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Police custody

*Extract from the 2nd General Report of the CPT,
published in 1992*

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.²

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.

² 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.



Developments concerning CPT standards in respect of police custody

*Extract from the 12th General Report of the CPT,
published in 2002*

32. More than a decade has elapsed since the CPT described, in its 2nd General Report, some of the main issues pursued by the Committee in relation to police custody. In the meantime, the Committee has carried out more than a hundred further visits and the number of Parties to the Convention has practically doubled. Naturally, the CPT's standards in respect of police custody have gradually evolved, in the light of new situations encountered and experience gathered. Following the approach taken in its 11th General Report in respect of imprisonment, the CPT would like to highlight in its 12th General Report a miscellany of issues related to police custody which illustrate the development of the CPT's standards.

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).

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.

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).

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 size² 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.

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.

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



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

*Extract from the 21st General Report of the CPT,
published in 2011*

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 liberty¹. 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

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.

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

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.

² Reference might be made here to the judgment of the European Court of Human Rights in the 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).



Preventing police torture and other forms of ill-treatment – reflections on good practices and emerging approaches

*Extract from the 28th General Report of the CPT,
published in 2019*

Introduction

61. In the course of the last three decades, the CPT has regularly reviewed the manner in which persons are treated by the police in European countries.¹ It is therefore in a unique position to assess the extent of torture and other forms of ill-treatment by police officers in the whole Council of Europe area.

62. At the outset, it must be underlined that, in the overwhelming majority of Council of Europe member states, most persons met by CPT visiting delegations who were, or had recently been, in police custody have not alleged to have suffered any kind of police abuse. Indeed, they considered that they had been treated correctly by the police officers who had apprehended them, escorted them to police establishments, kept them in custody, or interviewed them. Further, it is noteworthy that, in a few countries, police ill-treatment has not been a concern since the CPT started carrying out visits in the early 1990s. In some other states, police reforms have led to significant improvements.

63. At the same time, the CPT continues to encounter cases of police ill-treatment in a number of European countries, under various circumstances and involving different law enforcement agencies.

64. In several Council of Europe member states, police ill-treatment mainly occurs during the high-risk period around the time of **apprehension of persons** suspected of having committed criminal or other offences. CPT delegations have heard many accounts according to which the force used by police officers upon apprehension or shortly after was unnecessary or excessive. In particular, they heard allegations of punches, kicks, truncheon blows or use of pepper spray whilst the person concerned displayed no resistance or had already been brought under control. At times, such allegations were supported by convincing medical or other evidence. In some instances, the alleged misconduct was the result of action during crowd control operations or special interventions carried out by police officers who could subsequently not be identified (due to them wearing face-concealing hoods and the absence of any identification number on their uniforms). As highlighted

¹ Since its first visit in 1990, the CPT has carried out about 440 country visits, in the course of which the members of its delegations have spoken in private with tens of thousands of persons who were or had recently been detained by the police. It also reviewed the relevant documentation, including of a medical nature, in police and prison establishments.

by the European Court of Human Rights in its case-law, it may be legitimate for police officers to resort to force in the context of an apprehension. However, such force should be used only if it is lawful and strictly necessary, and it should not be excessive. Failure to meet these basic requirements may amount to a violation of Article 3 of the European Convention on Human Rights.² It should also be noted that CPT delegations have frequently found evidence of unduly tight handcuffing, which can have serious medical consequences. In addition, on many occasions they have heard allegations of verbal abuse, including racist remarks. The CPT has also observed that certain categories of person (such as persons with mental health problems and juveniles) could run a higher risk of ill-treatment during apprehension due to their specific vulnerabilities.

65. The infliction of ill-treatment during or in the context of **police interviews** remains a very serious problem in a significant number of Council of Europe member states. Within the last ten years, the CPT has received credible allegations, and gathered forensic medical and other evidence, of police ill-treatment which could be qualified as torture in almost one-third of Council of Europe member states. The alleged ill-treatment consisted *inter alia* of the infliction of electric shocks, blows to the soles of the feet, suspension or hyperextension by means of handcuffs, infliction of burns to various parts of the body, asphyxiation with a plastic bag or a gas mask, handcuffing of detained persons in stress positions for hours on end, severe beatings and mock executions. The CPT also continues to hear accounts of other forms of police ill-treatment, from slaps to more brutal forms of abuse. The deliberate nature of such treatment is evident. The treatment alleged was often applied by apprehending/operational officers in the initial period of custody and prior to a first formal police interview, for the purpose of obtaining a confession or other information. The CPT's findings suggest that, in some cases, police crime investigators have condoned or even encouraged such practices. In this connection, the possibility for police officers of inviting or summoning persons for "informal talks", "collecting information" or "explanations" is provided for in a number of countries under a simplified procedure. The CPT has on numerous occasions noted that the risk of ill-treatment was higher precisely in situations of this kind and that informal questioning of "persons of interest" was abused in order, *inter alia*, to deny procedural safeguards that would apply to persons formally considered as criminal suspects.

Professional policing

66. As part of its preventive mandate, the CPT has consistently highlighted the importance of **three procedural safeguards**, namely: the right of access to a lawyer, the right of access 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. This presupposes that persons deprived of their liberty are duly informed of these rights, both orally upon apprehension and, as soon as possible, in writing (e.g. through a "letter of rights" or other document setting out the rights of persons in police custody) in a language they understand.³ This "trinity of rights" should apply as from the very outset of deprivation of liberty by the police – that is, when the person concerned is obliged to remain with the police. The main reason for this has repeatedly emerged from the CPT's findings: it is during the first hours of deprivation of liberty by the police that the risk of ill-treatment is at its highest.

67. The CPT has progressively developed additional safeguards (such as appropriate record-keeping and the establishment of a single comprehensive custody register), as well as other specific

² Reference can be made, for instance, to the judgments [Bouyid v. Belgium \[GC\], no. 23380/09](#), §§ 100-113, ECHR 2015, [Rehbock v. Slovenia, no. 29462/95](#), §§ 71-78, ECHR 2000-XII, and [Layijov v. Azerbaijan, no. 22062/07](#), §§ 39-48, 10 April 2014.

³ See also [Directive 2012/13/EU](#) of the European Parliament and of the Council of 22 May 2012 on the right to information in criminal proceedings, and [Directive 2013/48/EU](#) of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings, and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty.

safeguards for vulnerable groups, such as juveniles, persons with mental health problems or foreign nationals.⁴

68. The CPT has noted with satisfaction that many states have followed its recommendations by incorporating procedural safeguards into their legislation. Nevertheless, the Committee has also found that, despite the existence of detailed legal provisions, the **practical implementation** of these safeguards frequently displays serious shortcomings. For instance, the Committee has observed undue delays in access to a lawyer (in particular, it is often the case that legal aid lawyers see their clients only after a first police interview or even not until the time of the first court hearing, thereby depriving the detained persons concerned of an important safeguard against police ill-treatment). In addition, medical examinations of persons in police custody are often carried out in a superficial manner and/or in the presence of police officers. Further, in a few countries, the introduction of procedural safeguards has led to the emergence of unwanted police practices, such as the questioning of suspects in unofficial places of detention, without the very fact of their deprivation of liberty being recorded and/or without any possibility of them being able to exercise any of the above-mentioned rights.

69. The introduction of legal safeguards is thus not an end in itself; experience has shown that in practice they can be circumvented as long as police officers – with the sanction of senior police officials – believe that ill-treating apprehended persons and suspects is an acceptable or even necessary and efficient way of carrying out police activities.

70. Practitioners in countries that have come a long way in overcoming police ill-treatment often refer to a **change of police culture**, or even a change of culture within the criminal justice system as a whole, as the key factor. In a number of states, the CPT is indeed pleased to witness positive developments in the manner in which persons in police custody are treated. It has even observed and supported significant culture changes within police services, such as in Georgia.

