as those applicable to other prisoner accommodation. Thus, they should be of an adequate size, enjoy access to natural light and be equipped with artificial lighting (in both cases sufficient to read by), and have adequate heating and ventilation. They should also be equipped with a means of communication with prison staff. Proper arrangements should be made for the prisoners to meet the needs of nature in a decent fashion at all times and to shower at least as often as prisoners in normal regime. Prisoners held in solitary confinement should be allowed to wear normal prison clothing and the food provided to them should be the normal prison diet, including special diets when required. As for the exercise area used by such prisoners, it should be sufficiently large to enable them genuinely to exert themselves and should have some means of protection from the elements.

59. All too often, CPT delegations find that one or more of these basic requirements are not met, in particular in respect of prisoners undergoing solitary confinement as a disciplinary sanction. For example, the cells designed for this type of solitary confinement are sometimes located in basement areas, with inadequate access to natural light and ventilation and prone to dampness. And it is not unusual for the cells to be too small, sometimes measuring as little as 3 to 4m²; in this connection, the CPT wishes to stress that any cell measuring less than 6m² should be withdrawn from service as prisoner accommodation. The exercise areas used by the prisoners concerned are also frequently inadequate.

60. It is common practice for cells accommodating prisoners undergoing solitary confinement as a punishment to have a limited amount of furniture, which is often secured to the floor. Nevertheless, such cells should be equipped, as a minimum, with a table, adequate seating for the daytime (i.e. a chair or bench), and a proper bed and bedding at night.

As regards the cells used to accommodate prisoners undergoing other types of solitary confinement, the CPT considers that they should be furnished in the same manner as cells used by prisoners on normal location.

Regimes in solitary confinement

61. As with all other regimes applied to prisoners, the principle that prisoners placed in solitary confinement should be subject to no more restrictions than are necessary for their safe and orderly confinement must be followed. Further, special efforts should be made to enhance the regime of those kept in long-term solitary confinement, who need particular attention to minimise the damage that this measure can do to them. It is not necessary to have an "all or nothing" approach to the question. Each particular restriction should only be applied as appropriate to the assessed risk of the individual prisoner. Equally, as already indicated, there should be a clear differentiation between the regimes applied to persons subject to solitary confinement, having regard to the type of solitary confinement involved.

(a) Prisoners placed in solitary confinement as part of remand conditions ordered by a court should be treated as far as possible like other remand prisoners, with extra restrictions applied only as strictly required for the administration of justice.

(b) Prisoners undergoing solitary confinement as a disciplinary sanction should never be totally deprived of contacts with their families and any restrictions on such contacts should be imposed only where the offence relates to such contacts. And there should be no restriction on their right of access to a lawyer. They should be entitled to at least one hour's outdoor exercise per day, from the very first day of placement in solitary confinement, and be encouraged to take outdoor exercise. They should also be permitted access to a reasonable range of reading material (which, for example, should not be restricted to religious texts). It is crucially important that they have some stimulation to assist in maintaining their mental wellbeing.

(c) Prisoners placed in administrative solitary confinement for preventative purposes should have an individual regime plan, geared to addressing the reasons for the measure. This plan should attempt to maximise contact with others – staff initially, but as soon as practicable with appropriate other prisoners – and provide as full a range of activities as is possible to fill the days. There should be strong encouragement from staff to partake in activities and contact with the outside world should be facilitated. Throughout the period of administrative solitary confinement, the overall objective should be to persuade the prisoner to re-engage with the normal regime.

(d) As regards prisoners placed in solitary confinement for protection purposes, there is a balance to be struck between on the one hand the need to avoid making this kind of solitary confinement too attractive to prisoners and on the other hand minimising the restrictions put on persons to whom the measure is applied. Certainly, at the outset of such a period of solitary confinement, steps should be taken to reintegrate the person as soon as possible; if it becomes clear that there is a need for long-term protection, and no other response is possible, regime enhancement should be pursued. Special efforts should be made to identify other prisoners with whom the prisoner concerned could safely associate and situations where it would be possible to bring the person out of cell.

The role of health-care staff in solitary confinement

62. Medical practitioners in prisons act as the personal doctors of prisoners and ensuring that there is a positive doctor-patient relationship between them is a major factor in safeguarding the health and well-being of prisoners. The practice of prison doctors certifying whether a prisoner is fit to undergo solitary confinement as a punishment (or any other type of solitary confinement imposed against the prisoner's wishes) is scarcely likely to promote that relationship. This point was recognised in the Committee of Ministers' Recommendation Rec (2006) 2 on the Revised Prison Rules; indeed, the rule in the previous version of the Rules obliging prison doctors to certify that prisoners are fit to undergo punishment has now been removed. The CPT considers that medical personnel should never participate in any part of the decision-making process resulting in any type of solitary confinement, except where the measure is applied for medical reasons.

63. On the other hand, health-care staff should be very attentive to the situation of all prisoners placed under solitary confinement. The health-care staff should be informed of every such placement and should visit the prisoner immediately after placement and thereafter, on a regular basis, at least once per day, and provide them with prompt medical assistance and treatment as required. They should report to the prison director whenever a prisoner's health is being put seriously at risk by being held in solitary confinement.

Conclusion

64. The aim of the CPT in setting out these standards is to minimise the use of solitary confinement in prisons, not only because of the mental, somatic and social damage it can do to prisoners but also given the opportunity it can provide for the deliberate infliction of ill-treatment. The CPT considers that solitary confinement should only be imposed in exceptional circumstances, as a last resort and for the shortest possible time.

Prisoners undergoing solitary confinement should be accommodated in decent conditions. Further, the measure should involve the minimum restrictions on prisoners consistent with its objective and the prisoner's behaviour, and should always be accompanied by strenuous efforts on the part of staff to resolve the underlying issues. More specifically, regimes in solitary confinement should be as positive as possible and directed at addressing the factors which have made the measure necessary. In addition, legal and practical safeguards need to be built into decision-making processes in relation to the imposition and review of solitary confinement.

Ensuring that solitary confinement is always a proportionate response to difficult situations in prisons will promote positive staff-prisoner interaction and limit the damage done to the very persons who are often already among the most disturbed members of the inmate population.

Health care services in prisons

Extract from the 3rd General Report [CPT/Inf (93) 12]

30. Health care services for persons deprived of their liberty is a subject of direct relevance to the CPT's mandate.[1] An inadequate level of health care can lead rapidly to situations falling within the scope of the term "inhuman and degrading treatment". Further, the health care service in a given establishment can potentially play an important role in combatting the infliction of ill-treatment, both in that establishment and elsewhere (in particular in police establishments). Moreover, it is well placed to make a positive impact on the overall quality of life in the establishment within which it operates.

31 In the following paragraphs, some of the main issues pursued by CPT delegations when examining health care services within prisons are described. However, at the outset the CPT wishes to make clear the importance which it attaches to the general principle - already recognised in most, if not all, of the countries visited by the Committee to date - that prisoners are entitled to the same level of medical care as persons living in the community at large. This principle is inherent in the fundamental rights of the individual.

32. The considerations which have guided the CPT during its visits to prison health care services can be set out under the following headings:

a. Access to a doctor
b. Equivalence of care
c. Patient's consent and confidentiality
d. Preventive health care
e. Humanitarian assistance
f. Professional independence
g. Professional competence.

[1] Reference should also be made to Recommendation No. R (98) 7 concerning the ethical and organisational aspects of health care in prison, adopted by the Committee of Ministers of the Council of Europe on 8 April 1998.

a. Access to a doctor

33. When entering prison, all prisoners should without delay be seen by a member of the establishment's health care service. In its reports to date the CPT has recommended that every newly arrived prisoner be properly interviewed and, if necessary, physically examined by a medical doctor as soon as possible after his admission. It should be added that in some countries, medical screening on arrival is carried out by a fully qualified nurse, who reports to a doctor. This latter approach could be considered as a more efficient use of available resources.[1]

It is also desirable that a leaflet or booklet be handed to prisoners on their arrival, informing them of the existence and operation of the health care service and reminding them of basic measures of hygiene.

34. While in custody, prisoners should be able to have access to a doctor at any time, irrespective of their detention regime (as regards more particularly access to a doctor for prisoners held in solitary confinement, see paragraph 56 of the CPT's 2nd General Report: CPT/Inf (92) 3). The health care service should be so organised as to enable requests to consult a doctor to be met without undue delay.

Prisoners should be able to approach the health care service on a confidential basis, for example, by means of a message in a sealed envelope. Further, prison officers should not seek to screen requests to consult a doctor.

35. A prison's health care service should at least be able to provide regular out-patient consultations and emergency treatment (of course, in addition there may often be a hospital-type unit with beds). The services of a qualified dentist should be available to every prisoner. Further, prison doctors should be able to call upon the services of specialists.

As regards emergency treatment, a doctor should always be on call. Further, someone competent to provide first aid should always be present on prison premises, preferably someone with a recognised nursing qualification.

Out-patient treatment should be supervised, as appropriate, by health care staff; in many cases it is not sufficient for the provision of follow-up care to depend upon the initiative being taken by the prisoner.

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[1] This requirement has subsequently been reformulated as follows: every newly-arrived prisoner should be properly interviewed and physically examined by a medical doctor as soon as posible after his admission; save for in exceptional circumstances, that interview/examination should be carried out on the day of admission, especially insofar as remand establishments are concerned. Such medical screening on admission could also be performed by a fully qualified nurse reporting to a doctor.

36. The direct support of a fully-equipped hospital service should be available, in either a civil or prison hospital.

If recourse is had to a civil hospital, the question of security arrangements will arise. In this respect, the CPT wishes to stress that prisoners sent to hospital to receive treatment should not be physically attached to their hospital beds or other items of furniture for custodial reasons. Other means of meeting security needs satisfactorily can and should be found; the creation of a custodial unit in such hospitals is one possible solution.

37. Whenever prisoners need to be hospitalised or examined by a specialist in a hospital, they should be transported with the promptness and in the manner required by their state of health.

b. Equivalence of care

i) general medicine

38. A prison health care service should be able to provide medical treatment and nursing care, as well as appropriate diets, physiotherapy, rehabilitation or any other necessary special facility, in conditions comparable to those enjoyed by patients in the outside community. Provision in terms of medical, nursing and technical staff, as well as premises, installations and equipment, should be geared accordingly.

There should be appropriate supervision of the pharmacy and of the distribution of medicines. Further, the preparation of medicines should always be entrusted to qualified staff (pharmacist/nurse, etc.).

39. A medical file should be compiled for each patient, containing diagnostic information as well as an ongoing record of the patient's evolution and of any special examinations he has undergone. In the event of a transfer, the file should be forwarded to the doctors in the receiving establishment.

Further, daily registers should be kept by health care teams, in which particular incidents relating to the patients should be mentioned. Such registers are useful in that they provide an overall view of the health care situation in the prison, at the same time as highlighting specific problems which may arise.

40. The smooth operation of a health care service presupposes that doctors and nursing staff are able to meet regularly and to form a working team under the authority of a senior doctor in charge of the service.

ii) psychiatric care

41. In comparison with the general population, there is a high incidence of psychiatric symptoms among prisoners. Consequently, a doctor qualified in psychiatry should be attached to the health care service of each prison, and some of the nurses employed there should have had training in this field.

The provision of medical and nursing staff, as well as the layout of prisons, should be such as to enable regular pharmacological, psychotherapeutic and occupational therapy programmes to be carried out.

42. The CPT wishes to stress the role to be played by prison management in the early detection of prisoners suffering from a psychiatric ailment (eg. depression, reactive state, etc.), with a view to enabling appropriate adjustments to be made to their environment. This activity can be encouraged by the provision of appropriate health training for certain members of the custodial staff.

43. A mentally ill prisoner should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff. That facility could be a civil mental hospital or a specially equipped psychiatric facility within the prison system.

On the one hand, it is often advanced that, from an ethical standpoint, it is appropriate for mentally ill prisoners to be hospitalised outside the prison system, in institutions for which the public health service is responsible. On the other hand, it can be argued that the provision of psychiatric facilities within the prison system enables care to be administered in optimum conditions of security, and the activities of medical and social services intensified within that system.

Whichever course is chosen, the accommodation capacity of the psychiatric facility in question should be adequate; too often there is a prolonged waiting period before a necessary transfer is effected. The transfer of the person concerned to a psychiatric facility should be treated as a matter of the highest priority.

44. A mentally disturbed and violent patient should be treated through close supervision and nursing support, combined, if considered appropriate, with sedatives. Resort to instruments of physical restraint shall only very rarely be justified and must always be either expressly ordered by a medical doctor or immediately brought to the attention of such a doctor with a view to seeking his approval. Instruments of physical restraint should be removed at the earliest possible opportunity. They should never be applied, or their application prolonged, as a punishment.

In the event of resort being had to instruments of physical restraint, an entry should be made in both the patient's file and an appropriate register, with an indication of the times at which the measure began and ended, as well as of the circumstances of the case and the reasons for resorting to such means.

c. Patient's consent and confidentiality

45. Freedom of consent and respect for confidentiality are fundamental rights of the individual. They are also essential to the atmosphere of trust which is a necessary part of the doctor/patient relationship, especially in prisons, where a prisoner cannot freely choose his own doctor.

i) patient's consent

46. Patients should be provided with all relevant information (if necessary in the form of a medical report) concerning their condition, the course of their treatment and the medication prescribed for them. Preferably, patients should have the right to consult the contents of their prison medical files, unless this is inadvisable from a therapeutic standpoint.

They should be able to ask for this information to be communicated to their families and lawyers or to an outside doctor.

47. Every patient capable of discernment is free to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances which are applicable to the population as a whole.

A classically difficult situation arises when the patient's decision conflicts with the general duty of care incumbent on the doctor. This might happen when the patient is influenced by personal beliefs (eg. refusal of a blood transfusion) or when he is intent on using his body, or even mutilating himself, in order to press his demands, protest against an authority or demonstrate his support for a cause.

In the event of a hunger strike, public authorities or professional organisations in some countries will require the doctor to intervene to prevent death as soon as the patient's consciousness becomes seriously impaired. In other countries, the rule is to leave clinical decisions to the doctor in charge, after he has sought advice and weighed up all the relevant facts.

48. As regards the issue of medical research with prisoners, it is clear that a very cautious approach must be followed, given the risk of prisoners' agreement to participate being influenced by their penal situation. Safeguards should exist to ensure that any prisoner concerned has given his free and informed consent.

The rules applied should be those prevailing in the community, with the intervention of a board of ethics. The CPT would add that it favours research concerning custodial pathology or epidemiology or other aspects specific to the condition of prisoners.

49. The involvement of prisoners in the teaching programmes of students should require the prisoners' consent.

ii) confidentiality

50. Medical secrecy should be observed in prisons in the same way as in the community. Keeping patients' files should be the doctor's responsibility.

51. All medical examinations of prisoners (whether on arrival or at a later stage) should be conducted out of the hearing and - unless the doctor concerned requests otherwise - out of the sight of prison officers. Further, prisoners should be examined on an individual basis, not in groups.

d. Preventive health care

52. The task of prison health care services should not be limited to treating sick patients. They should also be entrusted with responsibility for social and preventive medicine.

i) hygiene

53. It lies with prison health care services - as appropriate acting in conjunction with other authorities - to supervise catering arrangements (quantity, quality, preparation and distribution of food) and conditions of hygiene (cleanliness of clothing and bedding; access to running water; sanitary installations) as well as the heating, lighting and ventilation of cells. Work and outdoor exercise arrangements should also be taken into consideration.

Insalubrity, overcrowding, prolonged isolation and inactivity may necessitate either medical assistance for an individual prisoner or general medical action vis-à-vis the responsible authority.

ii) transmittable diseases [1]

54. A prison health care service should ensure that information about transmittable diseases (in particular hepatitis, AIDS, tuberculosis, dermatological infections) is regularly circulated, both to prisoners and to prison staff. Where appropriate, medical control of those with whom a particular prisoner has regular contact (fellow prisoners, prison staff, frequent visitors) should be carried out.

55. As regards more particularly AIDS, appropriate counselling should be provided both before and, if necessary, after any screening test. Prison staff should be provided with ongoing training in the preventive measures to be taken and the attitudes to be adopted regarding HIV-positivity and given appropriate instructions concerning non-discrimination and confidentiality.

56. The CPT wishes to emphasise that there is no medical justification for the segregation of an HIV+ prisoner who is well.[2]

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[1] See also "Imprisonment", section "transmissible diseases".

[2] Subsequently reformulated as follows: there is no medical justification for the segregation of a prisoner solely on the grounds that he is HIV positive.

iii) suicide prevention

57. Suicide prevention is another matter falling within the purview of a prison's health care service. It should ensure that there is an adequate awareness of this subject throughout the establishment, and that appropriate procedures are in place.

58. Medical screening on arrival, and the reception process as a whole, has an important role to play in this context; performed properly, it could identify at least certain of those at risk and relieve some of the anxiety experienced by all newly-arrived prisoners.

Further, prison staff, whatever their particular job, should be made aware of (which implies being trained in recognising) indications of suicidal risk. In this connection it should be noted that the periods immediately before and after trial and, in some cases, the pre-release period, involve an increased risk of suicide.

59. A person identified as a suicide risk should, for as long as necessary, be kept under a special observation scheme. Further, such persons should not have easy access to means of killing themselves (cell window bars, broken glass, belts or ties, etc).

Steps should also be taken to ensure a proper flow of information - both within a given establishment and, as appropriate, between establishments (and more specifically between their respective health care services) - about persons who have been identified as potentially at risk.

iv) prevention of violence

60. Prison health care services can contribute to the prevention of violence against detained persons, through the systematic recording of injuries and, if appropriate, the provision of general information to the relevant authorities. Information could also be forwarded on specific cases, though as a rule such action should only be undertaken with the consent of the prisoners concerned.

61. Any signs of violence observed when a prisoner is medically screened on his admission to the establishment should be fully recorded, together with any relevant statements by the prisoner and the doctor's conclusions. Further, this information should be made available to the prisoner.