71. A change of mindset starts with competitive and rigorous recruitment processes based on strict selection criteria, ensuring that the composition of the police force reflects the diversity of the population.⁵ In this connection, adequate remuneration of police officers is an important tool to attract the best candidates and retain highly competent staff. The development of appropriate police education, initial preparation and ongoing training in the application of human rights standards, national norms and safeguards are also key to improving police practices. In the CPT's experience, professional policing goes hand-in-hand with adequate training on the use of force in compliance with the principles of lawfulness, necessity and proportionality. Training should also provide opportunities to acquire appropriate investigative skills, taking due account of the age, gender, state of health, any disability or any other circumstances which may render certain persons under investigation particularly vulnerable. Moreover, no significant change can be expected without strong police leadership and management which scrupulously supervise the observance of procedural safeguards and convey firm and unambiguous messages of zero tolerance of police ill-treatment. Greater police accountability is indeed a crucial factor. Police officers should always be identifiable⁶ and clear reporting procedures and “whistle-blower” protective measures should be put in place. Any allegation or other information indicative of police ill-treatment should be effectively investigated and any perpetrators of police ill-treatment be brought to justice.⁷

⁴ See substantive sections of previous general reports of the CPT on police issues: [CPT/Inf \(92\) 3, paragraphs 36 ff.](#), [CPT/Inf \(2002\) 15, paragraphs 34 ff.](#), and [CPT/Inf \(2015\) 1, paragraph 98](#).

⁵ See in particular [General Policy Recommendation No. 11 of the European Commission against Racism and Intolerance \(ECRI\) on combating racism and racial discrimination in policing](#).

⁶ For instance, members of specialised police forces and uniformed police officers should always wear a clearly distinctive insignia and a prominent identification number on the outside of their uniform/on their helmet.

⁷ See, in this respect, the 14th General Report of the CPT: [CPT/Inf \(2004\)28, paragraphs 25 ff.](#)

72. Last but not least, the setting-up and development of effective – internal and external – monitoring mechanisms, in particular national preventive mechanisms (NPMs) established under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), can contribute to a significant change in police culture.

Investigative interviewing – a paradigm shift

73. In countries where the CPT receives allegations of torture and other forms of ill-treatment in the context of police interviews, the Committee generally finds that criminal investigations are too often geared towards the objective of obtaining confessional evidence or other information. In criminal justice systems that place a premium on confessions, the risk of ill-treatment and other unlawful action in the context of police interviews is increased. Indeed, the focus on confessional evidence has led to wrongful convictions. Moreover, in a few countries it has become apparent that key performance indicators for police officers are heavily based on high “clear-up” rates, which may have a negative effect on police behaviour when carrying out interviews.

74. Since its inception, the Committee has placed particular emphasis on the development of clear rules or guidelines on the carrying out of police interviews. More specifically, the CPT has repeatedly stressed that the aim of police interviews must be to obtain accurate and reliable information in order to seek the truth about matters under investigation and not to obtain a confession from a person already presumed, in the eyes of the interviewing officers, to be guilty. The CPT has underlined the importance of the principle of proceeding “from the evidence to the suspect” rather than “from the suspect to the evidence”. Such an approach must prevail in the daily practice of all those involved, from apprehending officers to police investigators, as well as other actors of the criminal justice system such as prosecutors and judges.

75. This “non-accusatory” approach captures in essence the PEACE⁸ model for **investigative interviewing**, which the police service of England and Wales adopted in the early 1990s as the methodology for interviewing suspects, as well as witnesses and victims. Introduced in the context of larger reforms, this methodology changed entirely the procedures applied when interviewing suspects and, in the longer term, the mindset of individual police officers and the police service at large.

76. More recently, during its 2018 periodic visit to Norway, the CPT also examined the techniques of investigative interviewing applied by the Norwegian police (the so-called KREATIV⁹ model). Since 2004, the KREATIV course has formed part of the syllabus for university training programmes for police officers.¹⁰

77. The aim of training in investigative interviewing is to help police officers to carry out interviews in a systematic manner with an open mind, avoiding common pitfalls associated with relying on preconceived conclusions.¹¹ Equally importantly, it facilitates communication and the information flow, and consequently the detection of crime. Furthermore, it reduces the risk of human error and false confessions, which can occur with techniques designed to make the suspect confess. Research into the causes of wrongful convictions has documented that problems associated with “tunnel vision” or “confirmation bias” (i.e. an unconscious tendency to seek out only

⁸ The acronym PEACE stands for “Planning and preparation, Engage and explain, Account, Closure and Evaluation”.

⁹ The Norwegian acronym stands for “(K) Communication, Rule of law, Ethics and empathy, Active awareness, Trust through openness, Information, (V) Scientific anchoring”.

¹⁰ See [CPT/Inf \(2019\) 1, paragraph 28](#).

¹¹ In this connection, see “[A brief introduction to investigative interviewing – A practitioner’s guide](#)”, Council of Europe, October 2018.

information that “fits” and to ignore or explain away information that does not confirm what the interviewer believes to be true) are the underlying causes of miscarriages of justice in most cases.

78. Police interviewers with an open mindset are far more effective; they apply in practice the presumption of innocence by generating and actively testing alternative hypotheses through systematic preparation, empathic rapport-building, the use of open-ended questions, active listening, and strategic probing and disclosure of potential evidence.

79. Unsurprisingly, the investigative interviewing approach – combined with the practical operation of procedural safeguards as from the very outset of deprivation of liberty – is gradually achieving broad acceptance at universal level.¹² It features a number of advantages: it dismantles the myth of the effectiveness of harsh interrogation methods (including ultimately torture), and replaces it with more effective methods of preventing, detecting, investigating and solving crime. It is also seen as one of the most effective approaches to counter terrorism when compared with traditional methods still applied by many police forces. This in turn has a positive impact on the outcome, fairness, efficiency and reliability of any subsequent criminal proceedings, and on how the general public perceives the police service.

80. The investigative interviewing approach has clearly inspired the CPT in its monitoring work. The Committee considers that all the police officers concerned should receive detailed guidance on how interviews with suspects should be carried out. This can be achieved through legislation, regulations or a set of rules, procedures or practices. By way of illustration, the CPT considers that, in principle, there should be no more than two interviewing officers. The authorised duration of an interview, the rest periods between interview sessions and breaks during an interview should also be clearly specified (for instance, interviews should last no more than two hours at a time and suspects should be allowed, within a time span of 24 hours, a continuous period of at least eight hours for rest, free from questioning or any activity in connection with the investigation). Police interviews should as a rule be carried out in rooms specifically designed and equipped for the purpose. The CPT has also recommended that a mechanism for the ongoing monitoring and systematic review of these police interviewing standards, procedures or practices be established. Further, the development of adequate initial and ongoing professional training on interviewing techniques is key in the effective implementation of any such framework for police interviewing.

81. The CPT has also stressed the importance of accurate recording of all police interviews (including the start and end times and the names of all persons present during the interview). The electronic recording of police interviews (with audio/video-recording equipment) has also become an effective means of preventing ill-treatment during police interviews whilst presenting significant advantages for the police officers involved. Electronic recordings should be kept securely for a reasonable period, be made available to the detained persons concerned, and/or their lawyers, and be accessible to representatives of international and national monitoring bodies (including NPMs), as well as to any officials responsible for investigating allegations or reports of police ill-treatment.¹³

¹² See in particular the interim report of the United Nations Special Rapporteur on Torture ([A/71/298](#), 5 August 2016), who made a convincing case for the benefits of investigative interviewing and called for the development of a universal protocol identifying a set of standards for non-coercive interviewing methods and procedural safeguards.

¹³ In parallel, the CPT considers that greater emphasis should be placed on a physical evidence-based approach and on modern, scientific methods of criminal investigation, namely seizure, retention, packaging, handling and evaluation of forensic exhibits and the chain of custody. In addition, ready access to up-to-date scientific tools, such as DNA technology and automated fingerprint identification systems, should be ensured (if necessary through investment in equipment).

Centralised police detention and designated custody officers – a promising practice

82. In a number of countries, the CPT has observed and encouraged a trend consisting of keeping persons in police custody in **centralised police detention facilities** rather than in police cells located in smaller establishments or special operational departments.

83. The CPT has frequently gained a positive impression of the functioning of such central police detention facilities, which can also provide better material conditions for persons in police custody.¹⁴ It has also noted the clear benefits of having **designated staff who exclusively fulfil the role of custodial officers**. In terms of resources, a division of labour between operational officers, custodial officers and investigators can lead to greater specialisation, professionalism and efficiency. By contrast, police officers who have to fulfil dual or even triple roles of apprehending persons suspected of criminal or other offences, looking after the well-being and rights of those who have been apprehended (possibly under difficult circumstances), and interviewing these persons in relation to an offence, will often find it personally challenging to assume all of these roles in a professional manner.

84. A separation of the different police tasks and the creation of a specialised group of custody officers may therefore lead to an enhanced sense of responsibility of such officers for the persons in their charge. It may also possibly break the harmful *esprit de corps* that often prevents officers from speaking out against their colleagues in cases of ill-treatment. This presupposes that custody officers are empowered by a working environment that acknowledges their important contribution to the professional functioning of any police service. Clear and consistent custody guidelines, which exist in a number of countries, are an important tool for professionalising the implementation of custody.¹⁵

85. Introducing designated custody officers could also strengthen the **practical implementation of various procedural and other safeguards**. While it remains incumbent on the apprehending officer(s) to inform detained persons of their rights, designated custody officers can double-check upon admission to the custody facility whether the detained person has actually been informed of all their rights, has understood and is able to exercise them. They may also provide the first opportunity for a detained person to make a formal complaint against apprehending officers, for example, regarding excessive use of force upon apprehension. The CPT has noted that, in certain states, every apprehended person has to be presented immediately to a designated, experienced, custody officer, before any other procedural steps can be taken. This custody officer is responsible for checking the psychological or physical integrity of the apprehended person, including whether they need to see a health-care professional, and for offering them the possibility to inform a third party of their choice of their situation and to contact a lawyer. Designated police officers are properly trained to pose the appropriate questions and to recognise and record indicative signs of a person in need of particular support and care. This is clearly good practice.

¹⁴ The CPT has generally found that basic material conditions, such as sanitary facilities, outdoor yards, meeting rooms for lawyers and medical examination rooms, as well as food, can be better provided in larger, specialised custody facilities than in small district police stations. It should be noted, however, that the existence of designated police custody facilities should not lead to the detention of persons remanded in custody in these facilities, as is still the case in several Council of Europe countries.

¹⁵ One example is the England and Wales [Police and Criminal Evidence Act \(PACE\) Code C](#) – Code of Practice for the detention, treatment and questioning of persons by Police Officers (Home Office of the United Kingdom, revised, 26 July 2018). In some countries, the role and tasks of custody officers are specified in the national legislation (see, for instance, Section 212 of the Ukrainian Code of Criminal Procedure).



Electrical discharge weapons

*Extract from the 20th General Report of the CPT,
published in 2010*

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.



Imprisonment

*Extract from the 2nd General Report of the CPT,
published in 1992*

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 (e.g. 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 (e.g. 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 otherwise¹, be given an opportunity to present his views on the matter, and be able to contest the measure before an appropriate authority.

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.

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).



Developments concerning CPT standards in respect of imprisonment

*Extract from the 11th General Report of the CPT,
published in 2001*

25. Almost a decade has elapsed since the CPT described, in its 2nd General Report, some of the main issues pursued by the Committee when visiting prison establishments. In the meantime, the Committee has carried out more than 100 visits and the number of Parties to the Convention has practically doubled. Naturally, the CPT's standards in respect of imprisonment have gradually evolved, in the light of the new situations encountered and the experience gathered.

The CPT intends, progressively, to draw up updated descriptions of its standards in all areas falling within its mandate. For the time being, the CPT would like, in this section of its 11th General Report, to highlight a miscellany of issues in the area of prison matters which are of particular current concern to the Committee and, no doubt, to those responsible for prison administration and to other interested circles throughout Europe.

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.

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 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.

¹ 2nd General Report - CPT/Inf (92) 3, paragraph 46, and 7th General Report - CPT/Inf (97) 10, paragraphs 12-15.

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.²

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.

² See also "Health care services in prisons", section "transmittable diseases".

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.



Strasbourg, 15 December 2015

CPT/Inf (2015) 44

Living space per prisoner in prison establishments: CPT standards

The CPT's minimum standard for personal living space in prison establishments is:

- 6m² of living space for a single-occupancy cell
+ sanitary facility
- 4m² of living space per prisoner in a multiple-occupancy cell
+ fully-partitioned sanitary facility
- at least 2m between the walls of the cell
- at least 2.5m between the floor and the ceiling of the cell

Introduction

1. Since the 1990s the CPT has developed and applied minimum standards regarding the living space that a prisoner should be afforded in a cell. While these standards have been frequently used in a large number of CPT visit reports, they have so far not been brought together in a single document.
2. At the same time, there is a growing interest in these standards, at the national level (among member states' authorities responsible for the prison estate, national detention monitoring bodies such as national preventive mechanisms established under OPCAT¹, domestic courts, NGOs, etc.) and at the international level, not least because of the problem of prison overcrowding and its consequences. Currently, the Council of Europe's Council for Penological Co-operation (PC-CP) is preparing a White Paper on prison overcrowding. For its part, the European Court of Human Rights is frequently being called upon to rule on complaints alleging a violation of Article 3 of the European Convention on Human Rights (ECHR) on account of insufficient living space available to a prisoner.
3. Against this background, the CPT decided in November 2015 to provide a clear statement of its position and standards regarding minimum living space per prisoner; such is the aim of this document.
4. The cells referred to in this document are ordinary cells designed for prisoners' accommodation, as well as special cells, such as disciplinary, security, isolation or segregation cells. However, waiting rooms or similar spaces used for very short periods of time are not covered here.²

Minimum standards for personal living space in prison establishments: general aspects

5. During its monitoring activities, the CPT has frequently encountered situations of prison overcrowding. The consequences of overcrowding have been highlighted repeatedly by the CPT in its visit reports: cramped and unhygienic accommodation; constant lack of privacy; 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. The CPT considers that the question of minimum living space per inmate is intrinsically linked to the commitment of every Council of Europe member state to respect the dignity of persons sent to prison.
6. Minimum standards for personal living space are not as straightforward a matter as they might appear at first sight. To begin with, the "minimum living space" standards used by the CPT differ according to the type of the establishment. A police cell for short-term detention of several hours up to a few days does certainly not have to meet the same size standards as a patients' room in a psychiatric institution; and a prison cell, whether for remand or sentenced prisoners, is again an entirely different matter.

¹ Optional Protocol to the Convention against Torture of the United Nations

² The issue of living space in other places where persons could be deprived of their liberty (police stations, psychiatric establishments, immigration detention facilities, etc.) is not covered by this document.

7. Secondly, a differentiation should be made according to the intended occupancy level of the accommodation in question (i.e. whether it is a single cell or a cell designed for multiple occupancy). The term “multiple occupancy” also needs to be defined. A double cell is arguably different from a cell designed for holding for instance six or more inmates. As regards large-scale dormitories, accommodating dozens and sometimes even up to one hundred inmates,³ the CPT has fundamental objections which are not only linked to the question of living space per inmate, but to the concept as such.

In its 11th General Report⁴ the CPT criticised the very principle of accommodation in large-capacity dormitories; frequently such dormitories hold prisoners in extremely cramped and insalubrious conditions. In addition to a lack of privacy, the Committee has found that the risk of intimidation and violence in such dormitories is high, and that proper staff control is extremely difficult. Further, an appropriate allocation of individual prisoners, based on a case-by-case risk and needs assessment, becomes an almost impossible task.⁵ The CPT has consequently long advocated a move away from large-capacity dormitories towards smaller living units.⁶

8. Thirdly, the CPT has also taken into consideration the regime offered to prisoners when assessing cell sizes in light of its standards (see paragraph 21 below).

The CPT’s minimum standard for personal living space

9. The CPT developed in the 1990s a basic “rule of thumb” standard for the minimum amount of living space that a prisoner should be afforded in a cell.

- 6m² of living space for a single-occupancy cell
- 4m² of living space per prisoner in a multiple-occupancy cell

10. As the CPT has made clear in recent years, the minimum standard of living space should exclude the sanitary facilities within a cell. Consequently, a single-occupancy cell should measure 6m² plus the space required for a sanitary annexe (usually 1m² to 2m²). Equally, the space taken up by the sanitary annexe should be excluded from the calculation of 4m² per person in multiple-occupancy cells. Further, in any cell accommodating more than one prisoner, the sanitary annexe should be fully partitioned.