The same approach should be followed whenever a prisoner is medically examined following a violent episode within the prison (see also paragraph 53 of the CPT's 2nd General report: CPT/Inf (92) 3) or on his readmission to prison after having been temporarily returned to police custody for the purposes of an investigation.

62. The health care service could compile periodic statistics concerning injuries observed, for the attention of prison management, the Ministry of Justice, etc.

v) social and family ties

63. The health care service may also help to limit the disruption of social and family ties which usually goes hand in hand with imprisonment. It should support - in association with the relevant social services - measures that foster prisoners' contacts with the outside world, such as properly-equipped visiting areas, family or spouse/partner visits under appropriate conditions, and leaves in family, occupational, educational and socio-cultural contexts.

According to the circumstances, a prison doctor may take action in order to obtain the grant or continued payment of social insurance benefits to prisoners and their families.

e. Humanitarian assistance

64. Certain specific categories of particularly vulnerable prisoners can be identified. Prison health care services should pay especial attention to their needs.

i) mother and child

65. It is a generally accepted principle that children should not be born in prison, and the CPT's experience is that this principle is respected.

66. A mother and child should be allowed to stay together for at least a certain period of time. If the mother and child are together in prison, they should be placed in conditions providing them with the equivalent of a creche and the support of staff specialised in post-natal care and nursery nursing.

Long-term arrangements, in particular the transfer of the child to the community, involving its separation from its mother, should be decided on in each individual case in the light of pedo-psychiatric and medico-social opinions.

ii) adolescents

67. Adolescence is a period marked by a certain reorganisation of the personality, requiring a special effort to reduce the risks of long-term social maladjustment.

While in custody, adolescents should be allowed to stay in a fixed place, surrounded by personal objects and in socially favourable groups. The regime applied to them should be based on intensive activity, including socio-educational meetings, sport, education, vocational training, escorted outings and the availability of appropriate optional activities.

iii) prisoners with personality disorders

68. Among the patients of a prison health care service there is always a certain proportion of unbalanced, marginal individuals who have a history of family traumas, long-standing drug addiction, conflicts with authority or other social misfortunes. They may be violent, suicidal or characterised by unacceptable sexual behaviour, and are for most of the time incapable of controlling or caring for themselves.

69. The needs of these prisoners are not truly medical, but the prison doctor can promote the development of socio-therapeutic programmes for them, in prison units which are organised along community lines and carefully supervised.

Such units can reduce the prisoners' humiliation, self-contempt and hatred, give them a sense of responsibility and prepare them for reintegration. Another direct advantage of programmes of this type is that they involve the active participation and commitment of the prison staff.

iv) prisoners unsuited for continued detention

70. Typical examples of this kind of prisoner are those who are the subject of a short-term fatal prognosis, who are suffering from a serious disease which cannot be properly treated in prison conditions, who are severely handicapped or of advanced age. The continued detention of such persons in a prison environment can create an intolerable situation. In cases of this type, it lies with the prison doctor to draw up a report for the responsible authority, with a view to suitable alternative arrangements being made.

f. Professional independence

71. The health-care staff in any prison is potentially a staff at risk. Their duty to care for their patients (sick prisoners) may often enter into conflict with considerations of prison management and security. This can give rise to difficult ethical questions and choices. In order to guarantee their independence in health-care matters, the CPT considers it important that such personnel should be aligned as closely as possible with the mainstream of health-care provision in the community at large.

72. Whatever the formal position under which a prison doctor carries on his activity, his clinical decisions should be governed only by medical criteria.

The quality and the effectiveness of medical work should be assessed by a qualified medical authority. Likewise, the available resources should be managed by such an authority, not by bodies responsible for security or administration.

73. A prison doctor acts as a patient's personal doctor. Consequently, in the interests of safeguarding the doctor/patient relationship, he should not be asked to certify that a prisoner is fit to undergo punishment. Nor should he carry out any body searches or examinations requested by an authority, except in an emergency when no other doctor can be called in.

74. It should also be noted that a prison doctor's professional freedom is limited by the prison situation itself: he cannot freely choose his patients, as the prisoners have no other medical option at their disposal. His professional duty still exists even if the patient breaks the medical rules or resorts to threats or violence.

g. Professional competence

75. Prison doctors and nurses should possess specialist knowledge enabling them to deal with the particular forms of prison pathology and adapt their treatment methods to the conditions imposed by detention.

In particular, professional attitudes designed to prevent violence - and, where appropriate, control it - should be developed.

76. To ensure the presence of an adequate number of staff, nurses are frequently assisted by medical orderlies, some of whom are recruited from among the prison officers. At the various levels, the necessary experience should be passed on by the qualified staff and periodically updated.

Sometimes prisoners themselves are allowed to act as medical orderlies. No doubt, such an approach can have the advantage of providing a certain number of prisoners with a useful job. Nevertheless, it should be seen as a last resort. Further, prisoners should never be involved in the distribution of medicines.

77. Finally, the CPT would suggest that the specific features of the provision of health care in a prison environment may justify the introduction of a recognised professional speciality, both for doctors and for nurses, on the basis of postgraduate training and regular in-service training.

III. Psychiatric establishments

Involuntary placement in psychiatric establishments

Extract from the 8th General Report [CPT/Inf (98) 12]

A. Preliminary remarks

25. The CPT is called upon to examine the treatment of all categories of persons deprived of their liberty by a public authority, including persons with mental health problems. Consequently, the Committee is a frequent visitor to psychiatric establishments of various types.

Establishments visited include mental hospitals accommodating, in addition to voluntary patients, persons who have been hospitalised on an involuntary basis pursuant to civil proceedings in order to receive psychiatric treatment. The CPT also visits facilities (special hospitals, distinct units in civil hospitals, etc) for persons whose admission to a psychiatric establishment has been ordered in the context of criminal proceedings. Psychiatric facilities for prisoners who develop a mental illness in the course of their imprisonment, whether located within the prison system or in civil psychiatric institutions, also receive close attention from the CPT.

26. When examining the issue of health-care services in prisons in its 3rd General Report (cf. CPT/Inf (93) 12, paragraphs 30 to 77), the CPT identified a number of general criteria which have guided its work (access to a doctor; equivalence of care; patient's consent and confidentiality; preventive health care; professional independence and professional competence). Those criteria also apply to involuntary placement in psychiatric establishments.

In the following paragraphs, some of the specific issues pursued by the CPT in relation to persons who are placed involuntarily in psychiatric establishments are described[1]. The CPT hopes in this way to give a clear advance indication to national authorities of its views concerning the treatment of such persons; the Committee would welcome comments on this section of its General Report.

[1] As regards psychiatric care for prisoners, reference should also be made to paragraphs 41 to 44 of the Committee's 3rd General Report.

B. Prevention of ill-treatment

27. In view of its mandate, the CPT's first priority when visiting a psychiatric establishment must be to ascertain whether there are any indications of the deliberate ill-treatment of patients. Such indications are seldom found. More generally, the CPT wishes to place on record the dedication to patient care observed among the overwhelming majority of staff in most psychiatric establishments visited by its delegations. This situation is on occasion all the more commendable in the light of the low staffing levels and paucity of resources at the staff's disposal.

Nevertheless, the CPT's own on-site observations and reports received from other sources indicate that the deliberate ill-treatment of patients in psychiatric establishments does occur from time to time. A number of questions will be addressed subsequently which are closely-linked to the issue of the prevention of ill-treatment (e.g. means of restraint; complaints procedures; contact with the outside world; external supervision). However, some remarks should be made at this stage as regards the choice of staff and staff supervision.

28. Working with the mentally ill and mentally handicapped will always be a difficult task for all categories of staff involved. In this connection it should be noted that health-care staff in psychiatric establishments are frequently assisted in their day-to-day work by orderlies; further, in some establishments a considerable number of personnel are assigned to security-related tasks. The information at the CPT's disposal suggests that when deliberate ill-treatment by staff in psychiatric establishments does occur, such auxiliary staff rather than medical or qualified nursing staff are often the persons at fault.

Bearing in mind the challenging nature of their work, it is of crucial importance that auxiliary staff be carefully selected and that they receive both appropriate training before taking up their duties and in-service courses. Further, during the performance of their tasks, they should be closely supervised by - and be subject to the authority of - qualified health-care staff.

29. In some countries, the CPT has encountered the practice of using certain patients, or inmates from neighbouring prison establishments, as auxiliary staff in psychiatric facilities. The Committee has serious misgivings about this approach, which should be seen as a measure of last resort. If such appointments are unavoidable, the activities of the persons concerned should be supervised on an on-going basis by qualified health-care staff.

30. It is also essential that appropriate procedures be in place in order to protect certain psychiatric patients from other patients who might cause them harm. This requires inter alia an adequate staff presence at all times, including at night and weekends. Further, specific arrangements should be made for particularly vulnerable patients; for example, mentally handicapped and/or mentally disturbed adolescents should not be accommodated together with adult patients.

31. Proper managerial control of all categories of staff can also contribute significantly to the prevention of ill-treatment. Obviously, the clear message must be given that the physical or psychological ill-treatment of patients is not acceptable and will be dealt with severely. More generally, management should ensure that the therapeutic role of staff in psychiatric establishments does not come to be considered as secondary to security considerations.

Similarly, rules and practices capable of generating a climate of tension between staff and patients should be revised accordingly. The imposition of fines on staff in the event of an escape by a patient is precisely the kind of measure which can have a negative effect on the ethos within a psychiatric establishment.

C. Patients' living conditions and treatment

32. The CPT closely examines patients' living conditions and treatment; inadequacies in these areas can rapidly lead to situations falling within the scope of the term "inhuman and degrading treatment". The aim should be to offer material conditions which are conducive to the treatment and welfare of patients; in psychiatric terms, a positive therapeutic environment. This is of importance not only for patients but also for staff working in psychiatric establishments. Further, adequate treatment and care, both psychiatric and somatic, must be provided to patients; having regard to the principle of the equivalence of care, the medical treatment and nursing care received by persons who are placed involuntarily in a psychiatric establishment should be comparable to that enjoyed by voluntary psychiatric patients.

33. The quality of patients' living conditions and treatment inevitably depends to a considerable extent on available resources. The CPT recognises that in times of grave economic difficulties, sacrifices may have to be made, including in health establishments. However, in the light of the facts found during some visits, the Committee wishes to stress that the provision of certain basic necessities of life must always be guaranteed in institutions where the State has persons under its care and/or custody. These include adequate food, heating and clothing as well as - in health establishments - appropriate medication.

living conditions

34. Creating a positive therapeutic environment involves, first of all, providing sufficient living space per patient as well as adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting hospital hygiene requirements.

Particular attention should be given to the decoration of both patients' rooms and recreation areas, in order to give patients visual stimulation. The provision of bedside tables and wardrobes is highly desirable, and patients should be allowed to keep certain personal belongings (photographs, books, etc). The importance of providing patients with lockable space in which they can keep their belongings should also be underlined; the failure to provide such a facility can impinge upon a patient's sense of security and autonomy.

Sanitary facilities should allow patients some privacy. Further, the needs of elderly and/or handicapped patients in this respect should be given due consideration; for example, lavatories of a design which do not allow the user to sit are not suitable for such patients. Similarly, basic hospital equipment enabling staff to provide adequate care (including personal hygiene) to bedridden patients must be made available; the absence of such equipment can lead to wretched conditions.

It should also be noted that the practice observed in some psychiatric establishments of continuously dressing patients in pyjamas/nightgowns is not conducive to strengthening personal identity and self-esteem; individualisation of clothing should form part of the therapeutic process.

35. Patients' food is another aspect of their living conditions which is of particular concern to the CPT. Food must be not only adequate from the standpoints of quantity and quality, but also provided to patients under satisfactory conditions. The necessary equipment should exist enabling food to be served at the correct temperature. Further, eating arrangements should be decent; in this regard it should be stressed that enabling patients to accomplish acts of daily life - such as eating with proper utensils whilst seated at a table - represents an integral part of programmes for the psycho-social rehabilitation of patients. Similarly, food presentation is a factor which should not be overlooked.

The particular needs of disabled persons in relation to catering arrangements should also be taken into account.

36. The CPT also wishes to make clear its support for the trend observed in several countries towards the closure of large-capacity dormitories in psychiatric establishments; such facilities are scarcely compatible with the norms of modern psychiatry. Provision of accommodation structures based on small groups is a crucial factor in preserving/restoring patients' dignity, and also a key element of any policy for the psychological and social rehabilitation of patients. Structures of this type also facilitate the allocation of patients to relevant categories for therapeutic purposes.

Similarly, the CPT favours the approach increasingly being adopted of allowing patients who so wish to have access to their room during the day, rather than being obliged to remain assembled together with other patients in communal areas.

treatment

37. Psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient. It should involve a wide range of rehabilitative and therapeutic activities, including access to occupational therapy, group therapy, individual psychotherapy, art, drama, music and sports. Patients should have regular access to suitably-equipped recreation rooms and have the possibility to take outdoor exercise on a daily basis; it is also desirable for them to be offered education and suitable work.

The CPT all too often finds that these fundamental components of effective psycho-social rehabilitative treatment are underdeveloped or even totally lacking, and that the treatment provided to patients consists essentially of pharmacotherapy. This situation can be the result of the absence of suitably qualified staff and appropriate facilities or of a lingering philosophy based on the custody of patients.

38. Of course, psychopharmacologic medication often forms a necessary part of the treatment given to patients with mental disorders. Procedures must be in place to ensure that medication prescribed is in fact provided, and that a regular supply of appropriate medicines is guaranteed. The CPT will also be on the look-out for any indications of the misuse of medication.

39. Electroconvulsive therapy (ECT) is a recognised form of treatment for psychiatric patients suffering from some particular disorders. However, care should be taken that ECT fits into the patient's treatment plan, and its administration must be accompanied by appropriate safeguards.

The CPT is particularly concerned when it encounters the administration of ECT in its unmodified form (i.e. without anaesthetic and muscle relaxants); this method can no longer be considered as acceptable in modern psychiatric practice. Apart from the risk of fractures and other untoward medical consequences, the process as such is degrading for both the patients and the staff concerned. Consequently, ECT should always be administered in a modified form.

ECT must be administered out of the view of other patients (preferably in a room which has been set aside and equipped for this purpose), by staff who have been specifically trained to provide this treatment. Further, recourse to ECT should be recorded in detail in a specific register. It is only in this way that any undesirable practices can be clearly identified by hospital management and discussed with staff.

40. Regular reviews of a patient's state of health and of any medication prescribed is another basic requirement. This will inter alia enable informed decisions to be taken as regards a possible dehospitalisation or transfer to a less restrictive environment.

A personal and confidential medical file should be opened for each patient. The file should contain diagnostic information (including the results of any special examinations which the patient has undergone) as well as an ongoing record of the patient's mental and somatic state of health and of his treatment. The patient should be able to consult his file, unless this is unadvisable from a therapeutic standpoint, and to request that the information it contains be made available to his family or lawyer. Further, in the event of a transfer, the file should be forwarded to the doctors in the receiving establishment; in the event of discharge, the file should be forwarded - with the patient's consent - to a treating doctor in the outside community.

41. Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.

Of course, consent to treatment can only be qualified as free and informed if it is based on full, accurate and comprehensible information about the patient's condition and the treatment proposed; to describe ECT as "sleep therapy" is an example of less than full and accurate information about the treatment concerned. Consequently, all patients should be provided systematically with relevant information about their condition and the treatment which it is proposed to prescribe for them. Relevant information (results, etc.) should also be provided following treatment.

D. Staff

42. Staff resources should be adequate in terms of numbers, categories of staff (psychiatrists, general practitioners, nurses, psychologists, occupational therapists, social workers, etc.), and experience and training. Deficiencies in staff resources will often seriously undermine attempts to offer activities of the kind described in paragraph 37; further, they can lead to high-risk situations for patients, notwithstanding the good intentions and genuine efforts of the staff in service.

43. In some countries, the CPT has been particularly struck by the small number of qualified psychiatric nurses among the nursing staff in psychiatric establishments, and by the shortage of personnel qualified to conduct social therapy activities (in particular, occupational therapists). The development of specialised psychiatric nursing training and a greater emphasis on social therapy would have a considerable impact upon the quality of care. In particular, they would lead to the emergence of a therapeutic milieu less centred on drug-based and physical treatments.

44. A number of remarks concerning staff issues and, more particularly, auxiliary staff, have already been made in an earlier section (cf. paragraphs 28 to 31). However, the CPT also pays close attention to the attitude of doctors and nursing staff. In particular, the Committee will look for evidence of a genuine interest in establishing a therapeutic relationship with patients. It will also verify that patients who might be considered as burdensome or lacking rehabilitative potential are not being neglected.

45. As in other health-care services, it is important that the different categories of staff working in a psychiatric unit meet regularly and form a team under the authority of a senior doctor. This will allow day-to-day problems to be identified and discussed, and guidance to be given. The lack of such a possibility could well engender frustration and resentment among staff members.

46. External stimulation and support are also necessary to ensure that the staff of psychiatric establishments do not become too isolated. In this connection, it is highly desirable for such staff to be offered training possibilities outside their establishment as well as secondment opportunities. Similarly, the presence in psychiatric establishments of independent persons (e.g. students and researchers) and external bodies (cf paragraph 55) should be encouraged.

E. Means of restraint

47. In any psychiatric establishment, the restraint of agitated and/or violent patients may on occasion be necessary. This is an area of particular concern to the CPT, given the potential for abuse and ill-treatment.

The restraint of patients should be the subject of a clearly-defined policy. That policy should make clear that initial attempts to restrain agitated or violent patients should, as far as possible, be non-physical (e.g. verbal instruction) and that where physical restraint is necessary, it should in principle be limited to manual control.

Staff in psychiatric establishments should receive training in both non-physical and manual control techniques vis-à-vis agitated or violent patients. The possession of such skills will enable staff to choose the most appropriate response when confronted by difficult situations, thereby significantly reducing the risk of injuries to patients and staff.