11. Additionally, the CPT considers that any cell used for prisoner accommodation should measure at least 2m between the walls of the cell and 2.5m between the floor and the ceiling.

³ For example, when visiting a prison in Romania in 1995, the CPT found that 88 prisoners were being held in a dormitory of some 80m²; in 2009, the CPT visited a colony in Ukraine where a dormitory measuring 200m² was equipped with 114 beds.

⁴ CPT/Inf (2001) 16, paragraph 29.

⁵ See, for example, the report on the 2013 visit to Greece where such a state of affairs was observed in two prisons (CPT/Inf (2014) 26, paragraphs 105 and 106).

⁶ See, for example, the report on the 2009 visit to Ukraine (CPT/Inf. (2011) 29, paragraph 113).

Promoting higher standards

12. Rule 18.5 of the European Prison Rules (2006) states that “*Prisoners shall normally be accommodated during the night in individual cells except where it is preferable for them to share sleeping accommodation.*” Indeed, in many Council of Europe countries, prisoners are provided with an individual cell, often measuring between 7.5m² and 9.5m². The CPT has consistently stated that single-occupancy cells of less than 6m² (excluding the sanitary annexe) should be either withdrawn from service or enlarged in order to provide adequate living space for one inmate.

13. When devising the standard of 4m² of living space, the CPT had in mind on the one hand the trend observed in a number of western European countries of doubling up 8 to 9m² cells that were originally designed for single occupancy, and on the other hand the existence of large-capacity dormitories in prison establishments (colonies) in various central and eastern European countries.

14. Although the CPT has never explicitly defined “multiple-occupancy”, an analysis of visit reports indicates that cells for two to four inmates implicitly fall under this notion.⁷ Consequently, the CPT has regularly implied that cells measuring 8m² were acceptable for two inmates, cells of 12m² for three, and cells measuring 16m² were adequate for four inmates. However, in a non-negligible number of cases, the CPT has also stated that cells of 8m² (or 8 to 9m²) should “preferably” (Slovenia, 2006; Hungary, 2013) or “*idéalement*” (Belgium, 2009) accommodate only one prisoner; or should be “used to accommodate no more than one prisoner save in exceptional cases when it would be inadvisable for a prisoner to be left alone” (UK, 2003). In the report on its 2011 visit to the Netherlands, the Committee stated that accommodation in double cells measuring between 8 and 10m² was “not without discomfort” to the prisoners, and in the report on the 2011 visit to Ireland, it recommended that “efforts be made to avoid as far as possible placing two prisoners in 8m² cells”.

15. Clearly, the aforementioned examples suggest that the 4m² per prisoner standard may still lead to cramped conditions when it comes to cells for a low number of inmates. Indeed, given that 6m² is the minimum amount of living space to be afforded to a prisoner accommodated in a single-occupancy cell, it is not self-evident that a cell of 8m² will provide satisfactory living space for two prisoners. In the CPT’s view, it is appropriate at least to strive for more living space than this. The 4m² standard is, after all, a *minimum* standard.

16. For these reasons, the CPT has decided to promote a *desirable* standard regarding multiple-occupancy cells of up to four inmates by adding 4m² per additional inmate to the minimum living space of 6m² of living space for a single-occupancy cell:

- | |
|---|
| <ul style="list-style-type: none">• 2 prisoners: at least 10m² (6m² + 4m²) of living space + sanitary annexe• 3 prisoners: at least 14m² (6m² + 8m²) of living space + sanitary annexe• 4 prisoners: at least 18 m² (6m² + 12m²) of living space + sanitary annexe |
|---|

17. In other words, it would be desirable for a cell of 8 to 9m² to hold no more than one prisoner, and a cell of 12m² no more than two prisoners.

18. The CPT encourages all Council of Europe member states to apply these higher standards, in particular when constructing new prisons.

⁷ See, for example, the report on the 2013 visit to Poland (CPT/Inf. (2014) 21, paragraph 49).

Minimum standards vs. inhuman and degrading treatment: the need to differentiate

19. The European Court of Human Rights is approached with an ever-increasing number of complaints from prisoners who allege that they are detained in inhuman or degrading conditions, having to share cells with large numbers of fellow-inmates, which leaves them with very little living space. The Court, in its judgments, is obliged to decide whether or not the holding of prisoners in cells offering a very limited living space per person (usually less than 4m²) constitutes a violation of Article 3 of the ECHR.

20. The role of the CPT, as a preventive monitoring body, is different. Its responsibility does not entail pronouncing on whether a certain situation amounts to inhuman or degrading treatment or punishment within the meaning of Article 3 of the ECHR.⁸ However, in the course of its visits the Committee has been confronted with prison conditions that beggared belief and were, as described in one visit report, an “affront to a civilised society”. Hence, in a number of visit reports it has stated that the conditions observed in grossly overcrowded prisons could be considered as amounting to “inhuman and degrading treatment”.

21. The CPT has never considered that its cell-size standards should be regarded as absolute. In other words, it does not automatically hold the view that a minor deviation from its minimum standards may in itself be considered as amounting to inhuman and degrading treatment of the prisoner(s) concerned, as long as other, alleviating, factors can be found, such as, in particular, the fact that inmates are able to spend a considerable amount of time each day outside their cells (in workshops, classes or other activities). Nevertheless, even in such cases, the CPT would still recommend that the minimum standard be adhered to.

22. On the other hand, for the Committee to say that conditions of detention could be considered as amounting to inhuman and degrading treatment, the cells either have to be extremely overcrowded or, as in most cases, combine a number of negative elements, such as an insufficient number of beds for all inmates, poor hygiene, infestation with vermin, insufficient ventilation, heating or light, lack of in-cell sanitation and in consequence the use of buckets or bottles for the needs of nature. In fact, the likelihood that a place of detention is very overcrowded but at the same time well ventilated, clean and equipped with a sufficient number of beds is extremely low. Thus, it is not surprising that the CPT often enumerates the factors that constitute appalling detention conditions, rather than just referring to inadequate living space. In addition – but by no means in every case – other factors not directly related to the conditions are taken into account by the CPT when assessing a particular situation. These factors include little out-of-cell time and generally a poor regime; reduced outdoor exercise; deprivation of contacts with relatives for several years, etc.

23. The Appendix to this document contains a non-exhaustive list of factors (other than the amount of living space per prisoner) to be taken into consideration when assessing detention conditions in prison.

⁸ See in this regard Article 17 (2) of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (ECPT).

Conclusion

24. This document seeks to provide guidelines to practitioners and other interested parties, by clearly stating the CPT's minimum standards regarding living space for prisoner(s) in a given cell. Ultimately, it is for the courts to decide whether a particular person has experienced suffering that has reached the threshold of inhuman or degrading treatment within the meaning of Article 3 of the ECHR, taking into account all kinds of factors, including the individual's personal constitution. The number of square metres available per person is but one factor, albeit often a very significant or even decisive one.

25. Conditions where inmates are left with less than 4m² per person in multiple-occupancy cells, or single cells measuring less than 6m² (both excluding a sanitary annexe) have consistently been criticised by the CPT, and authorities have regularly been called upon to enlarge (or withdraw from service) single cells or reduce the number of inmates in multiple-occupancy cells. The CPT expects that these minimum living space standards will be systematically applied in all prison establishments in Council of Europe member states, and hopes that more and more countries will strive to meet the CPT's "desirable" standards for multiple-occupancy cells.

APPENDIX

Examples of other factors to be taken into consideration when assessing detention conditions in prison

State of repair and cleanliness

- Cells, including furniture, should be in a decent state of repair and every effort should be made to keep the living areas clean and hygienic.
- Any infestation with vermin needs to be tackled vigorously.
- Inmates should be provided with the necessary personal hygiene products and cleaning materials.

Access to natural light, ventilation and heating

- All living accommodation for prisoners (both single- and multiple-occupancy cells) should have access to natural light as well as to artificial lighting which is sufficient for reading purposes.
- Equally, there needs to be sufficient ventilation to ensure a constant renewal of the air inside the cells.
- Cells should be adequately heated.