48. Resort to instruments of physical restraint (straps, strait-jackets, etc.) shall only very rarely be justified and must always be either expressly ordered by a doctor or immediately brought to the attention of a doctor with a view to seeking his approval. If, exceptionally, recourse is had to instruments of physical restraint, they should be removed at the earliest opportunity; they should never be applied, or their application prolonged, as a punishment.

The CPT has on occasion encountered psychiatric patients to whom instruments of physical restraint have been applied for a period of days; the Committee must emphasise that such a state of affairs cannot have any therapeutic justification and amounts, in its view, to ill-treatment.

49. Reference should also be made in this context to the seclusion (i.e. confinement alone in a room) of violent or otherwise "unmanageable" patients, a procedure which has a long history in psychiatry.

There is a clear trend in modern psychiatric practice in favour of avoiding seclusion of patients, and the CPT is pleased to note that it is being phased out in many countries. For so long as seclusion remains in use, it should be the subject of a detailed policy spelling out, in particular: the types of cases in which it may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact; the need for staff to be especially attentive.

Seclusion should never be used as a punishment.

50. Every instance of the physical restraint of a patient (manual control, use of instruments of physical restraint, seclusion) should be recorded in a specific register established for this purpose (as well as in the patient's file). The entry should include the times at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff.

This will greatly facilitate both the management of such incidents and the oversight of the extent of their occurrence.

F. Safeguards in the context of involuntary placement

51. On account of their vulnerability, the mentally ill and mentally handicapped warrant much attention in order to prevent any form of conduct - or avoid any omission - contrary to their well-being. It follows that involuntary placement in a psychiatric establishment should always be surrounded by appropriate safeguards. One of the most important of those safeguards - free and informed consent to treatment - has already been highlighted (cf. paragraph 41).

the initial placement decision

52. The procedure by which involuntary placement is decided should offer guarantees of independence and impartiality as well as of objective medical expertise.

As regards, more particularly, involuntary placement of a civil nature, in many countries the decision regarding placement must be taken by a judicial authority (or confirmed by such an authority within a short time-limit), in the light of psychiatric opinions. However, the automatic involvement of a judicial authority in the initial decision on placement is not foreseen in all countries. Committee of Ministers Recommendation N° R (83) 2 on the legal protection of persons suffering from mental disorder placed as involuntary patients allows for both approaches (albeit setting out special safeguards in the event of the placement decision being entrusted to a non-judicial authority). The Parliamentary Assembly has nevertheless reopened the debate on this subject via its Recommendation 1235 (1994) on psychiatry and human rights, calling for decisions regarding involuntary placement to be taken by a judge.

In any event, a person who is involuntarily placed in a psychiatric establishment by a non-judicial authority must have the right to bring proceedings by which the lawfulness of his detention shall be decided speedily by a court.

safeguards during placement

53. An introductory brochure setting out the establishment's routine and patients' rights should be issued to each patient on admission, as well as to their families. Any patients unable to understand this brochure should receive appropriate assistance.

Further, as in any place of deprivation of liberty, an effective complaints procedure is a basic safeguard against ill-treatment in psychiatric establishments. Specific arrangements should exist enabling patients to lodge formal complaints with a clearly-designated body, and to communicate on a confidential basis with an appropriate authority outside the establishment.

54. The maintenance of contact with the outside world is essential, not only for the prevention of ill-treatment but also from a therapeutic standpoint.

Patients should be able to send and receive correspondence, to have access to the telephone, and to receive visits from their family and friends. Confidential access to a lawyer should also be guaranteed.

55. The CPT also attaches considerable importance to psychiatric establishments being visited on a regular basis by an independent outside body (eg. a judge or supervisory committee) which is responsible for the inspection of patients' care. This body should be authorised, in particular, to talk privately with patients, receive directly any complaints which they might have and make any necessary recommendations.

discharge

56. Involuntary placement in a psychiatric establishment should cease as soon as it is no longer required by the patient's mental state. Consequently, the need for such a placement should be reviewed at regular intervals.

When involuntary placement is for a specified period, renewable in the light of psychiatric evidence, such a review will flow from the very terms of the placement. However, involuntary placement might be for an unspecified period, especially in the case of persons who have been compulsorily admitted to a psychiatric establishment pursuant to criminal proceedings and who are considered to be dangerous. If the period of involuntary placement is unspecified, there should be an automatic review at regular intervals of the need to continue the placement.

In addition, the patient himself should be able to request at reasonable intervals that the necessity for placement be considered by a judicial authority.

57. Although no longer requiring involuntary placement, a patient may nevertheless still need treatment and/or a protected environment in the outside community. In this connection, the CPT has found, in a number of countries, that patients whose mental state no longer required them to be detained in a psychiatric establishment nevertheless remained in such establishments, due to a lack of adequate care/accommodation in the outside community. For persons to remain deprived of their liberty as a result of the absence of appropriate external facilities is a highly questionable state of affairs.

G. Final remarks

58. The organisational structure of health-care services for persons with psychiatric disorders varies from country to country, and is certainly a matter for each State to determine. Nevertheless, the CPT wishes to draw attention to the tendency in a number of countries to reduce the number of beds in large psychiatric establishments and to develop community-based mental health units. The Committee considers this is a very favourable development, on condition that such units provide a satisfactory quality of care.

It is now widely accepted that large psychiatric establishments pose a significant risk of institutionalisation for both patients and staff, the more so if they are situated in isolated locations. This can have a detrimental effect on patient treatment. Care programmes drawing on the full range of psychiatric treatment are much easier to implement in small units located close to the main urban centres.

Means of restraint in psychiatric establishments for adults

Extract from the 16th General Report [CPT/Inf (2006) 35]

Preliminary remarks

36. In its 8th General Report covering the year 1997, the CPT addressed the issue of involuntary placement in psychiatric establishments for adults. In this context, the Committee made a number of remarks concerning the restraint of agitated and/or violent patients. During the intervening nine years, the debate over the use of restraint has continued to fire passions, with different psychiatric traditions advocating alternative approaches for managing such patients.

In many psychiatric establishments, recourse to means which limit the freedom of movement of agitated and/or violent patients may on occasion be necessary. Given the potential for abuse and ill-treatment, such use of means of restraint remains of particular concern for the CPT. Consequently, visiting delegations examine carefully the procedures and practice in psychiatric establishments as regards restraint as well as the frequency of resort to such means. Regrettably, it would appear that in many of the establishments visited there is an excessive recourse to means of restraint.

The CPT believes that the time is ripe to expand upon its earlier remarks and would welcome the comments of practitioners on this section of the General Report. It is in this spirit of constructive dialogue, with a view to assisting health-care staff in performing their arduous tasks and providing patients with appropriate care, that the following remarks are made.

On the use of restraint in general

37. As a matter of principle, hospitals should be safe places for both patients and staff. Psychiatric patients should be treated with respect and dignity, and in a safe, humane manner that respects their choices and self-determination. The absence of violence and abuse, of patients by staff or between patients, constitutes a minimum requirement.

That said, on occasion the use of physical force against a patient may be unavoidable in order to ensure the safety of staff and patients alike. Creating and maintaining good living conditions for patients, as well as a proper therapeutic climate - a primary task for hospital staff - presupposes an absence of aggression and violence amongst patients and against staff. For this reason, it is essential that staff be provided with the appropriate training and leadership to be capable of meeting in an ethically appropriate manner the challenge posed by an agitated and/or violent patient.

38. The line separating proportional physical force to control a patient from acts of violence can be a fine one. When that line is crossed, it is often due to inadvertence or unpreparedness rather than a result of malevolent intention. In many cases staff are simply not properly equipped to intervene when confronted with agitated and/or violent patients.

It should also be emphasised that CPT delegations have found that an active and alert role by management with respect to resort to means of restraint in a given establishment has usually resulted in a steady decline in their use.

Types of restraint in use

39. The CPT has come across various methods of controlling agitated and/or violent patients, which may be used separately or in combination: shadowing (when a staff member is constantly at the side of a patient and intervenes in his/her activities when necessary), manual control, mechanical restraints such as straps, straitjackets or enclosed beds, chemical restraint (medicating a patient against his/her will for the purpose of controlling behaviour) and seclusion (involuntary placement of a patient alone in a locked room). As a general rule, the method chosen in respect of a particular patient should be the most proportionate (among those available) to the situation encountered; for example, automatic resort to mechanical or chemical restraint is not called for in cases when a brief period of manual control combined with the use of psychological means of calming the person down would suffice.

As one might expect, using oral persuasion (i.e. talking to the patient to calm him/her down) would be the CPT's preferred technique but, at times, it may be necessary to resort to other means directly limiting the patient's freedom of movement.

40. Certain mechanical restraints, which are still to be found in some psychiatric hospitals visited by the CPT, are totally unsuitable for such a purpose and could well be considered as degrading. Handcuffs, metal chains and cage-beds clearly fall within this category; they have no rightful place in psychiatric practice and should be withdrawn from use immediately.

The use of net-beds, widespread in a number of countries until only a few years ago, appears to be in steady decline. Even in those few countries where they are still in use, net-beds are resorted to on a diminishing basis. This is a positive development and the CPT would like to encourage States to continue making efforts to reduce further the number of net-beds in use.

41. If recourse is had to chemical restraint such as sedatives, antipsychotics, hypnotics and tranquillisers, they should be subjected to the same safeguards as mechanical restraints. The side-effects that such medication may have on a particular patient need to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion.

42. As regards seclusion, this particular measure is not necessarily a proper alternative to the use of mechanical, chemical or other means of restraint. Placing a patient in seclusion may produce a calming effect in the short term, but is also known to cause disorientation and anxiety, at least for certain patients. In other words, placement in a seclusion room without appropriate, accompanying safeguards may have an adverse result. The tendency observed in several psychiatric hospitals to routinely forgo resort to other means of restraint in favour of seclusion is of concern to the CPT.

When to restrain a patient

43. As a general rule, a patient should only be restrained as a measure of last resort; an extreme action applied in order to prevent imminent injury or to reduce acute agitation and/or violence.

In reality, the CPT often finds that patients are restrained, usually with mechanical restraints, as a sanction for perceived misbehaviour or as a means to bring about a change of behaviour.

Moreover, in many psychiatric establishments visited by the CPT, the application of restraints is resorted to as a means of convenience for the staff; securing difficult patients while other tasks are performed. The usual justification provided to the CPT is that a lack of staff necessitates an increase in recourse to means of restraint.

This reasoning is unsound. The application of means of restraint in the correct manner and appropriate environment requires more - not fewer - medical staff, as each case of restraint necessitates a member of staff to provide direct, personal and continuous supervision (cf. paragraph 50).

Voluntary patients should only be restrained with their consent. If the application of restraint to a voluntary patient is deemed necessary and the patient disagrees, the legal status of the patient should be reviewed.

44. What can be done to prevent the misuse or overuse of means of restraint? First of all, experience has shown that in many psychiatric establishments the use of, in particular, mechanical restraint can be substantially reduced. Programmes set up in some countries for that purpose seem to have been successful, without this having led to an increased resort to chemical restraint or manual control. The question therefore arises whether complete (or almost complete) eradication of mechanical restraint might not be a realistic goal in the longer term.

It is imperative that every single case of resort to means of restraint be authorised by a doctor or, at least, brought without delay to a doctor's attention in order to seek approval for the measure. In the CPT's experience, means of restraint tend to be applied more frequently when prior blanket consent is given by the doctor, instead of decisions being taken on a case by case (situation by situation) basis.

45. When the emergency situation resulting in the application of restraint ceases to exist, the patient should be released immediately. On occasion, the CPT encounters patients to whom mechanical restraints have been applied for days on end. There can be no justification for such a practice, which in the CPT's view amounts to ill-treatment.

One of the main reasons why such practices linger on is that very few psychiatric establishments have developed clear rules on the duration of periods of restraint. Psychiatric establishments should consider adopting a rule whereby the authorisation of the use of a mechanical restraint lapses after a certain period of time, unless explicitly extended by a doctor. For a doctor, the existence of such a rule will act as a powerful incentive to visit the restrained patient in person and thus verify his/her state of mental and physical well-being.

46. Once means of restraint have been removed, it is essential that a debriefing of the patient take place. For the doctor, this will provide an opportunity to explain the rationale behind the measure, and thus reduce the psychological trauma of the experience as well as restore the doctor-patient relationship. For the patient, such a debriefing is an occasion to explain his/her emotions prior to the restraint, which may improve both the patient's own and the staff's understanding of his/her behaviour. The patient and staff together can try to find alternative means for the patient to maintain control over himself/herself, thereby possibly preventing future eruptions of violence and subsequent restraint.

How restraint should be used

47. Over the years, many patients have talked to CPT delegations about their experiences of being restrained. Patients have repeatedly said that they felt the whole ordeal to be humiliating, a feeling at times exacerbated by the manner in which the restraint was applied.

For the staff of a psychiatric hospital, it should be of the utmost concern that the conditions and circumstances surrounding the use of restraint do not aggravate the mental and physical health of the restrained patient. This implies, inter alia, that previously prescribed therapeutic treatment should, as far as possible, not be interrupted and that substance-dependent patients should receive adequate treatment for withdrawal symptoms. Whether these symptoms are caused by deprivation of illegal drugs, nicotine or other substances should not make any difference.

48. In general, the place where a patient is restrained should be specially designed for that specific purpose. It should be safe (e.g. without broken glass or tiles), and enjoy appropriate light and adequate heating, thereby promoting a calming environment for the patient.

Further, a restrained patient should be adequately clothed and not exposed to other patients, unless he/she explicitly requests otherwise or when the patient is known to have a preference for company. It must be guaranteed in all circumstances that patients subject to means of restraint are not harmed by other patients. Of course, staff should not be assisted by other patients when applying means of restraint to a patient.

When recourse is had to restraint, the means should be applied with skill and care in order not to endanger the health of the patient or cause pain. Vital functions of the patient, such as respiration, and the ability to communicate, eat and drink must not be hampered. If a patient has a tendency to bite, suck or spit, potential damage should be averted in a manner other than by covering the mouth.

49. Restraining an agitated or violent patient properly is no easy task for staff. Not only is training essential but refresher courses need to be organised at regular intervals. Such training should not only focus on instructing health-care staff how to apply means of restraint but, equally importantly, should ensure that they understand the impact the use of restraint may have on a patient and that they know how to care for a restrained patient.

50. The use of restraint in an appropriate manner requires considerable staff resources. For example, the CPT considers that when the limbs of a patient are held with straps or belts, a trained member of staff should be continuously present in order to maintain the therapeutic alliance and to provide assistance. Such assistance may include escorting the patient to a toilet facility or, in the exceptional case where the measure of restraint cannot be brought to an end in a matter of minutes, helping him/her to consume food.

Clearly, video surveillance cannot replace such a continuous staff presence. In cases where a patient is secluded, the staff member may be outside the patient's room, provided that the patient can fully see the staff member and the latter can continuously observe and hear the patient.

The adoption of a comprehensive restraint policy

51. Every psychiatric establishment should have a comprehensive, carefully developed, policy on restraint. The involvement and support of both staff and management in elaborating the policy is essential. Such a policy should make clear which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated.

The policy should also contain sections on other important issues such as: staff training; complaints policy; internal and external reporting mechanisms; and debriefing. In the CPT’s opinion, such a comprehensive policy is not only a major support for staff, but is also helpful in ensuring that patients and their guardians or proxies understand the rationale behind a measure of restraint that may be imposed.

Recording incidents of restraint

52. Experience has shown that detailed and accurate recording of instances of restraint can provide hospital management with an oversight of the extent of their occurrence and enable measures to be taken, where appropriate, to reduce their incidence.

Preferably, a specific register should be established to record all instances of recourse to means of restraint. This would be in addition to the records contained within the patient's personal medical file. The entries in the register should include the time at which the measure began and ended; the circumstances of the case; the reasons for resorting to the measure; the name of the doctor who ordered or approved it; and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this; at their request, they should receive a copy of the full entry.

53. Regular reporting to an outside monitoring body, for instance a Health-Care Inspectorate, might be considered as well. The obvious advantage of such a reporting mechanism is that it would facilitate a national or regional overview of restraint practices, thus facilitating efforts to better understand and, consequently, manage their use.

Final remarks

54. It should be acknowledged that resort to restraint measures appears to be substantially influenced by non-clinical factors such as staff perceptions of their role and patients' awareness of their rights. Comparative studies have shown that the frequency of use of restraint, including seclusion, is a function not only of staffing levels, diagnoses of patients or material conditions on the ward, but also of the "culture and attitudes" of hospital staff.

Reducing recourse to the use of restraint to a viable minimum requires a change of culture in many psychiatric establishments. The role of management is crucial in this regard. Unless the management encourages staff and offers them alternatives, an established practice of frequent recourse to means of restraint is likely to prevail.

IV. Immigration detention

Foreign nationals detained under aliens legislation

Extract from the 7th General Report [CPT/Inf (97) 10]

A. Preliminary remarks

24. CPT visiting delegations frequently encounter foreign nationals deprived of their liberty under aliens legislation (hereafter "immigration detainees"): persons refused entry to the country concerned; persons who have entered the country illegally and have subsequently been identified by the authorities; persons whose authorisation to stay in the country has expired; asylum-seekers whose detention is considered necessary by the authorities; etc.

In the following paragraphs, some of the main issues pursued by the CPT in relation to such persons are described. The CPT hopes in this way to give a clear advance indication to national authorities of its views concerning the treatment of immigration detainees and, more generally, to stimulate discussion in relation to this category of persons deprived of their liberty. The Committee would welcome comments on this section of its General Report.

B. Detention facilities

25. CPT visiting delegations have met immigration detainees in a variety of custodial settings, ranging from holding facilities at points of entry to police stations, prisons and specialised detention centres. As regards more particularly transit and "international" zones at airports, the precise legal position of persons refused entry to a country and placed in such zones has been the subject of some controversy. On more than one occasion, the CPT has been confronted with the argument that such persons are not "deprived of their liberty" as they are free to leave the zone at any moment by taking any international flight of their choice.