Sanitary facilities

- Each cell should possess a toilet and a washbasin as a minimum. In multiple-occupancy cells the sanitary facilities should be fully partitioned (i.e. up to the ceiling).
- In those few prisons where no in-cell sanitary facilities are available, the authorities must ensure that prisoners have ready access to the toilet whenever needed. Today, no prisoner in Europe should be obliged to “slop out”, a practice that is degrading both for the prisoners and for the staff members who have to supervise such a procedure.

Outdoor exercise

- The CPT considers that every prisoner should be offered a minimum of one hour of outdoor exercise every day. Outdoor exercise yards should be spacious and suitably equipped to give inmates a real opportunity to exert themselves physically (e.g., to practise sports); they should also be equipped with a means of rest (e.g., a bench) and a shelter against inclement weather.

Purposeful activities

- The CPT has long recommended that prisoners should be offered a range of varied purposeful activities (work, vocation, education, sport and recreation). To this end, the CPT has stated since the 1990s that the aim should be for prisoners – both sentenced and on remand – to spend eight hours or more a day outside their cells engaged in such activities, and that for sentenced prisoners the regime should be even more favourable.



Solitary confinement of prisoners

*Extract from the 21st General Report of the CPT,
published in 2011*

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.

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

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.

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.

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

(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.³ 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.

(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:

³ The maximum period should certainly be lower in respect of juveniles.

(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 re-examine 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 4 m²; in this connection, the CPT wishes to stress that any cell measuring less than 6 m² 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.



Remand detention

*Extract from the 26th General Report of the CPT,
published in 2017*

1. Introduction

52. In many European countries, the persistent problem of overcrowding in prisons, with all its related challenges, has to be ascribed to a large extent to the high proportion among the total prison population of remand prisoners (i.e. prisoners who are detained by court order and are still awaiting their trial or have not been convicted by a final judgment). However, this is not the only reason why the CPT pays close attention to remand prisoners during its visits. In the CPT's experience, remand prisoners in particular are all too often held in dilapidated and overcrowded cells and are frequently subjected to an impoverished regime. In a number of visit reports, the CPT has taken the view that the conditions of detention of remand prisoners in the establishments visited were totally unacceptable and could easily be considered to be inhuman and degrading. Moreover, remand prisoners are frequently subjected to various types of restrictions (in particular as regards contacts with the outside world), and, in a number of countries, certain remand prisoners are held in solitary confinement by court order (sometimes for prolonged periods).

The CPT also wishes to stress that, for the individual, detention on remand can have severe psychological effects – suicide rates among remand prisoners can be several times higher than among sentenced prisoners¹ – and other serious consequences, such as the breaking up of family ties or the loss of employment or accommodation.

53. Within the Council of Europe area, the frequency and duration of remand detention appears to differ enormously in practice from one country to another, with the proportion of remand prisoners of the total prison population ranging from 8% to 70%. On average, some 25% of all prisoners in the Council of Europe area are on remand. For foreign nationals in remand detention, the proportion is significantly higher, with an average of some 40% of the overall number of imprisoned foreign nationals.²

Due to its intrusive nature and bearing in mind the principle of presumption of innocence, the basic tenet is that remand detention should only be used as a measure of last resort (*ultima ratio*). It should be imposed for the shortest time possible and should be based on a case-by-case evaluation of the risks of committing a new crime, of absconding, or of tampering with evidence or witnesses

¹ Council of Europe Annual Penal Statistics, SPACE I – Prison Populations, Survey 2015, PC-CP (2016) 6, 15 December 2016, tables 5.1 and 13.1.

² Council of Europe Annual Penal Statistics, SPACE I – Prison Populations, Survey 2015, PC-CP (2016) 6, 15 December 2016, tables 4 and 5.1.

or otherwise interfering with the course of justice.³ Moreover, the nature and gravity of the offence the person is suspected of having committed should be duly taken into account when assessing the proportionality of the measure.

In the CPT's view, the principle that remand detention should only be imposed as a last resort implies in the first place that, as far as possible, non-custodial measures should be applied. This requires the availability of a broad range of measures, such as the conditional suspension of pre-trial detention, bail, house arrest, electronic monitoring, the obligation to comply with certain orders, judicial supervision, the removal of passports, etc. Such a range of alternatives should also be considered for foreign nationals, and the fact that such a person is neither a national nor a resident of the state, or that he/she does not have any other links with that state, should not, in itself, be sufficient to conclude that there is a risk of flight.⁴

2. Remand detention in prisons

54. Reception and induction programmes have an important role to play for persons remanded in custody who enter the prison system. If performed properly, they will enable prison staff to carry out an individual risk and needs assessment, including the identification of those most at risk of self-harm, and will relieve some of the anxiety experienced by all newly-arrived prisoners. Further, they will provide an opportunity to acquaint prisoners with the running of the prison, including the regime and daily routine, as well as ensure that they have been able to contact their family. To this end, prisoners should be provided with oral information and a comprehensive information booklet which should exist in an appropriate range of languages. Particular attention should be paid to ascertain that the information provided is understood by prisoners with reading and writing difficulties and by foreign nationals who do not speak the language(s) spoken by staff.

Given the strong impact a first-time admission to a prison may have on the person concerned, consideration might be given to extending the above-mentioned induction programme over several days in order to provide newly-admitted prisoners with a greater opportunity to absorb the information. If such an induction programme is not properly carried out, prisoners will rely on other prisoners to tell them about the regime and the rules, which can easily place certain prisoners in a superior position.

The CPT's experience shows that in some countries, reception and induction programmes may last for several weeks and the regime applied to prisoners undergoing them may be very restrictive, sometimes amounting to solitary confinement. The CPT considers in this respect that newly-admitted prisoners should be allocated to ordinary accommodation units as soon as possible after a risk and needs assessment has taken place upon admission. Moreover, conditions for newly-arrived prisoners should not amount to a solitary confinement-type regime for prolonged periods. Further, in addition to induction-related activities, a minimum of one hour of outdoor exercise per day should be provided from the outset of the induction period.⁵

³ See Articles 5(1)(c) and 5(3) of the European Convention on Human Rights and the relevant case-law of the European Court of Human Rights, as well as the White Paper on Prison Overcrowding, the Council of Europe's Committee on Crime Problems (CDPC), PC-CP (2015) 6 rev 7, paragraph 62.

⁴ See Rule 13.2 of Recommendation CM/Rec(2012)12 of the Committee of Ministers to member states concerning foreign prisoners.

⁵ See also paragraph 68 concerning juveniles.

55. Most countries make provision for separating remand and sentenced prisoners, as stipulated in the European Prison Rules (Rule 18.8) and other international instruments.⁶ The European Prison Rules (Rules 18.9 and 101) also allow exceptions in this regard to enable remand prisoners to participate in joint organised activities with sentenced prisoners, whilst generally keeping both categories of prisoner separate at night.

In some countries, arrangements are made to organise joint activities for remand and sentenced prisoners, with both categories sometimes being accommodated in the same cells/units. In the CPT's opinion, allowing remand prisoners to participate in organised activities together with sentenced prisoners is undoubtedly better than confining remand prisoners to their cells for up to 23 hours a day for prolonged periods as is currently the case in many Council of Europe member states. However, efforts should be made to accommodate remand prisoners separately from sentenced prisoners. In fact, the CPT has a preference for remand prisoners having a satisfactory programme of activities whilst always being separated from sentenced prisoners, in full respect for the principle of presumption of innocence. Such separation also protects remand prisoners who enter the prison environment for the first time and who may be innocent from the potential criminal influence of sentenced prisoners. In this connection, the importance of a risk and needs assessment of all persons entering prison, as described in paragraph 54, cannot be over-emphasised, as it may not be appropriate to mix first-time remand prisoners with the large numbers of persons re-entering prison for a second time or more.

56. During its many visits, the CPT found that remand prisoners frequently had to share cells which provided less than 3 m² of living space per person (and sometimes even less than 2 m²). Moreover, the cells were not always equipped for the number of inmates they accommodated. For instance, prisoners were compelled to sleep on mattresses placed directly on the floor or even had to share beds and sleep in shifts. Among other things, this results in a complete lack of privacy and may well increase tension between inmates. Such intolerable conditions, which may last for months or even years, are often exacerbated by the fact that remand prisoners have to spend most of the time in their cell, as the regime of organised activities is often extremely limited for this category of prisoner (see, in this regard, paragraph 58).

In the CPT's opinion, the *minimum* standards for personal living space in prison establishments should be 6 m² for a single-occupancy cell and 4 m² per prisoner for a multiple-occupancy cell (excluding sanitary facilities).⁷ Providing living space of less than 4 m² significantly increases the risk of a violation of Article 3 of the European Convention on Human Rights. In this context, in its recent Grand Chamber judgment in the case of *Muršić v. Croatia*,⁸ the European Court of Human Rights stated that “[w]hen the personal space available to a detainee falls below 3 sq. m of floor surface in multi-occupancy accommodation in prisons, the lack of personal space is considered so severe that a strong presumption of a violation of Article 3 arises. [...] In cases where a prison cell – measuring in the range of 3 to 4 sq. m of personal space per inmate – is at issue the space factor remains a weighty factor in the Court's assessment of the adequacy of conditions of detention.”

57. The Committee also wishes to reiterate that every effort should be made to phase out the practice of accommodating remand prisoners in dormitories and to move towards cellular accommodation for a small number of inmates. Ideally, remand prisoners (as well as sentenced prisoners) should be accommodated in single cells except where it is preferable for them to share sleeping accommodation.⁹

⁶ See, for instance, Article 10(2)(a) of the International Covenant on Civil and Political Rights and Rule 11(b) of the United Nations Standard Minimum Rules for the Treatment of Prisoners (*Nelson Mandela Rules*).

⁷ 25th General Report on the CPT's activities (CPT/Inf (2016) 10), paragraph 84.

⁸ *Muršić v. Croatia* [GC], no. 7334/13, 20 October 2016.

⁹ See also Rules 18.5 and 96 of the European Prison Rules.

58. Since the beginning of its activities in the early 1990s, the CPT has emphasised the crucial importance a satisfactory programme of activities has for prisoners, including those on remand. In this regard, it is a matter of serious concern that, in a considerable number of countries, the specific recommendations made by the Committee concerning the regime of remand prisoners remain to be implemented. Whilst acknowledging that the provision of organised activities in remand prisons, where there is likely to be a high turnover of inmates, poses particular challenges, it is not acceptable to lock up remand prisoners in their cells for up to 23 hours per day and to leave them to their own devices for months or even years on end.

The CPT calls upon the prison authorities of the countries concerned to devise and implement a comprehensive regime of out-of-cell activities. The aim should be to ensure that remand prisoners (as well as sentenced prisoners) are able to spend a reasonable part of the day (i.e. eight hours or more) outside their cells, engaged in purposeful activity of a varied nature (work, preferably with vocational value,¹⁰ education, sport, recreation/association). The longer the period of remand detention, the more varied the regime should be. All prisoners, without exception, must be offered at least one hour of outdoor exercise a day, in suitable facilities.

59. As regards contact with the outside world, the CPT considers that remand prisoners should in principle be allowed to communicate with their family and other persons (correspondence, visits, telephone) in the same way as sentenced prisoners.¹¹ All inmates should benefit from a visiting entitlement of at least one hour every week and have access to a telephone at the very least once a week (in addition to the contacts with their lawyer(s)). Moreover, the use of modern technology (such as free-of-charge Voice over Internet Protocol (VoIP) services) may help prisoners to maintain contact with their families and other persons.

60. In certain countries, the CPT observed that, according to the applicable rules, certain restrictions were imposed on all remand prisoners as a matter of policy, for instance, a total ban on telephone calls, visits or the obligation to receive visits only under closed conditions (i.e. through a glass partition). In the CPT's view, applying such restrictions indiscriminately to all remand prisoners is not acceptable; any restrictions must be based on a thorough individual assessment of the risk which prisoners may present.

61. Further, in a number of countries, remand prisoners are obliged to request authorisation from a judge or prosecutor for every single visit. In this regard, the CPT considers that remand prisoners should be entitled to receive visits (and make telephone calls) as a matter of principle, rather than these being subject to authorisation by a judicial authority. Any refusal in a given case to permit such contacts should be specifically substantiated by the needs of the investigation, require the approval of a judicial authority and be applied for a specific period of time. If it is considered that there is an ongoing risk of collusion, particular visits (or telephone calls) can be monitored.

62. The CPT has repeatedly come across situations where far-reaching restrictions are imposed on remand prisoners by judicial authorities, in the interests of an ongoing criminal investigation. Such restrictions may entail a total prohibition of contacts with the outside world (except with the lawyer) combined with segregation from all other prisoners, the result being that the prisoners are held for a certain period under conditions amounting to solitary confinement.

¹⁰ It should be added, however, that, according to Rule 100.1 of the European Prison Rules, "[u]ntried prisoners shall be offered the opportunity to work but shall not be required to work".

¹¹ See Rule 99 of the European Prison Rules.

The CPT acknowledges that there may be justification, in an individual case, for keeping a given remand prisoner apart from certain other prisoners or, in even more exceptional circumstances, from prisoners in general, and for restricting his/her contact with the outside world. However, in the CPT's view, the starting point for devising regimes for remand prisoners must be the presumption of innocence and the principle whereby prisoners must not be subject to more restrictions than are strictly necessary to ensure that they are incarcerated without risk and that the interests of justice are duly served. Any restrictions should be kept to a minimum and last for as short a time as possible. Whatever the circumstances, restrictions should never be applied for the purpose of bringing pressure to bear on persons remanded in custody in order to induce them to co-operate with the justice system. Placement in solitary confinement (or in conditions which in practice amount to this) must be resorted to only in exceptional situations and where there is direct evidence of a serious threat to the course of justice if the person concerned associates with particular individuals or other persons in general.

63. Decisions imposing restrictions described in the previous paragraph should normally be taken when the remand prisoner appears in court and be subject to appeal in a separate procedure. The written decision should provide reasons for every restriction imposed and should be given to the prisoner concerned and/or his/her lawyer. The restrictions must be reviewed by the competent court on a frequent basis to ensure that there is a continuing need for them. The longer a restriction is imposed on a prisoner in remand custody, the more rigorous should be the test as to whether the measure remains necessary and proportionate.

64. The material conditions and the detention regimes provided to inmates held in solitary confinement must meet the standards laid down by the CPT;¹² in particular, prisoners should be provided with appropriate human contact throughout the duration of the measure and the prison authorities should make every possible effort to alleviate the potentially damaging effects of solitary confinement on the prisoner concerned.

3. Juveniles on remand

65. In principle, the remarks made in the preceding sections also apply to juveniles. However, in the CPT's view, there are a number of specific standards which should be taken into account when dealing with juveniles in remand detention. These standards are set out in more detail in the 24th General Report on the CPT's activities.¹³ For ease of reference, the Committee wishes to recall certain key aspects which deserve particular attention.

66. First of all, it is a well-established precept that, in all action concerning juveniles, their best interests shall be a primary consideration and they should only be deprived of their liberty as a last resort and for the shortest possible period of time.¹⁴

67. Further, the CPT considers that detained juveniles who are suspected (or convicted) of a criminal offence should, as a rule, not be held in institutions for adults but in facilities which are specifically designed for persons of this age group, offer a non-carceral environment and a regime tailored to their specific needs and are staffed by persons trained in dealing with juveniles.

¹² 21st General Report on the CPT's activities (CPT/Inf (2011) 28), paragraphs 53 to 64.

¹³ See paragraphs 96 to 132 of CPT/Inf (2015) 1 (Juveniles deprived of their liberty under criminal legislation).

¹⁴ See Articles 3 and 37.b of the United Nations Convention on the Rights of the Child and Rules 5 and 10 of the European Rules for Juvenile Offenders; see also Rule 13.1 of the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (*Beijing Rules*), Rule 17 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (*Havana Rules*) and the 2010 Guidelines of the Committee of Ministers of the Council of Europe on child friendly justice.