For its part, the CPT has always maintained that a stay in a transit or "international" zone can, depending on the circumstances, amount to a deprivation of liberty within the meaning of Article 5 (1)(f) of the European Convention on Human Rights, and that consequently such zones fall within the Committee's mandate. The judgement delivered on 25 June 1996 by the European Court of Human Rights in the case of Amuur against France can be considered as vindicating this view. In that case, which concerned four asylum seekers held in the transit zone at Paris-Orly Airport for 20 days, the Court stated that "The mere fact that it is possible for asylum seekers to leave voluntarily the country where they wish to take refuge cannot exclude a restriction ("atteinte") on liberty ...." and held that "holding the applicants in the transit zone .... was equivalent in practice, in view of the restrictions suffered, to a deprivation of liberty".

26. **Point of entry holding facilities** have often been found to be inadequate, in particular for extended stays. More specifically, CPT delegations have on several occasions met persons held for days under makeshift conditions in airport lounges. It is axiomatic that such persons should be provided with suitable means for sleeping, granted access to their luggage and to suitably-equipped sanitary and washing facilities, and allowed to exercise in the open air on a daily basis. Further, access to food and, if necessary, medical care should be guaranteed.

27. In certain countries, CPT delegations have found immigration detainees held in **police stations** for prolonged periods (for weeks and, in certain cases, months), subject to mediocre material conditions of detention, deprived of any form of activity and on occasion obliged to share cells with criminal suspects. Such a situation is indefensible.

The CPT recognises that, in the very nature of things, immigration detainees may have to spend some time in an ordinary police detention facility. However, conditions in police stations will frequently - if not invariably - be inadequate for prolonged periods of detention. Consequently, the period of time spent by immigration detainees in such establishments should be kept to the absolute minimum.

28. On occasion, CPT delegations have found immigration detainees held in **prisons**. Even if the actual conditions of detention for these persons in the establishments concerned are adequate -which has not always been the case - the CPT considers such an approach to be fundamentally flawed. A prison is by definition not a suitable place in which to detain someone who is neither convicted nor suspected of a criminal offence.

Admittedly, in certain exceptional cases, it might be appropriate to hold an immigration detainee in a prison, because of a known potential for violence. Further, an immigration detainee in need of in-patient treatment might have to be accommodated temporarily in a prison health-care facility, in the event of no other secure hospital facility being available. However, such detainees should be held quite separately from prisoners, whether on remand or convicted.

29. In the view of the CPT, in those cases where it is deemed necessary to deprive persons of their liberty for an extended period under aliens legislation, they should be accommodated in **centres specifically designed for that purpose**, offering material conditions and a regime appropriate to their legal situation and staffed by suitably-qualified personnel. The Committee is pleased to note that such an approach is increasingly being followed in Parties to the Convention.

Obviously, such centres should provide accommodation which is adequately-furnished, clean and in a good state of repair, and which offers sufficient living space for the numbers involved. Further, care should be taken in the design and layout of the premises to avoid as far as possible any impression of a carceral environment. As regards regime activities, they should include outdoor exercise, access to a day room and to radio/television and newspapers/magazines, as well as other appropriate means of recreation (e.g. board games, table tennis). The longer the period for which persons are detained, the more developed should be the activities which are offered to them.

The staff of centres for immigration detainees have a particularly onerous task. Firstly, there will inevitably be communication difficulties caused by language barriers. Secondly, many detained persons will find the fact that they have been deprived of their liberty when they are not suspected of any criminal offence difficult to accept. Thirdly, there is a risk of tension between detainees of different nationalities or ethnic groups. Consequently, the CPT places a premium upon the supervisory staff in such centres being carefully selected and receiving appropriate training. As well as possessing well-developed qualities in the field of interpersonal communication, the staff concerned should be familiarised with the different cultures of the detainees and at least some of them should have relevant language skills. Further, they should be taught to recognise possible symptoms of stress reactions displayed by detained persons (whether post-traumatic or induced by socio-cultural changes) and to take appropriate action.

C. Safeguards during detention

30. Immigration detainees should - in the same way as other categories of persons deprived of their liberty - be entitled, as from the outset of their detention, to inform a person of their choice of their situation and to have access to a lawyer and a doctor. Further, they should be expressly informed, without delay and in a language they understand, of all their rights and of the procedure applicable to them.

The CPT has observed that these requirements are met in some countries, but not in others. In particular, visiting delegations have on many occasions met immigration detainees who manifestly had not been fully informed in a language they understood of their legal position. In order to overcome such difficulties, immigration detainees should be systematically provided with a document explaining the procedure applicable to them and setting out their rights. This document should be available in the languages most commonly spoken by those concerned and, if necessary, recourse should be had to the services of an interpreter.

31. The right of access to a lawyer should apply throughout the detention period and include both the right to speak with the lawyer in private and to have him present during interviews with the authorities concerned.

All detention facilities for immigration detainees should provide access to medical care. Particular attention should be paid to the physical and psychological state of asylum seekers, some of whom may have been tortured or otherwise ill-treated in the countries from which they have come. The right of access to a doctor should include the right - if a detainee so wishes - to be examined by a doctor of his choice; however, the detainee might be expected to cover the cost of such a second examination.

More generally, immigration detainees should be entitled to maintain contact with the outside world during their detention, and in particular to have access to a telephone and to receive visits from relatives and representatives of relevant organisations.

D. Risk of ill-treatment after expulsion

32. The prohibition of torture and inhuman or degrading treatment or punishment englobes the obligation not to send a person to a country where there are substantial grounds for believing that he would run a real risk of being subjected to torture or ill-treatment. Whether Parties to the Convention are fulfilling this obligation is obviously a matter of considerable interest to the CPT. What is the precise role that the Committee should seek to play in relation to that question?

33. Any communications addressed to the CPT in Strasbourg by persons alleging that they are to be sent to a country where they run a risk of being subjected to torture or ill-treatment are immediately brought to the attention of the European Commission of Human Rights [1]. The Commission is better placed than the CPT to examine such allegations and, if appropriate, take preventive action.

If an immigration detainee (or any other person deprived of his liberty) interviewed in the course of a visit alleges that he is to be sent to a country where he runs a risk of being subjected to torture or ill-treatment, the CPT's visiting delegation will verify that this assertion has been brought to the attention of the relevant national authorities and is being given due consideration. Depending on the circumstances, the delegation might request to be kept informed of the detainee's position and/or inform the detainee of the possibility of raising the issue with the European Commission of Human Rights (and, in the latter case, verify that he is in a position to submit a petition to the Commission).

34. However, in view of the CPT's essentially preventive function, the Committee is inclined to focus its attention on the question of whether the decision-making process as a whole offers suitable guarantees against persons being sent to countries where they run a risk of torture or ill-treatment. In this connection, the CPT will wish to explore whether the applicable procedure offers the persons concerned a real opportunity to present their cases, and whether officials entrusted with handling such cases have been provided with appropriate training and have access to objective and independent information about the human rights situation in other countries. Further, in view of the potential gravity of the interests at stake, the Committee considers that a decision involving the removal of a person from a State's territory should be appealable before another body of an independent nature prior to its implementation.

[1] Since 1 November 1998: "European Court of Human Rights"

E. Means of coercion in the context of expulsion procedures

35. Finally, the CPT must point out that it has received disturbing reports from several countries about the means of coercion employed in the course of expelling immigration detainees. Those reports have contained in particular allegations of beating, binding and gagging, and the administration of tranquillizers against the will of the persons concerned.

36. The CPT recognises that it will often be a difficult task to enforce an expulsion order in respect of a foreign national who is determined to stay on a State's territory. Law enforcement officials may on occasion have to use force in order to effect such a removal. However, the force used should be no more than is reasonably necessary. It would, in particular, be entirely unacceptable for persons subject to an expulsion order to be physically assaulted as a form of persuasion to board a means of transport or as punishment for not having done so. Further, the Committee must emphasise that to gag a person is a highly dangerous measure.

The CPT also wishes to stress that any provision of medication to persons subject to an expulsion order must only be done on the basis of a medical decision and in accordance with medical ethics.

Safeguards for irregular migrants deprived of their liberty

Extract from the 19th General Report [CPT/Inf (2009) 27]

Preliminary remarks

75. In the substantive section of its 7th General Report, published in 1997, the CPT described in some detail its position in relation to safeguards and conditions for foreign nationals deprived of their liberty under aliens legislation ("immigration detainees"), as well as its views concerning the expulsion of such persons.[1] In the intervening period, the CPT has carried out frequent visits to dedicated immigration detention centres as well as to police stations and prison establishments, in which immigration detainees continue to be held in a number of countries. These visits have, all too often, reinforced the Committee's opinion that immigration detainees are particularly vulnerable to various forms of ill-treatment, whether at the moment of apprehension, during the period of custody or while being deported.

Given the vulnerable nature of this group of persons, the CPT has, in the course of many of its visits, focused its attention on the treatment of immigration detainees. Further, the Committee has continued to develop its own standards, for example by the elaboration in the 13th General Report of guidelines on the deportation of foreign nationals by air, including immigration detainees.[2]

76. In this 19th General Report, the CPT is setting out its views on the safeguards that should be afforded to detained irregular migrants, with an additional special emphasis on children.[3] "Detained irregular migrants" is the term used to denote persons who have been deprived of their liberty under aliens legislation either because they have entered a country illegally (or attempted to do so) or because they have overstayed their legal permission to be in the country in question.

It should be noted that asylum seekers are not irregular migrants, although the persons concerned may become so should their asylum application be rejected and their leave to stay in a country rescinded. Whenever asylum seekers are deprived of their liberty pending the outcome of their application, they should be afforded a wide range of safeguards in line with their status, going beyond those applicable to irregular migrants which are set out in the following paragraphs.[4]

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1 See paragraphs 24 to 36 of doc. CPT/Inf (97) 10.

2 See paragraphs 27 to 45 of doc. CPT/Inf (2003) 35.

3 This is not to suggest that children are the only vulnerable group. Elderly persons and unaccompanied women, for instance, are also vulnerable.

4 For asylum seekers, certain international safeguards originate under the 1951 Geneva Convention relating to the Status of Refugees and its 1967 Protocol. Further, European Union legislation, in particular Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers, has established a number of guarantees; however, the applicability of this legislation is limited to EU member States. Reference should also be made to the Guidelines on human rights protection in the context of accelerated asylum procedures, adopted by the Committee of Ministers of the Council of Europe on 1 July 2009.

Deprivation of liberty of irregular migrants

77. In the course of its visits, the CPT has noted that a number of member States of the Council of Europe have made a concerted effort to improve the conditions of detention for irregular migrants. However, there are still far too many instances where the CPT comes across places of deprivation of liberty for irregular migrants, and on occasion asylum seekers, which are totally unsuitable. An illustrative example of such a place would be a disused warehouse, with limited or no sanitation, crammed with beds or mattresses on the floor, accommodating upwards of a hundred persons locked in together for weeks or even months, with no activities, no access to outdoor exercise and poor hygiene. CPT delegations also continue to find irregular migrants held in police stations, in conditions that are barely acceptable for twenty-four hours, let alone weeks.

In some States, irregular migrants are detained in prisons. In the CPT's opinion, a prison establishment is by definition not a suitable place in which to hold someone who is neither accused nor convicted of a criminal offence. Interestingly, prison managers and staff in the various establishments visited by the CPT often agree that they are not appropriately equipped or trained to look after irregular migrants. In this context, the CPT wishes to reiterate that staff working in centres for irregular migrants have a particularly onerous task. Consequently, they should be carefully selected and receive appropriate training.

78. Despite the existence of many detention facilities for irregular migrants in Council of Europe member States, there is still no comprehensive instrument covering the whole of the European continent[1] and setting out the minimum standards and safeguards for irregular migrants deprived of their liberty, in line with the specific needs of this particular group of persons.

The 2006 European Prison Rules apply to those irregular migrants who are detained in prisons. However, it is stressed in the Commentary to the Rules that immigration detainees should in principle not be held in prison. Therefore, the Rules do not address the special needs and status of irregular migrants, such as those issues related to the preparation and execution of deportation procedures. It should be noted here that in accordance with Article 5 (1) f of the European Convention on Human Rights, irregular migrants may be deprived of their liberty either when action is being taken with a view to deportation or in order to prevent an unauthorised entry into the country. The purpose of deprivation of liberty of irregular migrants is thus significantly different from that of persons held in prison either on remand or as convicted offenders.

[1] Directive 2008/115/EC of the European Parliament and of the Council of the European Union of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals provides, inter alia, standards related to irregular migrants deprived of their liberty. The Directive is applicable in most EU member States and some other countries and should be transposed into national legislation by the end of 2010.

79. Conditions of detention for irregular migrants should reflect the nature of their deprivation of liberty, with limited restrictions in place and a varied regime of activities. For example, detained irregular migrants should have every opportunity to remain in meaningful contact with the outside world (including frequent opportunities to make telephone calls and receive visits) and should be restricted in their freedom of movement within the detention facility as little as possible. Even when conditions of detention in prisons meet these requirements – and this is certainly not always the case – the CPT considers the detention of irregular migrants in a prison environment to be fundamentally flawed, for the reasons indicated above.

80. More generally, in certain countries, authorities routinely resort to administrative detention of irregular migrants pending deportation, sometimes with no time limitation or judicial review. It is clear that automatic administrative detention under such conditions runs the risk of being in contradiction with, inter alia, the case law of the European Court of Human Rights. In the CPT's view, States should be selective when exercising their power to deprive irregular migrants of their liberty; detention should only be resorted to after a careful examination of each individual case.

Basic rights at the initial stages of deprivation of liberty

81. The CPT considers that detained irregular migrants should, from the very outset of their deprivation of liberty, enjoy three basic rights, in the same way as other categories of detained persons. These rights are: (1) to have access to a lawyer, (2) to have access to a medical doctor, and (3) to be able to inform a relative or third party of one's choice about the detention measure.

82. The right of access to a lawyer should include the right to talk with a lawyer in private, as well as to have access to legal advice for issues related to residence, detention and deportation. This implies that when irregular migrants are not in a position to appoint and pay for a lawyer themselves, they should benefit from access to legal aid.

Further, all newly arrived detainees should be promptly examined by a doctor or by a fully-qualified nurse reporting to a doctor. The right of access to a doctor should include the right – if an irregular migrant so wishes – to be examined by a doctor of his/her choice; however, the detainee might be expected to meet the cost of such an examination.

Notifying a relative or third party of one's choice about the detention measure is greatly facilitated if irregular migrants are allowed to keep their mobile phones during deprivation of liberty or at least to have access to them.

83. In addition to these three basic rights, international treaties recognise the right of a detained irregular migrant to ask for consular assistance. However, as not all irregular migrants may wish to contact their national authorities, the exercise of this right must be left to the person concerned.

84. It is essential that newly arrived irregular migrants be immediately given information on these rights in a language they understand. To this end, they should be systematically provided with a document explaining the procedure applicable to them and setting out their rights in clear and simple terms. This document should be available in the languages most commonly spoken by the detainees and, if necessary, recourse should be had to the services of an interpreter.

General safeguards during deprivation of liberty

85. Every instance of deprivation of liberty should be covered by a proper individual detention order, readily available in the establishment where the person concerned is being held; and the detention order should be drawn up at the outset of the deprivation of liberty or as soon as possible thereafter. This basic requirement applies equally to irregular migrants who are deprived of their liberty. Further, the fundamental safeguards of persons detained by law enforcement agencies are reinforced if a single and comprehensive custody record is kept for every such person, recording all aspects of his/her custody and all action taken in connection with it.

86. Detained irregular migrants should benefit from an effective legal remedy enabling them to have the lawfulness of their deprivation of liberty decided speedily by a judicial body. This judicial review should entail an oral hearing with legal assistance, provided free of charge for persons without sufficient means, and interpretation (if required). Moreover, detained irregular migrants should be expressly informed of this legal remedy. The need for continued detention should be reviewed periodically by an independent authority.

87. Arrangements should be made enabling detained irregular migrants to consult a lawyer or a doctor on an ongoing basis, and to receive visits from NGO representatives, family members or other persons of their choice, and to have telephone contact with them.

If members of the same family are deprived of their liberty under aliens legislation, every effort should be made to avoid separating them.

88. It is in the interests of both irregular migrants and staff that there be clear house rules for all detention facilities, and copies of the rules should be made available in a suitable range of languages. The house rules should primarily be informative in nature and address the widest range of issues, rights and duties which are relevant to daily life in detention. The house rules should also contain disciplinary procedures and provide detainees with the right to be heard on the subject of violations that they are alleged to have committed, and to appeal to an independent authority against any sanctions imposed. Without such rules, there is a risk of an unofficial (and uncontrolled) disciplinary system developing.

In case of the application of a segregation measure for security reasons or for the irregular migrant's own protection, these procedures should be accompanied by effective safeguards. The person concerned should be informed of the reasons for the measure taken against him/her, be given the opportunity to present his/her views on the matter prior to the measure being implemented, and be able to contest the measure before an appropriate authority.

89. Independent monitoring of detention facilities for irregular migrants is an important element in the prevention of ill-treatment and, more generally, of ensuring satisfactory conditions of detention. To be fully effective, monitoring visits should be both frequent and unannounced. Further, monitoring bodies should be empowered to interview irregular migrants in private and should examine all issues related to their treatment (material conditions of detention, custody records and other documentation, the exercise of detained persons' rights, health care, etc.).

Health-related safeguards

90. The assessment of the state of health of irregular migrants during their deprivation of liberty is an essential responsibility in relation to each individual detainee and in relation to a group of irregular migrants as a whole. The mental and physical health of irregular migrants may be negatively affected by previous traumatic experiences. Further, the loss of accustomed personal and cultural surroundings and uncertainty about one's future may lead to mental deterioration, including exacerbation of pre-existing symptoms of depression, anxiety and post-traumatic disorder.

91. At a minimum, a person with a recognised nursing qualification must be present on a daily basis at all centres for detained irregular migrants. Such a person should, in particular, perform the initial medical screening of new arrivals (in particular for transmissible diseases, including tuberculosis), receive requests to see a doctor, ensure the provision and distribution of prescribed medicines, keep the medical documentation and supervise the general conditions of hygiene.

92. Obviously, medical confidentiality should be observed in the same way as in the outside community; in particular, irregular migrants' medical files should not be accessible to non-medical staff but, on the contrary, should be kept under lock and key by the nurse or doctor. Moreover, all medical examinations should be conducted out of the hearing and – unless the doctor concerned requests otherwise in a particular case – out of the sight of custodial staff.

Whenever members of the medical and/or nursing staff are unable to make a proper diagnostic evaluation because of language problems, they should be able to benefit without delay from the services of a qualified interpreter. Further, detained irregular migrants should be fully informed about the treatment being offered to them.

Three other important safeguards

93. The prohibition of torture and inhuman or degrading treatment or punishment entails the obligation not to send a person to a country where there are substantial grounds for believing that he or she would run a real risk of being subjected to torture or other forms of ill-treatment. Accordingly, irregular migrants should have ready access to an asylum procedure (or other residence procedure) which guarantees both confidentiality and an objective and independent analysis of the human rights situation in other countries; an individual assessment of the risk of ill-treatment in case of deportation to the country of origin or a third country should be carried out. The CPT is concerned that in certain countries the time-limit for submitting an application for asylum is limited by law to a number of days from the date of arrival in the country or in a detention facility; applications submitted after the deadline are not considered. Such an approach increases the possibility of persons being sent to a country where they run a real risk of being subjected to torture or other forms of ill-treatment.

94. In this context, the CPT has grave misgivings about the policy adopted by certain countries of intercepting, at sea, boats transporting irregular migrants and returning the persons concerned to North or North-West Africa. A practice with similar implications allegedly takes place at certain European land borders.

Countries that implement such policies or practices could well be at risk of breaching the fundamental principle of "non-refoulement", a principle which forms part of international human rights law as well as of European Union law. This is particularly the case when the countries to which irregular migrants are sent have not ratified or acceded to the 1951 Geneva Convention relating to the Status of Refugees.

95. In line with the Twenty guidelines on forced return adopted by the Committee of Ministers on 4 May 2005, removal orders should be issued in each and every case based on a decision following national laws and procedures, and in accordance with international human rights obligations. The removal order should be handed over in writing to the person concerned. Moreover, there should be the possibility to appeal against the order, and the deportation should not be carried out before the decision on any appeal has been delivered. The assistance of a lawyer and an interpreter should be guaranteed also at this stage of the procedure.

96. Thirdly, in respect of any place where persons are deprived of their liberty by a public authority, the CPT consistently recommends that any sign of injury to a person who alleges ill-treatment, as well as the relevant statements made by the person concerned and the doctor's conclusions (as to the degree of consistency between the person's statement and the injuries observed), be duly recorded by the doctor on a form designed for that purpose. A similar record should be made even in the absence of a specific allegation, when there are grounds to believe that ill-treatment may have occurred. Procedures should be in place to ensure that whenever injuries are recorded by a doctor which are consistent with allegations of ill-treatment made by the person concerned (or which, even in the absence of an allegation, are clearly indicative of ill-treatment), the record is systematically brought to the attention of the competent judicial or prosecuting authorities.

Additional safeguards for children

97. The CPT considers that every effort should be made to avoid resorting to the deprivation of liberty of an irregular migrant who is a minor.[1] Following the principle of the "best interests of the child", as formulated in Article 3 of the United Nations Convention on the Rights of the Child, detention of children, including unaccompanied and separated children,[2] is rarely justified and, in the Committee's view, can certainly not be motivated solely by the absence of residence status.

When, exceptionally, a child is detained, the deprivation of liberty should be for the shortest possible period of time; all efforts should be made to allow the immediate release of unaccompanied or separated children from a detention facility and their placement in more appropriate care. Further, owing to the vulnerable nature of a child, additional safeguards should apply whenever a child is detained, particularly in those cases where the children are separated from their parents or other carers, or are unaccompanied, without parents, carers or relatives.

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[1] In case of uncertainty about whether a particular irregular migrant is a minor (i.e. under 18 years of age), the person in question should be treated as if he or she is a minor until the contrary is proven.

[2] "Unaccompanied children" (also called unaccompanied minors) are children who have been separated from both parents and other relatives and who are not being cared for by an adult who, by law or custom, is responsible for doing so. "Separated children" are children who have been separated from both parents, or from their previous legal or customary primary carer, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members.

98. As soon as possible after the presence of a child becomes known to the authorities, a professionally qualified person should conduct an initial interview, in a language the child understands. An assessment should be made of the child's particular vulnerabilities, including from the standpoints of age, health, psychosocial factors and other protection needs, including those deriving from violence, trafficking or trauma. Unaccompanied or separated children deprived of their liberty should be provided with prompt and free access to legal and other appropriate assistance, including the assignment of a guardian or legal representative. Review mechanisms should also be introduced to monitor the ongoing quality of the guardianship.

99. Steps should be taken to ensure a regular presence of, and individual contact with, a social worker and a psychologist in establishments holding children in detention. Mixed-gender staffing is another safeguard against ill-treatment; the presence of both male and female staff can have a beneficial effect in terms of the custodial ethos and foster a degree of normality in a place of detention. Children deprived of their liberty should also be offered a range of constructive activities (with particular emphasis on enabling a child to continue his or her education).

100. In order to limit the risk of exploitation, special arrangements should be made for living quarters that are suitable for children, for example, by separating them from adults, unless it is considered in the child's best interests not to do so. This would, for instance, be the case when children are in the company of their parents or other close relatives. In that case, every effort should be made to avoid splitting up the family.

Deportation of foreign nationals by air

Extract from the 13th General Report [CPT/Inf (2003) 35]

27. As from the beginning of its activities, the CPT has examined the conditions of detention of persons deprived of their liberty under aliens legislation, and this issue was dealt with in a section of the CPT's 7th General Report (CPT/Inf (97) 10, paragraphs 24 to 36). The CPT set out in that report some basic rules concerning the use of force and means of restraint in the context of procedures for the deportation of immigration detainees.

28. The CPT's visits since that report have enabled it to flesh out its knowledge of practices concerning the deportation of foreign nationals by air. During its visits, the CPT has concentrated on procedures involving forcible departure with an escort[1], and on a number of cases brought to its attention, in particular because of the death of the deported person, the extent of the means of restraint used and/or allegations of ill-treatment. The CPT did not confine its examination to the procedure followed when the person concerned boarded the plane and during the flight; it also monitored many other aspects, such as detention prior to deportation, steps taken to prepare for the immigration detainee's return to the country of destination, measures to ensure suitable selection and training of escort staff, internal and external systems for monitoring the conduct of staff responsible for deportation escorts, measures taken following an abortive deportation attempt, etc.

29. In order to be able to make a detailed study of the procedures and means used during deportation operations, the CPT obtained copies of the relevant instructions and directives. It also obtained copies of many other documents (statistics on deportation operations, escort assignment orders, escort assignment reports, incident reports, reports in the context of legal proceedings, medical certificates, etc.) and examined the restraint equipment used during deportation operations. It also had detailed interviews in various countries with those in charge of units responsible for deportation operations and with prospective deportees met on the spot, some of whom had been brought back to holding facilities after an abortive deportation attempt.

30. After its visits, the CPT drew up a number of guidelines, which it recommended the countries concerned to follow. In order to promote widespread application of these guidelines in all the States Parties to the Convention, the Committee has decided to group together the most important principles and comment on them below.

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[1] Deportation procedures tend to be classified according to a number of factors, such as the extent to which force is used, the type of means of restraint employed, and the number of persons escorting the deportee. For example, one of the countries visited recently distinguished between departures in which no resistance was offered, forcible departures without an escort and forcible departures with an escort. In general, the most problematic procedures were those involving the combined use of force, several means of restraint and a large number of escort staff until the deportee's arrival in the country of final destination.

Of course, what follows must be read in the light of a State's fundamental obligation not to send a person to a country where there are substantial grounds for believing that he/she would run a real risk of being subjected to torture or ill-treatment.

31. The CPT recognizes that it will often be a difficult and stressful task to enforce a deportation order in respect of a foreign national who is determined to stay on a State's territory. It is also clear, in the light of all the CPT's observations in various countries – and particularly from an examination of a number of deportation files containing allegations of ill-treatment – that deportation operations by air entail a manifest risk of inhuman and degrading treatment. This risk exists both during preparations for deportation and during the actual flight; it is inherent in the use of a number of individual means/methods of restraint, and is even greater when such means/methods are used in combination.

32. At the outset it should be recalled that **it is entirely unacceptable for persons subject to a deportation order to be physically assaulted as a form of persuasion to board a means of transport or as a punishment for not having done so.** The CPT welcomes the fact that this rule is reflected in many of the relevant instructions in the countries visited. For instance, some instructions which the CPT examined prohibit the use of means of restraint designed to punish the foreigner for resisting or which cause unnecessary pain.

33. Clearly, one of the key issues arising when a deportation operation is carried out is the use of force and means of restraint by escort staff. The CPT acknowledges that such staff are, on occasion, obliged to use force and means of restraint in order to effectively carry out the deportation; however, **the force and the means of restraint used should be no more than is reasonably necessary.** The CPT welcomes the fact that in some countries the use of force and means of restraint during deportation procedures is reviewed in detail, in the light of the principles of lawfulness, proportionality and appropriateness.

34. The question of the use of force and means of restraint arises from the moment the detainee concerned is taken out of the cell in which he/she is being held pending deportation (whether that cell is located on airport premises, in a holding facility, in a prison or a police station). The techniques used by escort personnel to immobilise the person to whom means of physical restraint – such as steel handcuffs or plastic strips – are to be applied deserve special attention. In most cases, the detainee will be in full possession of his/her physical faculties and able to resist handcuffing violently. In cases where resistance is encountered, escort staff usually immobilise the detainee completely on the ground, face down, in order to put on the handcuffs. Keeping a detainee in such a position, in particular with escort staff putting their weight on various parts of the body (pressure on the ribcage, knees on the back, immobilisation of the neck) when the person concerned puts up a struggle, entails a risk of positional asphyxia[1].

[1] See, in particular, "Positional Asphyxia – Sudden Death", US Department of Justice, June 1995, and the proceedings of the "Safer Restraint" Conference held in London in April 2002 under the aegis of the UK Police Complaints Authority (cf. www.pca.gov.uk).

There is a similar risk when a deportee, having been placed on a seat in the aircraft, struggles and the escort staff, by applying force, oblige him/her to bend forward, head between the knees, thus strongly compressing the ribcage. In some countries, the use of force to make the person concerned bend double in this way in the passenger seat is, as a rule, prohibited, this method of immobilisation being permitted only if it is absolutely indispensable in order to carry out a specific, brief, authorised operation, such as putting on, checking or taking off handcuffs, and only for the duration strictly necessary for this purpose.

The CPT has made it clear that **the use of force and/or means of restraint capable of causing positional asphyxia should be avoided whenever possible and that any such use in exceptional circumstances must be the subject of guidelines designed to reduce to a minimum the risks to the health of the person concerned.**

35. The CPT has noted with interest the directives in force in certain countries, according to which means of restraint must be removed during the flight (as soon as take-off has been completed). If, exceptionally, the means of restraint had to be left in place, because the deportee continued to act aggressively, the escort staff were instructed to cover the foreigner's limbs with a blanket (such as that normally issued to passengers), so as to conceal the means of restraint from other passengers.

On the other hand, instructions such as those followed until recently in one of the countries visited in connection with the most problematic deportation operations, whereby the persons concerned were made to wear nappies and prevented from using the toilet throughout the flight on account of their presumed dangerousness, can only lead to a degrading situation.

36. In addition to the avoidance of the risks of positional asphyxia referred to above, the CPT has systematically recommended **an absolute ban on the use of means likely to obstruct the airways (nose and/or mouth) partially or wholly.** Serious incidents that have occurred in various countries over the last ten years in the course of deportations have highlighted the considerable risk to the lives of the persons concerned of using these methods (gagging the mouth and/or nose with adhesive tape, putting a cushion or padded glove on the face, pushing the face against the back of the seat in front, etc.). The CPT drew the attention of States Parties to the Convention to the dangers of methods of this kind as far back as 1997, in its 7th General Report. It notes that this practice is now expressly prohibited in many States Parties and **invites States which have not already done so to introduce binding provisions in this respect without further delay**.

37. It is essential that, in the event of a flight emergency while the plane is airborne, the rescue of the person being deported is not impeded. Consequently, **it must be possible to remove immediately any means restricting the freedom of movement of the deportee, upon an order from the crew**.

Account should also be taken of the health risks connected with the so-called "economy-class syndrome" in the case of persons who are confined to their seats for long periods[1].

38. Two particular points were of concern to the CPT after visits to certain countries: the wearing of masks by deportation escorts and the use, by the latter, of incapacitating or irritant gases to remove immigration detainees from their cells in order to transfer them to the aircraft.

In the CPT's opinion, **security considerations can never serve to justify escort staff wearing masks during deportation operations.** This practice is highly undesirable, since it could make it very difficult to ascertain who is responsible in the event of allegations of ill-treatment.

The CPT also has very serious reservations about the use of incapacitating or irritant gases to bring recalcitrant detainees under control in order to remove them from their cells and transfer them to the aircraft. The use of such gases in very confined spaces, such as cells, entails manifest risks to the health of both the detainee and the staff concerned. Staff should be trained in other control techniques (for instance, manual control techniques or the use of shields) to immobilise a recalcitrant detainee.

39. Certain incidents that have occurred during deportation operations have highlighted **the importance of allowing immigration detainees to undergo a medical examination before the decision to deport them is implemented**. This precaution is particularly necessary when the use of force and/or special measures is envisaged.

Similarly, **all persons who have been the subject of an abortive deportation operation must undergo a medical examination as soon as they are returned to detention** (whether in a police station, a prison or a holding facility specially designed for foreigners). In this way it will be possible to verify the state of health of the person concerned and, if necessary, establish a certificate attesting to any injuries. Such a measure could also protect escort staff against unfounded allegations.

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[1] See, in particular, "Frequency and prevention of symptomless deep-vein thrombosis in long-haul flights: a randomised trial", John Scurr et al, *The Lancet*, Vol. 357, 12 May 2001.

40. During many visits, the CPT has heard allegations that immigration detainees had been injected with medication having a tranquillising or sedative effect, in order to ensure that their deportation proceeded without difficulty. On the other hand, it also noted in certain countries that instructions prohibited the administration, against the will of the person concerned, of tranquillisers or other medication designed to bring him or her under control. **The CPT considers that the administration of medication to persons subject to a deportation order must always be carried out on the basis of a medical decision taken in respect of each particular case. Save for clearly and strictly defined exceptional circumstances, medication should only be administered with the informed consent of the person concerned.**

41. **Operations involving the deportation of immigration detainees must be preceded by measures to help the persons concerned organise their return, particularly on the family, work and psychological fronts.** It is essential that immigration detainees be informed sufficiently far in advance of their prospective deportation, so that they can begin to come to terms with the situation psychologically and are able to inform the people they need to let know and to retrieve their personal belongings. The CPT has observed that a constant threat of forcible deportation hanging over detainees who have received no prior information about the date of their deportation can bring about a condition of anxiety that comes to a head during deportation and may often turn into a violent agitated state. In this connection, the CPT has noted that, in some of the countries visited, there was a psycho-social service attached to the units responsible for deportation operations, staffed by psychologists and social workers who were responsible, in particular, for preparing immigration detainees for their deportation (through ongoing dialogue, contacts with the family in the country of destination, etc.). Needless to say, **the CPT welcomes these initiatives and invites those States which have not already done so to set up such services**.

42. The proper conduct of deportation operations depends to a large extent on the quality of the staff assigned to escort duties. Clearly, **escort staff must be selected with the utmost care and receive appropriate, specific training designed to reduce the risk of ill-treatment to a minimum.** This was often far from being the case in the States Parties visited. In some countries, however, special training had been organised (methods and means of restraint, stress and conflict management, etc.). Moreover, certain management strategies had had a beneficial effect: the assignment of escort duties to staff who volunteered, combined with compulsory rotation (in order to avoid professional exhaustion syndrome and the risks related to routine, and ensure that the staff concerned maintained a certain emotional distance from the operational activities in which they were involved) as well as provision, on request, of specialised psychological support for staff.

43. **The importance of establishing internal and external monitoring systems in an area as sensitive as deportation operations by air cannot be overemphasised.** The CPT observed that in many countries, specific monitoring systems had, unfortunately, been introduced only after particularly serious incidents, such as the death of deportees.

44. **Deportation operations must be carefully documented.** The establishment of a comprehensive file and a deportation record, to be kept for all operations carried out by the units concerned, is a basic requirement. Information on abortive deportation attempts should receive special attention and, in particular, the reasons for abandoning a deportation operation (a decision taken by the escort team on managerial orders, a refusal on the part of the captain of the aircraft, violent resistance on the part of the deportee, a request for asylum, etc.) should be systematically recorded. The information recorded should cover every incident and every use of means of restraint (handcuffs; ankle cuffs; knee cuffs; use of self-defence techniques; carrying the deportee on board; etc.).

Other means, for instance audiovisual, may also be envisaged, and are used in some of the countries visited, in particular for deportations expected to be problematic. In addition, surveillance cameras could be installed in various areas (corridors providing access to cells, route taken by the escort and the deportee to the vehicle used for transfer to the aircraft, etc.).

45. **It is also beneficial if each deportation operation where difficulties are foreseeable is monitored by a manager from the competent unit, able to interrupt the operation at any time.** In some of the countries visited, the CPT found that there were spot checks, both during preparations for deportation and during boarding, by members of internal police supervisory bodies. What is more, in an admittedly limited number of cases, members of the supervisory bodies boarded aircraft incognito and thus monitored the deportee and the escort until arrival at the destination. The CPT can only welcome these initiatives, which are all too rare at present in Europe.