Regrettably, in many Council of Europe member states, it remains the case that juveniles on remand in particular are frequently held in prisons for adults. The CPT acknowledges that, in such cases, juveniles are nowadays usually accommodated separately from adults, often in a designated unit. In addition, significant improvements have been observed in recent years in terms of material conditions in juvenile units.

However, in a number of countries, the regime offered to juvenile remand prisoners held in adult prisons still leaves much to be desired, especially in remand establishments which usually accommodate only very small numbers of juveniles (in particular female juveniles). On several occasions, the CPT observed that only one juvenile was being held on remand in a given establishment or unit. In this regard, the Committee acknowledges that there may be an argument in favour of juveniles participating in out-of-cell activities with suitable adult inmates, on the strict condition that there is appropriate supervision by staff. This also has the benefit of avoiding a situation of *de facto* solitary confinement of the juveniles concerned.

68. As repeatedly stated by the CPT in the past, 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 in remand detention should be offered a full programme of out-of-cell activities suited to their age, such as education, sport, vocational training and recreational activities. Physical education should constitute an important part of that programme. Juveniles should also be offered at least two hours of outdoor exercise every day, from the moment they arrive at a detention establishment. As already mentioned in paragraph 58 regarding remand prisoners in general, the longer the period of detention on remand, the more varied should be the activities on offer.

4. Remand detention in law enforcement establishments

69. The CPT has serious reservations about the practice observed in a number of countries of holding persons remanded in custody by courts in a law enforcement establishment well beyond the statutory time limit of police custody, pending their transfer to a remand prison, or of returning persons placed in a remand prison to a law enforcement establishment for the purpose of investigative actions.

Such periods of stay may last several days or weeks and, on occasion, even longer. Usually, persons remanded in custody remain in a law enforcement establishment after their court hearing or are returned to the law enforcement establishment from a prison for the purpose of investigative actions, at the request of the law enforcement official who is responsible for the criminal investigation. In some cases, delays in transferring persons remanded in custody to a remand prison are explained by logistical obstacles in arranging escorts or by the lack of space for accommodation in the remand prison (due to severe overcrowding).

70. The CPT recalls that, as a matter of principle, remand prisoners should not be held in law enforcement establishments;¹⁵ such facilities are not designed for lengthy periods of stay. Moreover, prolonged detention on the premises of law enforcement agencies increases the risk of intimidation and ill-treatment by law enforcement officials dealing with the criminal investigation against the person concerned. Therefore, persons remanded in custody should always be promptly transferred to a prison.

Further, the return of remand prisoners to detention facilities of law enforcement agencies should be sought and authorised only very exceptionally and when it is absolutely unavoidable, for specific reasons and for the shortest possible time. Such a return should in each case be subject to the express authorisation of a prosecutor or judge. As a rule, the prisoners concerned should not be held

¹⁵ See also Rule 10.2 of the European Prison Rules.

overnight in law enforcement establishments. It is axiomatic that the fact that a remand prisoner has been returned to a law enforcement establishment should be duly recorded (at both the prison and the law enforcement establishment concerned) and that, upon re-admission to the remand prison, the prisoner concerned should again be subjected to medical screening (see paragraph 72). If further police questioning is necessary, it is far preferable for this to be carried out at the remand prison, rather than transferring the remand prisoner concerned back to a law enforcement establishment.

5. Remand detention and health care

71. In the CPT's experience, remand prisons in particular are not always equipped with a health-care system that is able to provide medical treatment (including preventive and specialised treatment) and nursing care, or psychological assistance and physiotherapy, in conditions equivalent to those enjoyed by patients in the outside community.

In this regard, the CPT considers that all detained persons, irrespective of their legal status and the place in which they are being held, should have effective access to medical services. Further, remand prisoners should in principle be given the opportunity to consult and be treated by their own doctor (it being understood that this may be carried out at their own expense).¹⁶

72. The CPT has repeatedly stressed the importance of medical screening of newly-arrived prisoners, especially in establishments which constitute points of entry to the prison system. Such screening is essential, in particular to prevent suicide and the spread of transmissible diseases (such as tuberculosis, hepatitis B/C, HIV). Prison health-care services can also make a significant contribution to the prevention of ill-treatment during the period immediately prior to imprisonment, namely when persons are in the custody of law enforcement agencies, through the systematic and timely recording of injuries and, when appropriate, the provision of information to the relevant authorities.¹⁷

Every newly-arrived remand prisoner should be properly interviewed and physically examined, as soon as possible and no later than 24 hours after his/her admission, by a medical doctor (or a fully qualified nurse reporting to a doctor), under conditions guaranteeing medical confidentiality. In this connection, particular attention should be paid to the specific needs of vulnerable groups such as juveniles, elderly persons, substance-addicted persons and persons with mental disorders.

73. In the CPT's experience, medical treatment which has been started in the outside community is sometimes interrupted when a person is remanded in custody and placed in a prison. Likewise, treatment is on occasion interrupted when a prisoner is released or transferred from one establishment to another. In some countries, the CPT has observed that treatment which requires a longer-term commitment is not provided to remand prisoners because of the short-term or uncertain remand period. Such an approach is contrary to the state's duty of care vis-à-vis persons it has deprived of their liberty. The Committee considers that the necessary arrangements must be made to ensure continuity of care after admission to, or release from, prison, as well as following a transfer from one penitentiary establishment to another.

As regards more specifically newly-arrived substance-addicted remand prisoners, particular attention should also be paid to withdrawal symptoms resulting from the use of drugs, medication or alcohol, and opiate substitution treatment which has started prior to their admission to the prison should be continued in prison.¹⁸

¹⁶ See also paragraph 37 of Recommendation Rec(2006)13 of the Committee of Ministers to member states on the use of remand in custody, the conditions in which it takes place and the provision of safeguards against abuse.

¹⁷ For further details, see paragraphs 71 to 84 of the 23rd General Report on the CPT's activities (CPT/Inf(2013)29).

¹⁸ See also World Health Organization (WHO) Europe, Status Paper on Prisons, Drugs and Harm Reduction, May 2005, available on-line at http://www.euro.who.int/_data/assets/pdf_file/0006/78549/E85877.pdf.



Factsheets are issued under the authority of the Executive Secretary of the CPT.

They aim to present the CPT's standards on key issues. However, they do not claim to be exhaustive, in particular as regards the references to CPT country visit reports.

Women in prison

Introduction

- In fulfilling its mandate, the CPT endeavours to examine the treatment and conditions of all categories of incarcerated persons, including women. Women usually make up a very small minority of the overall prison population, albeit a growing one in some countries.¹ Importantly, they are characterised by having particular needs and vulnerabilities which differ from those of men. In combination with these differences, the fact that women are far fewer in number poses a variety of challenges for prison administrations, often resulting in less favourable treatment as compared to imprisoned men. This stems from the fact that prison rules and facilities have been developed for a prison population in which the male prisoner is considered to be the norm.
- Whether or not they are imprisoned, women must enjoy the fundamental right not to be discriminated against – directly or indirectly – on the grounds of their biological sex or gender. Substantive equality may require the adoption of special measures in order to address existing inequalities. As in the community, particular measures may be required by prison administrations in order to ensure that women enjoy equal rights with men. The growing recognition of the benefits of fully embracing substantive gender equality in all areas of policy-making should extend to the prevention of ill-treatment in prison. Greater efforts are therefore needed in order to ensure a gender-sensitive monitoring of prisons, attuned to the potential compounding of problems women face in prison.
- Women in prison constitute a group with distinctive needs, biological as well as gender-specific. Some female prisoners also have particular vulnerabilities due to their social situation and cultural roles. There is a risk that the specific needs of women will be disregarded, especially as they are a minority category of prisoners. It is important that a number of factors are taken into account when dealing with women prisoners, notably any physical, sexual or psychological form of violence, including domestic violence, they might have suffered before the imprisonment, a high level of mental health-care needs, a high level of drug or alcohol dependency, specific (for example, reproductive) health-care needs, caretaking responsibilities for their children and/or their families, and the high likelihood of post-release victimisation and abandonment by their families.²

¹ SPACE I 2015 reported a median proportion of 5.2% female inmates in the total prison population, up from 4.7% in 2013, notwithstanding a decrease in absolute numbers over the same period. In 2015 very few Council of Europe countries had overall female prison populations of more than 7%.