Further, **the CPT wishes to stress the role to be played by external supervisory (including judicial) authorities, whether national or international, in the prevention of ill-treatment during deportation operations**. These authorities should keep a close watch on all developments in this respect, with particular regard to the use of force and means of restraint and the protection of the fundamental rights of persons deported by air.

V. Juveniles deprived of their liberty

Extract from the 9th General Report [CPT/Inf (99) 12]

Preliminary remarks

20. In certain of its previous general reports, the CPT has set out the criteria which guide its work in a variety of places of detention, including police stations, prisons, holding centres for immigration detainees and psychiatric establishments.

The Committee applies the above-mentioned criteria, to the extent to which they are appropriate, in respect of juveniles (i.e. persons under the age of 18) deprived of their liberty. However - regardless of the reason for which they may have been deprived of their liberty - juveniles are inherently more vulnerable than adults. In consequence, particular vigilance is required to ensure that their physical and mental well-being is adequately protected. In order to highlight the importance which it attaches to the prevention of ill-treatment of juveniles deprived of their liberty, the CPT has chosen to devote this chapter of its 9th General Report to describing some of the specific issues which it pursues in this area.

In the following paragraphs, the Committee identifies a number of the safeguards against ill-treatment which it considers should be offered to all juveniles deprived of their liberty, before focussing on the conditions which should obtain in detention centres specifically designed for juveniles. The Committee hopes in this way to give a clear indication to national authorities of its views regarding the manner in which such persons ought to be treated. As in previous years, **the CPT would welcome comments on this substantive section of its General Report.**

21. The Committee wishes to stress at the outset that any standards which it may be developing in this area should be seen as being complementary to those set out in a panoply of other international instruments, including the 1989 United Nations Convention on the Rights of the Child; the 1985 United Nations Standard Minimum Rules for the Administration of Juvenile Justice (*the Beijing Rules*); the 1990 United Nations Rules for the Protection of Juveniles Deprived of their Liberty and the 1990 United Nations Guidelines for the Prevention of Juvenile Delinquency (*the Riyadh Guidelines*).

The Committee also wishes to express its approval of one of the cardinal principles enshrined in the above-mentioned instruments, namely that juveniles should only be deprived of their liberty as a last resort and for the shortest possible period of time (cf. Article 37 b. of the Convention on the Rights of the Child and Rules 13 and 19 of *the Beijing Rules*).

Safeguards against the ill-treatment of juveniles

22. Given its mandate, the CPT's first priority during visits to places where juveniles are deprived of their liberty is to seek to establish whether they are being subjected to deliberate ill-treatment. The Committee's findings to date would suggest that, in most of the establishments which it visits, this is a comparatively rare occurrence.

23. However, as is the case for adults, it would appear that juveniles run a higher risk of being deliberately ill-treated in police establishments than in other places of detention. Indeed, on more than one occasion, CPT delegations have gathered credible evidence that juveniles have featured amongst the persons tortured or otherwise ill-treated by police officers.

In this context, the CPT has stressed that it is during the period immediately following deprivation of liberty that the risk of torture and ill-treatment is at its greatest. It follows that it is essential that all persons deprived of their liberty (including juveniles) enjoy, as from the moment when they are first obliged to remain with the police, the rights to notify a relative or another third party of the fact of their detention, the right of access to a lawyer and the right of access to a doctor.

Over and above these safeguards, certain jurisdictions recognise that the inherent vulnerability of juveniles requires that additional precautions be taken. These include placing police officers under a formal obligation themselves to ensure that an appropriate person is notified of the fact that a juvenile has been detained (regardless of whether the juvenile requests that this be done). It may also be the case that police officers are not entitled to interview a juvenile unless such an appropriate person and/or a lawyer is present. The CPT welcomes this approach.

24. In a number of other establishments visited, CPT delegations have been told that it was not uncommon for staff to administer the occasional "pedagogic slap" to juveniles who misbehaved. The Committee considers that, in the interests of the prevention of ill-treatment, all forms of physical chastisement must be both formally prohibited and avoided in practice. Inmates who misbehave should be dealt with only in accordance with prescribed disciplinary procedures.

25. The Committee's experience also suggests that when ill-treatment of juveniles does occur, it is more often the result of a failure adequately to protect the persons concerned from abuse than of a deliberate intention to inflict suffering. An important element in any strategy to prevent such abuse is observance of the principle that juveniles in detention should as a rule be accommodated separately from adults.

Examples of a failure to respect this principle which have been observed by the CPT have included: adult male prisoners being placed in cells for male juveniles, often with the intention that they maintain control in those cells; female juveniles being accommodated together with adult women prisoners; juvenile psychiatric patients sharing accommodation with chronically ill adult patients.

The Committee accepts that there may be exceptional situations (e.g. children and parents being held as immigration detainees) in which it is plainly in the best interests of juveniles not to be separated from particular adults. However, to accommodate juveniles and unrelated adults together inevitably brings with it the possibility of domination and exploitation.

26. Mixed gender staffing is another safeguard against ill-treatment in places of detention, in particular where juveniles are concerned. The presence of both male and female staff can have a beneficial effect in terms of both the custodial ethos and in fostering a degree of normality in a place of detention.

Mixed gender staffing also allows for appropriate staff deployment when carrying out gender sensitive tasks, such as searches. In this respect, the CPT wishes to stress that, regardless of their age, persons deprived of their liberty should only be searched by staff of the same gender and that any search which requires an inmate to undress should be conducted out of the sight of custodial staff of the opposite gender; these principles apply *a fortiori* in respect of juveniles.

27. Lastly, in a number of establishments visited, CPT delegations have observed custodial staff who come into direct contact with juveniles openly carrying batons. Such a practice is not conducive to fostering positive relations between staff and inmates. Preferably, custodial staff should not carry batons at all. If, nevertheless, it is considered indispensable for them to do so, the CPT recommends that the batons be hidden from view.

Detention centres for juveniles

1. introduction

28. In the view of the CPT, all juveniles deprived of their liberty because they are accused or convicted of criminal offences ought to be held in detention centres specifically designed for persons of this age, offering regimes tailored to their needs and staffed by persons trained in dealing with the young.

Moreover, the care of juveniles in custody requires special efforts to reduce the risks of long-term social maladjustment. This calls for a multidisciplinary approach, drawing upon the skills of a range of professionals (including teachers, trainers and psychologists), in order to respond to the individual needs of juveniles within a secure educative and socio-therapeutic environment.

2. material conditions of detention

29. A well-designed juvenile detention centre will provide positive and personalised conditions of detention for young persons deprived of their liberty. In addition to being of an adequate size, well lit and ventilated, juveniles' sleeping and living areas should be properly furnished, well-decorated and offer appropriate visual stimuli. Unless there are compelling security reasons to the contrary, juveniles should be allowed to keep a reasonable quantity of personal items.

30. The CPT would add that, in certain establishments, it has observed a tendency to overlook the personal hygiene needs of female detainees, including juvenile girls. For this population in custody, ready access to sanitary and washing facilities as well as provision of hygiene items, such as sanitary towels, is of particular importance. The failure to provide such basic necessities can amount, in itself, to degrading treatment.

3. regime activities

31. Although a lack of purposeful activity is detrimental for any prisoner, it is especially harmful for juveniles, who have a particular need for physical activity and intellectual stimulation. Juveniles deprived of their liberty should be offered a full programme of education, sport, vocational training, recreation and other purposeful activities. Physical education should constitute an important part of that programme.

It is particularly important that girls and young women deprived of their liberty should enjoy access to such activities on an equal footing with their male counterparts. All too often, the CPT has encountered female juveniles being offered activities which have been stereotyped as "appropriate" for them (such as sewing or handicrafts), whilst male juveniles are offered training of a far more vocational nature. In this respect, the CPT wishes to express its approval of the principle set forth in Rule 26.4 of the *Beijing Rules*, to the effect that every effort must be made to ensure that female juveniles deprived of their liberty "by no means receive less care, protection, assistance, treatment and training than young male offenders. Their fair treatment shall be ensured."

32. The regimes of a number of the juvenile detention centres visited by the Committee have included generalised incentive schemes, which allow juveniles to attain additional privileges in exchange for displaying approved behaviour.

It is not for the CPT to express a view on the socio-educative value of such schemes. However, it pays particularly close attention to the content of the base-level regime being offered to juveniles subject to such schemes, and to whether the manner in which they may progress (and regress) within a given scheme includes adequate safeguards against arbitrary decision-making by staff.

4. staffing issues

33. The custody and care of juveniles deprived of their liberty is a particularly challenging task. The staff called upon to fulfil that task should be carefully selected for their personal maturity and ability to cope with the challenges of working with - and safeguarding the welfare of - this age group. More particularly, they should be committed to working with young people, and be capable of guiding and motivating the juveniles in their charge. All such staff, including those with purely custodial duties, should receive professional training, both during induction and on an ongoing basis, and benefit from appropriate external support and supervision in the exercise of their duties.

Moreover, the management of such centres should be entrusted to persons with advanced leadership skills, who have the capacity to respond in an effective manner to the complex and competing demands placed upon them, both by juveniles and by staff.

5. contact with the outside world

34. The CPT attaches considerable importance to the maintenance of good contact with the outside world for all persons deprived of their liberty. The guiding principle should be to promote contact with the outside world; any restrictions on such contacts should be based exclusively on security concerns of an appreciable nature or considerations linked to available resources.

The active promotion of such contacts can be especially beneficial for juveniles deprived of their liberty, many of whom may have behavioural problems related to emotional deprivation or a lack of social skills.

The CPT also wishes to stress that a juvenile's contact with the outside world should never be restricted or denied as a disciplinary measure.

6. discipline

35. Places where juveniles may be deprived of their liberty almost invariably make provision for disciplinary sanctions to be applied to inmates who misbehave.

In this connection, the CPT is particularly concerned about the placement of juveniles in conditions resembling solitary confinement, a measure which can compromise their physical and/or mental integrity. The Committee considers that resort to such a measure must be regarded as highly exceptional. If juveniles are held separately from others, this should be for the shortest possible period of time and, in all cases, they should be guaranteed appropriate human contact, granted access to reading material and offered at least one hour of outdoor exercise every day.

All disciplinary procedures applied to juveniles should be accompanied by formal safeguards and be properly recorded. In particular, juveniles should have the right to be heard on the subject of the offence which they are alleged to have committed, and to appeal before a higher authority against any sanctions imposed; full details of all such sanctions should be recorded in a register kept in each establishment where juveniles are deprived of their liberty.

7. complaints and inspection procedures

36. Effective complaints and inspection procedures are basic safeguards against ill-treatment in juvenile establishments.

Juveniles should have avenues of complaint open to them, both within and outside the establishments' administrative system, and be entitled to confidential access to an appropriate authority.

The CPT also attaches particular importance to regular visits to all juvenile establishments by an independent body (for example, a visiting committee or a judge) with authority to receive - and, if necessary, take action on - juveniles' complaints and to inspect the accommodation and facilities.

8. medical issues

37. When examining the issue of health-care services in prisons in its 3rd General Report (cf. CPT/Inf (93) 12, paragraphs 30 to 77), the CPT identified a number of general criteria which have guided its work (access to a doctor; equivalence of care; patient's consent and confidentiality; preventive health care; professional independence and professional competence). Those criteria apply with equal force to detention centres for juveniles.

38. Of course, the CPT pays special attention to the specific medical needs of juveniles deprived of their liberty.

It is particularly important that the health care service offered to juveniles constitutes an integrated part of a multidisciplinary (medico-psycho-social) programme of care. This implies inter alia that there should be close co-ordination between the work of an establishment's health care team (doctors, nurses, psychologists, etc.) and that of other professionals (including social workers and teachers) who have regular contact with inmates. The goal should be to ensure that the health care delivered to juveniles deprived of their liberty forms part of a seamless web of support and therapy.

It is also desirable that the content of a detention centre's programme of care be set out in writing and made available to all members of staff who may be called upon to participate in it.

39. All juveniles deprived of their liberty should be properly interviewed and physically examined by a medical doctor as soon as possible after their admission to the detention centre; save for in exceptional circumstances, the interview/examination should be carried out on the day of admission. However, a newly-arrived juvenile's first point of contact with the health care service could be a fully-qualified nurse who reports to a doctor.

If properly performed, such medical screening on admission should enable the establishment's health care service to identify young persons with potential health problems (e.g. drug addiction, suicidal tendencies). The identification of such problems at a sufficiently early stage will facilitate the taking of effective preventive action within the framework of the establishment's medico-psycho-social programme of care.

40. Further, it is axiomatic that all juveniles deprived of their liberty should be able to have confidential access to a doctor at any time, regardless of the regime (including disciplinary confinement) to which they may be subjected. Appropriate access to a range of specialist medical care, including dentistry, should also be guaranteed.

41. The task of the health care service in any place of detention should not be limited to treating sick patients; it should also be entrusted with responsibility for social and preventive medicine. In this connection, the CPT wishes to highlight two aspects of particular concern as regards juveniles deprived of their liberty, namely, inmates' nutrition and the provision of health education.

Health care staff should play an active part in monitoring the quality of the food which is being provided to inmates. This is particularly important for juveniles, who may not have reached their full growth potential. In such cases, the consequences of inadequate nutrition may become evident more rapidly - and be more serious - than for those who have reached full physical maturity.

It is also widely recognised that juveniles deprived of their liberty have a tendency to engage in risk-taking behaviour, especially with respect to drugs (including alcohol) and sex. In consequence, the provision of health education relevant to young persons is an important element of a preventive health care programme. Such a programme should, in particular, include the provision of information about the risks of drug abuse and about transmittable diseases.

VI. Women deprived of their liberty

Extract from the 10th General Report [CPT/Inf (2000) 13]

Preliminary remarks

21. In certain of its previous general reports, the CPT has set out the criteria which guide its work in a variety of places of detention, including police stations, prisons, holding centres for immigration detainees, psychiatric establishments and detention centres for juveniles.

Naturally, the Committee applies the above-mentioned criteria in respect of both women and men who are deprived of their liberty. However, in all Council of Europe member States, women inmates represent a comparatively small minority of persons deprived of their liberty. This can render it very costly for States to make separate provision for women in custody, with the result that they are often held at a small number of locations (on occasion, far from their homes and those of any dependent children), in premises which were originally designed for (and may be shared by) male detainees. In these circumstances, particular care is required to ensure that women deprived of their liberty are held in a safe and decent custodial environment.

In order to highlight the importance which it attaches to the prevention of ill-treatment of women deprived of their liberty, the CPT has chosen to devote this chapter of its 10th General Report to describing some of the specific issues which it pursues in this area. The Committee hopes in this way to give a clear indication to national authorities of its views regarding the manner in which women deprived of their liberty ought to be treated. As in previous years, **the CPT would welcome comments on this substantive section of its General Report.**

22. It should be stressed at the outset that the CPT's concerns about the issues identified in this chapter apply irrespective of the nature of the place of detention. Nevertheless, in the CPT's experience, risks to the physical and/or psychological integrity of women deprived of their liberty may be greater during the period immediately following apprehension. Consequently, particular attention should be paid to ensuring that the criteria enunciated in the following sections are respected during that phase.

The Committee also wishes to emphasise that any standards which it may be developing in this area should be seen as being complementary to those set out in other international instruments, including the European Convention on Human Rights, the United Nations Convention on the Rights of the Child, the United Nations Convention on the Elimination of All Forms of Discrimination Against Women and the United Nations Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment.

Mixed gender staffing

23. As the CPT stressed in its 9th General Report, mixed gender staffing is an important safeguard against ill-treatment in places of detention. The presence of male and female staff can have a beneficial effect in terms of both the custodial ethos and in fostering a degree of normality in a place of detention.

Mixed gender staffing also allows for appropriate staff deployment when carrying out gender sensitive tasks, such as searches. In this context, the CPT wishes again to emphasise that persons deprived of their liberty should only be searched by staff of the same gender and that any search which requires an inmate to undress should be conducted out of the sight of custodial staff of the opposite gender.

Separate accommodation for women deprived of their liberty

24. The duty of care which is owed by a State to persons deprived of their liberty includes the duty to protect them from others who may wish to cause them harm. The CPT has occasionally encountered allegations of woman upon woman abuse. However, allegations of ill-treatment of women in custody by men (and, more particularly, of sexual harassment, including verbal abuse with sexual connotations) arise more frequently, in particular when a State fails to provide separate accommodation for women deprived of their liberty with a preponderance of female staff supervising such accommodation.

As a matter of principle, women deprived of their liberty should be held in accommodation which is physically separate from that occupied by any men being held at the same establishment. That said, some States have begun to make arrangements for couples (both of whom are deprived of their liberty) to be accommodated together, and/or for some degree of mixed gender association in prisons. The CPT welcomes such progressive arrangements, provided that the prisoners involved agree to participate, and are carefully selected and adequately supervised.

Equality of access to activities

25. Women deprived of their liberty should enjoy access to meaningful activities (work, training, education, sport etc.) on an equal footing with their male counterparts. As the Committee mentioned in its last General Report, CPT delegations all too often encounter women inmates being offered activities which have been deemed "appropriate" for them (such as sewing or handicrafts), whilst male prisoners are offered training of a far more vocational nature.

In the view of the CPT, such a discriminatory approach can only serve to reinforce outmoded stereotypes of the social role of women. Moreover, depending upon the circumstances, denying women equal access to regime activities could be qualified as degrading treatment**.**

Ante natal and post natal care

26. Every effort should be made to meet the specific dietary needs of pregnant women prisoners, who should be offered a high protein diet, rich in fresh fruit and vegetables.

27. It is axiomatic that babies should not be born in prison, and the usual practice in Council of Europe member States seems to be, at an appropriate moment, to transfer pregnant women prisoners to outside hospitals.

Nevertheless, from time to time, the CPT encounters examples of pregnant women being shackled or otherwise restrained to beds or other items of furniture during gynaecological examinations and/or delivery. Such an approach is completely unacceptable, and could certainly be qualified as inhuman and degrading treatment. Other means of meeting security needs can and should be found.

28. Many women in prison are primary carers for children or others, whose welfare may be adversely affected by their imprisonment.[1]

One particularly problematic issue in this context is whether - and, if so, for how long - it should be possible for babies and young children to remain in prison with their mothers. This is a difficult question to answer given that, on the one hand, prisons clearly do not provide an appropriate environment for babies and young children while, on the other hand, the forcible separation of mothers and infants is highly undesirable.

29. In the view of the CPT, the governing principle in all cases must be the welfare of the child. This implies in particular that any ante and post natal care provided in custody should be equivalent to that available in the outside community. Where babies and young children are held in custodial settings, their treatment should be supervised by specialists in social work and child development. The goal should be to produce a child-centred environment, free from the visible trappings of incarceration, such as uniforms and jangling keys.

Arrangements should also be made to ensure that the movement and cognitive skills of babies held in prison develop normally. In particular, they should have adequate play and exercise facilities within the prison and, wherever possible, the opportunity to leave the establishment and experience ordinary life outside its walls.

Facilitating child-minding by family members outside the establishment can also help to ensure that the burden of child-rearing is shared (for example, by the child's father). Where this is not possible, consideration should be given to providing access to creche-type facilities. Such arrangements can enable women prisoners to participate in work and other activities inside the prison to a greater extent than might otherwise be possible.

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[1] Cf. also Recommendation 1469 (2000) of the Parliamentary Assembly of the Council of Europe on the subject of mothers and babies in prison.

Hygiene and health issues

30. The Committee also wishes to call attention to a number of hygiene and health issues in respect of which the needs of women deprived of their liberty differ significantly from those of men.

31. The specific **hygiene** needs of women should be addressed in an adequate manner. Ready access to sanitary and washing facilities, safe disposal arrangements for blood-stained articles, as well as provision of hygiene items, such as sanitary towels and tampons, are of particular importance. The failure to provide such basic necessities can amount, in itself, to degrading treatment.

32. It is also essential that the **health care** provided to persons deprived of their liberty be of a standard equivalent to that enjoyed by patients in the outside community.

Insofar as women deprived of their liberty are concerned, ensuring that this principle of equivalence of care is respected will require that health care is provided by medical practitioners and nurses who have specific training in women's health issues, including in gynaecology.

Moreover, to the extent that preventive health care measures of particular relevance to women, such as screening for breast and cervical cancer, are available in the outside community, they should also be offered to women deprived of their liberty.

Equivalence of care also requires that a woman's right to bodily integrity should be respected in places of detention as in the outside community. Thus, where the so-called "morning after" pill and/or other forms of abortion at later stages of a pregnancy are available to women who are free, they should be available under the same conditions to women deprived of their liberty.

33. As a matter of principle, prisoners who have begun a course of treatment before being incarcerated should be able to continue it once detained. In this context, efforts should be made to ensure that adequate supplies of specialist medication required by women are available in places of detention.

As regards, more particularly, the contraceptive pill, it should be recalled that this medication may be prescribed for medical reasons other than preventing conception (e.g. to alleviate painful menstruation). The fact that a woman's incarceration may - in itself - greatly diminish the likelihood of conception while detained is not a sufficient reason to withhold such medication.

VII. Documenting and reporting medical evidence of ill-treatment

Extract from the 23rd General Report [CPT/Inf (2013) 29]

71. As from an early stage of its activities, the CPT has emphasised the important contribution which health-care services in places of deprivation of liberty can and should make to combating ill-treatment of detained persons, through the methodical recording of injuries and the provision of information to the relevant authorities[1]. The accurate and timely documenting and reporting of such medical evidence will greatly facilitate the investigation of cases of possible ill-treatment and the holding of perpetrators to account, which in turn will act as a strong deterrent against the commission of ill-treatment in the future.

The CPT has paid particular attention to the role to be played by prison health-care services in relation to combating ill-treatment. Naturally, that role relates in part to possible ill-treatment of detained persons during their imprisonment, whether it is inflicted by staff or by fellow inmates. However, health-care services in establishments which constitute points of entry into the prison system also have a crucial contribution to make as regards the prevention of ill-treatment during the period immediately prior to imprisonment, namely when persons are in the custody of law enforcement agencies (e.g. the police or gendarmerie).

72. As an attentive reader of CPT reports will know, the situation as regards the documenting and reporting of medical evidence of ill-treatment is at present far from satisfactory in many States visited by the Committee. The procedures in place do not always ensure that injuries borne by detained persons will be recorded in good time; and even when injuries are recorded, this is often done in a superficial manner. Moreover, there is frequently no guarantee that medical evidence which is documented will then be reported to the relevant authorities.

Consequently, the Committee considered that it would be useful to set out in the following paragraphs the standards which it has developed as regards the documenting and reporting of medical evidence of ill-treatment. Various related issues are also discussed.

1 See, for example, paragraphs 60 to 62 of the CPT's 3rd General Report, CPT/Inf (93) 12.

73. It is axiomatic that persons committed to prison should be properly interviewed and physically examined by a health-care professional as soon as possible after their admission. The CPT considers that the interview/examination should be carried out within 24 hours of admission. This systematic medical screening of new arrivals is essential for various reasons; more specifically, if performed properly, it will ensure that any injuries borne by the persons concerned – as well as related allegations – are recorded without undue delay. The same procedure should be followed when a prisoner who has been transferred back to police custody for investigative reasons is returned to the prison; unfortunately, such transfers are still a common practice in some States visited by the CPT, and they can entail a high risk of ill-treatment (see also paragraph 80). Similarly, any prisoner who has been involved in a violent episode within prison should be medically screened without delay.

In addition to prisons, there are other places of deprivation of liberty where persons may be detained for a prolonged period (i.e. more than a few days). This is the case, for example, of detention centres used to accommodate persons held under aliens legislation. Further, in a number of countries visited by the CPT, various categories of detained persons (e.g. administrative offenders; persons remanded in custody who are awaiting transfer to a prison or undergoing further investigation) can be held for prolonged periods in "arrest houses" or "temporary detention facilities". Systematic medical screening of new arrivals should also be carried out in such places.

74. The record drawn up after the medical screening referred to in paragraph 73 should contain: i) an account of statements made by the person which are relevant to the medical examination (including his/her description of his/her state of health and any allegations of ill-treatment), ii) a full account of objective medical findings based on a thorough examination, and iii) the health-care professional's observations in the light of i) and ii), indicating the consistency between any allegations made and the objective medical findings. The record should also contain the results of additional examinations carried out, detailed conclusions of specialised consultations and a description of treatment given for injuries and of any further procedures performed.

Recording of the medical examination in cases of traumatic injuries should be made on a special form provided for this purpose, with body charts for marking traumatic injuries that will be kept in the medical file of the prisoner. Further, it would be desirable for photographs to be taken of the injuries, and the photographs should also be placed in the medical file. In addition, a special trauma register should be kept in which all types of injury observed should be recorded.

75. It is important to make a clear distinction between the above-mentioned medical screening and the procedure followed when a detained person is handed over to the custody of a prison. The latter procedure entails the drawing up of documentation, co-signed by the prison staff on duty and the police escort as well as perhaps by the detained person. Any visible injuries observed on the prisoner at the moment of handover of custody will usually be recorded in that documentation.

This procedure is of an administrative nature, even if – as is sometimes the case – it takes place in the presence of a member of the prison's health-care staff. It can in no event serve as a substitute for the medical screening procedure already described. Moreover, given the presence of the police escort as well as the anxiety often felt at the very moment of entering prison, prisoners should not be questioned at this initial stage about the origin of any visible injuries observed on them. Nevertheless, the record made of visible injuries observed should be immediately forwarded to the prison's health-care service.

76. The CPT sets much store by the observance of medical confidentiality in prisons and other places of deprivation of liberty. Consequently, in the same way as any other medical examination of a detained person, the medical screening referred to in paragraph 73 must be conducted out of the hearing and – unless the health-care professional concerned expressly requests otherwise in a given case – out of the sight of non-medical staff. This requirement is at present far from being met in all States visited by the CPT.

77. However, the principle of confidentiality must not become an obstacle to the reporting of medical evidence indicative of ill-treatment which health-care professionals gather in a given case. To allow this to happen would run counter to the legitimate interests of detained persons in general and to society as a whole[1]. The CPT is therefore in favour of an automatic reporting obligation for health-care professionals working in prisons or other places of deprivation of liberty when they gather such information. In fact, such an obligation already exists under the law of many States visited by the CPT, but is often not fully respected in practice.

In several recent visit reports, the CPT has recommended that existing procedures be reviewed in order to ensure that whenever injuries are recorded by a health-care professional which are consistent with allegations of ill-treatment made by a detained person, that information is immediately and systematically brought to the attention of the relevant authority, regardless of the wishes of the person concerned. If a detained person is found to bear injuries which are clearly indicative of ill-treatment (e.g. extensive bruising of the soles of the feet) but refuses to reveal their cause or gives a reason unrelated to ill-treatment, his/her statement should be accurately documented and reported to the authority concerned together with a full account of the objective medical findings.

[1] For a description of the dilemmas that can be faced by health-care professionals working in places of deprivation of liberty, see paragraphs 65 to 72 of the 1999 Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman of Degrading Treatment or Punishment).

78. The "relevant authority" to which the health-care professional's report should be sent is first and foremost the independent body empowered to carry out an official investigation into the matter and, if appropriate, bring criminal charges. Other authorities to be informed could include bodies responsible for disciplinary investigations or for monitoring the situation of persons detained in the establishment where ill-treatment may have occurred. The report should also be made available to the detained person concerned and to his/her lawyer.

The actual mechanism for transmission of the report to the relevant authority(ies) will vary from country to country in the light of organisational structures and may well not involve direct communication between the health-care professional and that authority. The report might be transmitted through the hierarchy of the health-care professional (e.g. a Medical Department at ministerial level) or the management of the detention facility in which he/she works (e.g. prison director). However, whichever approach is followed, the rapid transmission of the report to the relevant authority must be ensured.

79. A corollary of the automatic reporting obligation referred to in paragraph 77 is that the health-care professional should advise the detained person concerned of the existence of that obligation, explaining that the writing of such a report falls within the framework of a system for preventing ill-treatment and that the forwarding of the report to the relevant authority is not a substitute for the lodging of a complaint in proper form. The appropriate moment to provide that information to the detained person would be as from the moment that he/she begins to make allegations of ill-treatment and/or is found to bear injuries indicative of ill-treatment.

If the process is handled with sensitivity, the great majority of the detained persons concerned will not object to disclosure. As for those that remain reluctant, the health-care professional might choose to limit the content of the report to the objective medical findings.

80. The reporting to the relevant authority of medical evidence indicative of ill-treatment must be accompanied by effective measures to protect the person who is the subject of the report as well as other detained persons. For example, prison officers who have allegedly been involved in ill-treatment should be transferred to duties not requiring day-to-day contact with prisoners, pending the outcome of the investigation. If the possible ill-treatment relates to the acts of fellow inmates, alternative accommodation should be found for the detained person concerned. Naturally, if the report concerns possible ill-treatment by law enforcement officials, the detained person should under no circumstances be returned to their custody. More generally, the CPT considers that the objective should be to end the practice of returning remand prisoners to law enforcement agencies for investigative purposes; in particular, any further questioning of the person concerned which may be necessary should be conducted on prison premises.

81. In addition to the reporting by name of each case in which medical evidence indicative of ill-treatment is gathered, the Committee recommends that all traumatic injuries resulting from all possible causes be monitored and periodically reported to the bodies

concerned (e.g. prison management, ministerial authorities) through anonymous statistics. Such information can be invaluable for the purpose of identifying problem areas.

82. To ensure compliance with the standards described above, special training should be offered to health-care professionals working in prisons and other places where persons may be detained for a prolonged period. In addition to developing the necessary competence in the documentation and interpretation of injuries as well as ensuring full knowledge of the reporting obligation and procedure, that training should cover the technique of interviewing persons who may have been ill-treated.

It would also be advisable for the health-care professionals concerned to receive, at regular intervals, feedback on the measures taken by the authorities following the forwarding of their reports. This can help to sensitise them to specific points in relation to which their documenting and reporting skills can be improved and, more generally, will serve as a reminder of the importance of this particular aspect of their work.

83. Prior to the systematic medical screening referred to in paragraph 73, detained persons will often spend some time in the custody of law enforcement officials for the purpose of questioning and other investigative measures. During this period, which may vary from several hours to one or more days depending on the legal system concerned, the risk of ill-treatment can be particularly high. Consequently, the CPT recommends that specific safeguards be in place during this time, including the right of access to a doctor[1]. As the Committee has repeatedly emphasised, a request by a person in police/gendarmerie custody to see a doctor should always be granted; law enforcement officials should not seek to filter such requests.

84. The record drawn up after any medical examination of a person in police/gendarmerie custody should meet the requirements set out in paragraph 74 above, and the confidentiality of the examination should be guaranteed as described in paragraph 76. Further, the automatic reporting obligation referred to in paragraph 77 should apply whenever medical evidence indicative of ill-treatment is gathered in the course of the examination. All these conditions should be complied with, irrespective of whether the health-care professional concerned has been called following a request by the detained person or is in attendance following an initiative taken by a law enforcement official.

The means of implementing the reporting obligation in such cases should reflect the urgency of the situation. The health-care professional should transmit his/her report directly and immediately to the authority which is in the best position to intervene rapidly and put a stop to any ill-treatment taking place; the identity of that authority will depend on the legal system and the precise circumstances of the case.

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[1] Other essential safeguards include the right to have one's detention notified to a third party of one's choice and the right of access to a lawyer.

VIII. Combating impunity

Extract from the 14th General Report [CPT/Inf (2004) 28]

25. The *raison d'être* of the CPT is the "prevention" of torture and inhuman or degrading treatment or punishment; it has its eyes on the future rather than the past. However, assessing the effectiveness of action taken when ill-treatment has occurred constitutes an integral part of the Committee's preventive mandate, given the implications that such action has for future conduct.

The credibility of the prohibition of torture and other forms of ill-treatment is undermined each time officials responsible for such offences are not held to account for their actions. If the emergence of information indicative of ill-treatment is not followed by a prompt and effective response, those minded to ill-treat persons deprived of their liberty will quickly come to believe – and with very good reason – that they can do so with impunity. All efforts to promote human rights principles through strict recruitment policies and professional training will be sabotaged. In failing to take effective action, the persons concerned – colleagues, senior managers, investigating authorities – will ultimately contribute to the corrosion of the values which constitute the very foundations of a democratic society.

Conversely, when officials who order, authorise, condone or perpetrate torture and ill-treatment are brought to justice for their acts or omissions, an unequivocal message is delivered that such conduct will not be tolerated. Apart from its considerable deterrent value, this message will reassure the general public that no one is above the law, not even those responsible for upholding it. The knowledge that those responsible for ill-treatment have been brought to justice will also have a beneficial effect for the victims.

26. Combating impunity must start at home, that is within the agency (police or prison service, military authority, etc.) concerned. Too often the esprit de corps leads to a willingness to stick together and help each other when allegations of ill-treatment are made, to even cover up the illegal acts of colleagues. Positive action is required, through training and by example, to **promote a culture** where it is regarded as unprofessional – and unsafe from a career path standpoint – to work and associate with colleagues who have resort to ill-treatment, where it is considered as correct and professionally rewarding to belong to a team which abstains from such acts.

An atmosphere must be created in which the right thing to do is to report ill-treatment by colleagues; there must be a clear understanding that culpability for ill-treatment extends beyond the actual perpetrators to anyone who knows, or should know, that ill-treatment is occurring and fails to act to prevent or report it. This implies the existence of a clear reporting line as well as the adoption of whistle-blower protective measures.

27. In many States visited by the CPT, torture and acts such as ill-treatment in the performance of a duty, coercion to obtain a statement, abuse of authority, etc. constitute specific criminal offences which are prosecuted *ex officio*. The CPT welcomes the existence of legal provisions of this kind.

Nevertheless, the CPT has found that, in certain countries, prosecutorial authorities have considerable discretion with regard to the opening of a preliminary investigation when information related to possible ill-treatment of persons deprived of their liberty comes to light. In the Committee's view, even in the absence of a formal complaint, such authorities should be under a **legal obligation to undertake an investigation** whenever they receive credible information, from any source, that ill-treatment of persons deprived of their liberty may have occurred. In this connection, the legal framework for accountability will be strengthened if public officials (police officers, prison directors, etc.) are formally required to notify the relevant authorities immediately whenever they become aware of any information indicative of ill-treatment.

28. The existence of a suitable legal framework is not of itself sufficient to guarantee that appropriate action will be taken in respect of cases of possible ill-treatment. Due attention must be given to **sensitising the relevant authorities** to the important obligations which are incumbent upon them.

When persons detained by law enforcement agencies are brought before prosecutorial and judicial authorities, this provides a valuable opportunity for such persons to indicate whether or not they have been ill-treated. Further, even in the absence of an express complaint, these authorities will be in a position to take action in good time if there are other indicia (e.g. visible injuries; a person's general appearance or demeanour) that ill-treatment might have occurred.

However, in the course of its visits, the CPT frequently meets persons who allege that they had complained of ill-treatment to prosecutors and/or judges, but that their interlocutors had shown little interest in the matter, even when they had displayed injuries on visible parts of the body. The existence of such a scenario has on occasion been borne out by the CPT's findings. By way of example, the Committee recently examined a judicial case file which, in addition to recording allegations of ill-treatment, also took note of various bruises and swellings on the face, legs and back of the person concerned. Despite the fact that the information recorded in the file could be said to amount to *prima-facie* evidence of ill-treatment, the relevant authorities did not institute an investigation and were not able to give a plausible explanation for their inaction.

It is also not uncommon for persons to allege that they had been frightened to complain about ill-treatment, because of the presence at the hearing with the prosecutor or judge of the very same law enforcement officials who had interrogated them, or that they had been expressly discouraged from doing so, on the grounds that it would not be in their best interests.

It is imperative that prosecutorial and judicial authorities take resolute action when any information indicative of ill-treatment emerges. Similarly, they must conduct the proceedings in such a way that the persons concerned have a real opportunity to make a statement about the manner in which they have been treated.

29. **Adequately assessing allegations of ill-treatment** will often be a far from straightforward matter. Certain types of ill-treatment (such as asphyxiation or electric shocks) do not leave obvious marks, or will not, if carried out with a degree of proficiency. Similarly, making persons stand, kneel or crouch in an uncomfortable position for hours on end, or depriving them of sleep, is unlikely to leave clearly identifiable traces. Even blows to the body may leave only slight physical marks, difficult to observe and quick to fade. Consequently, when allegations of such forms of ill-treatment come to the notice of prosecutorial or judicial authorities, they should be especially careful not to accord undue importance to the absence of physical marks. The same applies *a fortiori* when the ill-treatment alleged is predominantly of a psychological nature (sexual humiliation, threats to the life or physical integrity of the person detained and/or his family, etc.). Adequately assessing the veracity of allegations of ill-treatment may well require taking evidence from all persons concerned and arranging in good time for on-site inspections and/or specialist medical examinations.

Whenever criminal suspects brought before prosecutorial or judicial authorities allege ill-treatment, those allegations should be recorded in writing, a forensic medical examination (including, if appropriate, by a forensic psychiatrist) should be immediately ordered, and the necessary steps taken to ensure that the allegations are properly investigated. Such an approach should be followed whether or not the person concerned bears visible external injuries. Even in the absence of an express allegation of ill-treatment, a forensic medical examination should be requested whenever there are other grounds to believe that a person could have been the victim of ill-treatment.

30. It is also important that no barriers should be placed between persons who allege ill-treatment (who may well have been released without being brought before a prosecutor or judge) and doctors who can provide forensic reports recognised by the prosecutorial and judicial authorities. For example, access to such a doctor should not be made subject to prior authorisation by an investigating authority.

31. The CPT has had occasion, in a number of its visit reports, to assess the activities of the authorities empowered to conduct official investigations and bring criminal or disciplinary charges in cases involving allegations of ill-treatment. In so doing, the Committee takes account of the case law of the European Court of Human Rights as well as the standards contained in a panoply of international instruments. It is now a well established principle that **effective investigations**, capable of leading to the identification and punishment of those responsible for ill-treatment, are essential to give practical meaning to the prohibition of torture and inhuman or degrading treatment or punishment.

Complying with this principle implies that the authorities responsible for investigations are provided with all the necessary resources, both human and material. Further, investigations must meet certain basic criteria.

32. For an investigation into possible ill-treatment to be effective, it is essential that the persons responsible for carrying it out are independent from those implicated in the events. In certain jurisdictions, all complaints of ill-treatment against the police or other public officials must be submitted to a prosecutor, and it is the latter – not the police – who determines whether a preliminary investigation should be opened into a complaint; the CPT welcomes such an approach. However, it is not unusual for the day-to-day responsibility for the operational conduct of an investigation to revert to serving law enforcement officials. The involvement of the prosecutor is then limited to instructing those officials to carry out inquiries, acknowledging receipt of the result, and deciding whether or not criminal charges should be brought. It is important to ensure that the officials concerned are not from the same service as those who are the subject of the investigation. Ideally, those entrusted with the operational conduct of the investigation should be completely independent from the agency implicated. Further, prosecutorial authorities must exercise close and effective supervision of the operational conduct of an investigation into possible ill-treatment by public officials. They should be provided with clear guidance as to the manner in which they are expected to supervise such investigations.

33. An investigation into possible ill-treatment by public officials must comply with the criterion of thoroughness. It must be capable of leading to a determination of whether force or other methods used were or were not justified under the circumstances, and to the identification and, if appropriate, the punishment of those concerned. This is not an obligation of result, but of means. It requires that all reasonable steps be taken to secure evidence concerning the incident, including, inter alia, to identify and interview the alleged victims, suspects and eyewitnesses (e.g. police officers on duty, other detainees), to seize instruments which may have been used in ill-treatment, and to gather forensic evidence. Where applicable, there should be an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death.

The investigation must also be conducted in a comprehensive manner. The CPT has come across cases when, in spite of numerous alleged incidents and facts related to possible ill-treatment, the scope of the investigation was unduly circumscribed, significant episodes and surrounding circumstances indicative of ill-treatment being disregarded.

34. In this context, the CPT wishes to make clear that it has strong misgivings regarding the practice observed in many countries of law enforcement officials or prison officers wearing masks or balaclavas when performing arrests, carrying out interrogations, or dealing with prison disturbances; this will clearly hamper the identification of potential suspects if and when allegations of ill-treatment arise. This practice should be strictly controlled and only used in exceptional cases which are duly justified; it will rarely, if ever, be justified in a prison context.

Similarly, the practice found in certain countries of blindfolding persons in police custody should be expressly prohibited; it can severely hamper the bringing of criminal proceedings against those who torture or ill-treat, and has done so in some cases known to the CPT.

35. To be effective, the investigation must also be conducted in a prompt and reasonably expeditious manner. The CPT has found cases where the necessary investigative activities were unjustifiably delayed, or where prosecutorial or judicial authorities demonstrably lacked the requisite will to use the legal means at their disposal to react to allegations or other relevant information indicative of ill-treatment. The investigations concerned were suspended indefinitely or dismissed, and the law enforcement officials implicated in ill-treatment managed to avoid criminal responsibility altogether. In other words, the response to compelling evidence of serious misconduct had amounted to an "investigation" unworthy of the name.

36. In addition to the above-mentioned criteria for an effective investigation, there should be a sufficient element of public scrutiny of the investigation or its results, to secure accountability in practice as well as in theory. The degree of scrutiny required may well vary from case to case. In particularly serious cases, a public inquiry might be appropriate. In all cases, the victim (or, as the case may be, the victim's next-of-kin) must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests.

37. **Disciplinary proceedings** provide an additional type of redress against ill-treatment, and may take place in parallel to criminal proceedings. Disciplinary culpability of the officials concerned should be systematically examined, irrespective of whether the misconduct in question is found to constitute a criminal offence. The CPT has recommended a number of procedural safeguards to be followed in this context; for example, adjudication panels for police disciplinary proceedings should include at least one independent member.

38. Inquiries into possible disciplinary offences by public officials may be performed by a separate internal investigations department within the structures of the agencies concerned. Nevertheless, the CPT strongly encourages the creation of a fully-fledged independent investigation body. Such a body should have the power to direct that disciplinary proceedings be instigated.

Regardless of the formal structure of the investigation agency, the CPT considers that its functions should be properly publicised. Apart from the possibility for persons to lodge complaints directly with the agency, it should be mandatory for public authorities such as the police to register all representations which could constitute a complaint; to this end, appropriate forms should be introduced for acknowledging receipt of a complaint and confirming that the matter will be pursued.

If, in a given case, it is found that the conduct of the officials concerned may be criminal in nature, the investigation agency should always notify directly – without delay – the competent prosecutorial authorities.

39. Great care should be taken to ensure that persons who may have been the victims of ill-treatment by public officials are not dissuaded from lodging a complaint. For example, the potential negative effects of a possibility for such officials to bring proceedings for defamation against a person who wrongly accuses them of ill-treatment should be kept under review. The balance between competing legitimate interests must be evenly established. Reference should also be made in this context to certain points already made in paragraph 28.

40. Any evidence of ill-treatment by public officials which emerges during **civil proceedings** also merits close scrutiny. For example, in cases in which there have been successful claims for damages or out-of-court settlements on grounds including assault by police officers, the CPT has recommended that an independent review be carried out. Such a review should seek to identify whether, having regard to the nature and gravity of the allegations against the police officers concerned, the question of criminal and/or disciplinary proceedings should be (re)considered.

41. It is axiomatic that no matter how effective an investigation may be, it will be of little avail if the **sanctions imposed for ill-treatment** are inadequate. When ill-treatment has been proven, the imposition of a suitable penalty should follow. This will have a very strong dissuasive effect. Conversely, the imposition of light sentences can only engender a climate of impunity.

Of course, judicial authorities are independent, and hence free to fix, within the parameters set by law, the sentence in any given case. However, via those parameters, the intent of the legislator must be clear: that the criminal justice system should adopt a firm attitude with regard to torture and other forms of ill-treatment. Similarly, sanctions imposed following the determination of disciplinary culpability should be commensurate to the gravity of the case.

42. Finally, no one must be left in any doubt concerning the **commitment of the State authorities** to combating impunity. This will underpin the action being taken at all other levels. When necessary, those authorities should not hesitate to deliver, through a formal statement at the highest political level, the clear message that there must be “zero tolerance” of torture and other forms of ill-treatment.

IX. Electrical discharge weapons

Extract from the 20th General Report [CPT/Inf (2010) 28]

Preliminary remarks

65. It is becoming increasingly common in countries visited by the CPT for police officers and other law enforcement officials to be issued with electrical discharge weapons (EDW), and the presence of such devices in places of detention (in particular prisons) has also been observed by the Committee in certain countries. There are various types of EDW, ranging from electric shock batons and other hand-held weapons requiring direct contact with the person who is the intended target to weapons capable of delivering dart-like projectiles which administer an electric shock to a person located at some distance.

66. The use of EDW by law enforcement and other public officials is a controversial subject. There are conflicting views as regards both the specific circumstances in which resort to such weapons can be justified and the potential negative effects on health that the weapons can cause. It is also a fact that by their very nature, EDW lend themselves to misuse. The CPT has on several occasions gathered credible evidence that such weapons have been exploited to inflict severe ill-treatment on persons deprived of their liberty, and the Committee has frequently received allegations that detained persons have been threatened with ill-treatment via the use of EDW.

67. The CPT has already addressed the issue of EDW in several of its visit reports. In the following paragraphs, the Committee wishes to highlight the positions it has adopted to date and indicate some areas of concern. The CPT would welcome comments on this section of its General Report, so as to help the Committee develop its standards in relation to this complex subject.

General principles

68. The CPT understands the wish of national authorities to provide their law enforcement officials with means enabling them to give a more graduated response to dangerous situations with which they are confronted. There is no doubt that the possession of less lethal weapons such as EDW may in some cases make it possible to avoid recourse to firearms. However, electrical discharge weapons can cause acute pain and, as already indicated, they are open to abuse. Consequently, any decision to issue law enforcement officials or other public servants with EDW should be the result of a thorough debate at the level of the country's national executive and legislature. Further, the criteria for deploying EDW should be both defined by law and spelt out in specific regulations.

69. The CPT considers that the use of electric discharge weapons should be subject to the principles of necessity, subsidiarity, proportionality, advance warning (where feasible) and precaution. These principles entail, inter alia, that public officials to whom such weapons are issued must receive adequate training in their use. As regards more specifically EDW capable of discharging projectiles, the criteria governing their use should be directly inspired by those applicable to firearms.

70. In the CPT's view, the use of EDW should be limited to situations where there is a real and immediate threat to life or risk of serious injury. Recourse to such weapons for the sole purpose of securing compliance with an order is inadmissible. Furthermore, recourse to such weapons should only be authorised when other less coercive methods (negotiation and persuasion, manual control techniques, etc) have failed or are impracticable and where it is the only possible alternative to the use of a method presenting a greater risk of injury or death.

Application of these principles to specific situations

71. Applying these principles to specific situations, the CPT has, for example, come out clearly against the issuing of EDW to members of units responsible for deportation operations vis-à-vis immigration detainees. Similarly, the Committee has expressed strong reservations about the use of electric discharge weapons in prison (and a fortiori closed psychiatric) settings. Only very exceptional circumstances (e.g. a hostage-taking situation) might justify the resort to EDW in such a secure setting, and this subject to the strict condition that the weapons concerned are used only by specially trained staff. There should be no question of any form of EDW being standard issue for staff working in direct contact with persons held in prisons or any other place of deprivation of liberty.

72. Electrical discharge weapons are increasingly being used when effecting arrests, and there have been well-publicised examples of their misuse in this context (e.g. the repeated administration of electric shocks to persons lying on the ground). Clearly, the resort to EDW in such situations must be strictly circumscribed. The guidance found by the CPT in some countries, to the effect that these weapons may be used when law enforcement officials are facing violence – or a threat of violence – of such a level that they would need to use force to protect themselves or others, is so broad as to leave the door open to a disproportionate response. If EDW gradually become the weapon of choice whenever faced with a recalcitrant attitude at the time of arrest, this could have a profoundly negative effect on the public's perception of law enforcement officials.

73. Having regard to the limits of its mandate, the CPT has been reluctant to adopt a firm position vis-à-vis the use of electrical discharge weapons in the context of operations for the maintenance or restoration of public order (e.g. control of demonstrations). That said, in the light of the principles set out in paragraph 70 above, the resort to EDW during such operations can be considered inappropriate unless there is a real and immediate threat to life or risk of serious injury. The law enforcement officials involved will (or should) have at their disposal other means of protection and action that are specifically adapted to the task in hand. It is noteworthy that some police forces in Europe have excluded the use of EDW in the course of operations to control public demonstrations.

74. Particular reference should be made to stun belts and similar devices. The CPT has made clear its opposition to the use of equipment of this kind for controlling the movements of detained persons, whether inside or outside places of deprivation of liberty. Such equipment is, in the Committee's opinion, inherently degrading for the person to whom it is applied, and the scope for misuse is particularly high. Alternative means of ensuring security during the movements of detained persons can and should be found.

Instructions and training

75. Following any decision to issue EDW, the authorities concerned must ensure that detailed instructions are disseminated within the services which will have such weapons at their disposal. Further, the officials who may use the weapons must be specifically selected – taking into account their resistance to stress and faculty of discernment – and suitably trained. An in-service training programme should be put in place together with regular testing (see also paragraph 80).

Technical aspects

76. As with any weapon system, before the EDW in question are made available they should be the subject of a technical authorisation procedure. This procedure should, in particular, ensure that the number, duration and intensity of the electrical discharges is limited to a safe level. The CPT knows of cases in which persons deprived of their liberty have been subjected to several electrical discharges in quick succession; such excessive, unnecessary use of force certainly qualifies as ill-treatment. In addition, provision should be made for a regular maintenance/servicing procedure.

77. EDW should be equipped with devices (generally a memory chip) that can be used for recording various items of information and conducting checks on the use of the weapon (such as the exact time of use; the number, duration and intensity of electrical discharges, etc). The information stored on these chips should be systematically read by the competent authorities at appropriate intervals (at least every three months). Further, the weapons should be provided with built-in laser aiming and video recording devices, making safe aiming possible and enabling the circumstances surrounding their use to be recorded.

78. Electrical discharge weapons issued to law enforcement officials commonly offer different modes of use, in particular a "firing" and a "contact" (drive-stun) mode. In the former, the weapon fires projectiles which attach to the person targeted at a short distance from each other, and an electrical discharge is generated. In the great majority of cases, this discharge provokes generalised muscular contraction which induces temporary paralysis and causes the person concerned to fall to the ground. In contrast, when the "contact" mode is used, electrodes on the end of the weapon produce an electrical arc and when they are brought into contact with the person targeted the electrodes cause very intense, localised pain, with the possibility of burns to the skin. The CPT has strong reservations concerning this latter mode of use. Indeed, properly trained law enforcement officials will have many other control techniques available to them when they are in touching distance of a person who has to be brought under control.

Medical aspects

79. The potential effects of EDW on the physical and mental health of persons against whom they are used is the subject of much argument, a debate that has been fuelled in part by a number of cases of persons dying shortly after having been the target of such a weapon. Although the research on this matter remains for the time being largely inconclusive, it is undisputed that the use of EDW does present specific health risks, such as the possibility of injury on falling after being struck by projectiles or of burns in the event of prolonged use of such a weapon in the "contact" mode. In the absence of detailed research on the potential effects of EDW on particularly vulnerable persons (e.g. the elderly, pregnant women, young children, persons with a pre-existing heart condition), the CPT believes that their use vis-à-vis such persons should in any event be avoided. The use of EDW on people who are delirious or intoxicated is another sensitive issue; persons in this state of mind may well not understand the significance of an advance warning that the weapon will be used and could instead become ever more agitated in such a situation. Deaths during arrest have been attributed to these medical conditions, in particular when EDW have been deployed. Therefore, particular caution is warranted and the use of EDW should be avoided in such a case and, in general, in situations where EDW might increase the risk of death or injury.

80. The training of officials to be issued with EDW should include information about when it is inappropriate, for medical reasons, to use them as well as concerning emergency care (in the event of a fall, burns, wounds from the projectiles, cardiac disturbances, agitated delirium, etc). Further, once brought under control, a person who has been the target of an EDW should be informed that the weapon has only a temporary effect.

81. The CPT considers that anyone against whom an EDW has been used should, in all cases, be seen by a doctor and, where necessary, taken to hospital. Doctors and accident/emergency services should be informed of the ways in which persons who have been the target of such weapons may be affected and of the relevant forms of treatment, from the standpoint of both physical and psychological health. Further, a medical certificate should be given to the persons concerned (and/or to their lawyer, upon request).

Post-incident procedure

82. Following each use of an EDW, there should be a debriefing of the law enforcement official who had recourse to the weapon. Further, the incident should be the subject of a detailed report to a higher authority. This report should indicate the precise circumstances considered to justify resort to the weapon, the mode of use, as well as all other relevant information (presence of witnesses, whether other weapons were available, medical care given to the person targeted, etc). The technical information registered on the memory chip and the video recording of the use of the EDW should be included in the report.

83. This internal procedure should be accompanied by an external monitoring element. This could consist of systematically informing, at regular intervals, an independent body responsible for supervising law enforcement agencies of all cases of resort to EDW.

84. Whenever it transpires that the use of an EDW may not have been in accordance with the relevant laws or regulations, an appropriate investigation (disciplinary and/or criminal) should be set in motion.

Further information:

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