² [Ireland: 2014 visit, paragraph 86](#). See also, for example, Rules 41, 42 and 44 of the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the “Bangkok Rules”).

- Women should be held in an environment suited to their needs. However, the challenges involved in making separate provision for the small numbers of women in prison often result in their being held at a limited number of locations (on occasion, far from their homes and families, including dependent children³), in premises which were originally designed for (and may be shared by⁴) male prisoners.⁵
- This factsheet presents the main standards which the CPT has developed so far, as regards adult women in prison. It is not intended to cover the full range of standards applicable generally to all imprisoned persons, including women. Many of the issues addressed may also apply by analogy to other categories of detained persons, such as transgender or female juvenile prisoners.
- The CPT's standards in this area are evolving. They should not be seen in isolation from international instruments such as the European Convention on Human Rights and the relevant case-law of the European Court of Human Rights, the Council of Europe's European Prison Rules,⁶ the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the "Bangkok Rules")⁷ and the United Nations Standard Minimum Rules for the Treatment of Prisoners (the "Nelson Mandela Rules").⁸

1. Appropriate accommodation

- The CPT has recommended that prison administrations move away from large-capacity accommodation formats, in favour of smaller living units. Women are no exception: smaller living units allow for an approach which is better tailored to their particular needs.⁹
- In the CPT's experience, although violence among women in prison can certainly occur, violence against women by men (and, more particularly, sexual harassment, including verbal abuse with sexual connotations) is a much more common phenomenon. Women in prison should, therefore, as a matter of principle, be held in accommodation which is physically separate from that occupied by any men being held at the same establishment.¹⁰
- The CPT has encountered some specific situations in which prisons permit men and women to share an accommodation unit in pursuit of "normalcy", i.e. promoting conditions of living that approximate as far as possible those in the community, with prisoners taking responsibility for their own lives. Nevertheless, great care should be taken in establishing and following the criteria for assigning both male and female prisoners to such units, and in ensuring rigorous supervision of relations between the inmates concerned. Clearly, persons likely to abuse others, or who are particularly vulnerable to abuse, should not be placed in such a unit. Whatever the arrangements, it is essential that proactive measures be taken to prevent sexual exploitation where male and female prisoners come into contact in a prison environment.¹¹

³ [Ireland: 2014 visit, paragraph 110.](#)

⁴ See, for example, [Ukraine: 2000 visit, paragraph 77.](#)

⁵ Extract from the [10th General Report on the CPT's activities, paragraph 21.](#)

⁶ Recommendation (2006) 2 of the Committee of Ministers of the Council of Europe, adopted on 11 January 2006.

⁷ United Nations General Assembly Resolution 65/229, adopted on 21 December 2010.

⁸ United Nations General Assembly Resolution 70/175, annex, adopted on 17 December 2015.

⁹ [Georgia: 2003-2004 visits, paragraph 86](#); [Slovenia: 2006 visit, paragraphs 52 and 55](#); [United Kingdom \(Scotland\): 2012 visit, paragraph 44.](#)

¹⁰ [10th General Report on the CPT's activities, paragraph 24.](#)

¹¹ [Denmark: 2014 visit, paragraph 31.](#)

- The CPT has encountered numerous women in prison who, for a variety of reasons, are not provided with adequate accommodation. The small number of facilities for women are at times overcrowded. Yet early release measures envisaged in the event of overcrowding are not offered to women who have nowhere to go, for example, where no homeless shelter is available.¹² The lack of capacity¹³ or of appropriate specialised facilities for women,¹⁴ the requirement to separate detention categories (remand/sentenced; short/long sentences; preventive detention), or the fact that an establishment holds only one woman, may result in a woman being accommodated for extended periods in a detention unit subject to an unduly restrictive regime,¹⁵ or she may *de facto* be subjected to a regime akin to solitary confinement.¹⁶ In such cases, the authorities should seek to transfer the woman to appropriate accommodation; if such transfer is not possible, the authorities should make the necessary efforts to provide the woman with purposeful out-of-cell activities and appropriate human contact.¹⁷

2. Equal access to activities

- Women in prison should enjoy access to a comprehensive programme of meaningful activities (work, training, education and sports) on an equal footing with men. CPT visiting delegations find all too often that female prisoners are offered activities deemed “appropriate” for them (such as sewing or handicrafts), and are excluded from far more vocational training reserved for men. The small number of women may mean that it is not considered viable to establish a workshop exclusively for them. However, such a discriminatory approach can only serve to reinforce outmoded stereotypes of the social role of women.¹⁸
- Consideration might also be given to offering activities in prison – including access to outdoor exercise – in which both men and women may participate together,¹⁹ provided those involved consent to such arrangements and the persons are carefully selected and adequately supervised.²⁰

¹² [Ireland: 2014 visit, paragraphs 89 and 91.](#)

¹³ [Ibid., paragraph 97; United Kingdom \(Scotland\): 2012 visit, paragraph 44.](#)

¹⁴ [Spain: 2007 visit, paragraph 100; United Kingdom \(Scotland\): 2012 visit, paragraph 64.](#)

¹⁵ [Luxembourg: 2015 visit, paragraph 43.](#)

¹⁶ [Latvia: 2007 visit, paragraphs 70 and 72; Germany: 2013 visit, paragraphs 26 and 28.](#)

¹⁷ [Liechtenstein: 2016 visit, paragraph 36;](#) on alleviating the effects of *de facto* solitary confinement through regime activities, see also part 2 below.

¹⁸ [Montenegro: 2013 visit, paragraph 53; the Netherlands \(Caribbean Part\): 2014 visit, paragraph 158; Switzerland: 2011 visit, paragraph 62.](#)

¹⁹ [United Kingdom \(Gibraltar\): 2014 visit, paragraph 32.](#)

²⁰ [10th General Report on the CPT's activities, paragraph 24; Czech Republic: 2006 visit, paragraph 68; Liechtenstein: 2016 visit, paragraph 36.](#)

3. Adequate hygiene and health care

Hygiene

- Women's specific hygiene needs should be adequately addressed. Ready access to sanitary and washing facilities, adequate quantities of essential hygiene products, such as sanitary towels and tampons, and safe disposal arrangements for blood-stained articles, are of particular importance. The failure to provide women in prison with such items can amount, in itself, to degrading treatment.²¹
- All prisoners should have access to toilets at all times. It is not acceptable, in the absence of in-cell sanitation, to fail to provide ready access to toilets due to low staffing levels. Ready access to sanitation is all the more important for women, given their special needs during menstrual periods.²² Positive differentiation in terms of additional access to washing facilities may also be necessary.²³

Health care

- The health care provided to persons deprived of their liberty should be of a standard equivalent to that enjoyed by the population in the outside community.²⁴ Ensuring that this principle of equivalence of care is respected as regards women in prison will require that health care is provided by medical practitioners and nurses who have specific training in women's health issues, including in gynaecology.²⁵
- 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 in prison.²⁶
- Adequate supplies of medication specifically required by women should be available in prison, allowing women who have begun a course of treatment before being incarcerated to continue it in prison.²⁷
- The contraceptive pill, for whatever reason it has been prescribed, should not be withheld from women wishing to take it.²⁸ A woman's right to bodily integrity is not diminished by virtue of her imprisonment. Where the abortion pill and/or other forms of abortion at later stages of a pregnancy are available to women in the outside community, they should be available under the same conditions to women in prison.²⁹
- The CPT has encountered many women prisoners who suffer from severe personality and behavioural disorders, and/or have a history of self-harming, abuse and abandonment. Where such prisoners are not eligible for transfer to a psychiatric hospital, a multifaceted approach should be adopted, involving clinical psychologists in the design of individual programmes, including psycho-social support, counselling and treatment. The absence of such programmes may bring about an increase in incidents of self-harm and an excessive use of prolonged segregation.³⁰

²¹ [10th General Report on the CPT's activities, paragraph 31](#); [Estonia: 2012 visit, paragraph 60](#).

²² [Bulgaria: 2006 visit, paragraph 85](#).

²³ [Ibid., paragraph 55](#).

²⁴ [10th General Report on the CPT's activities, paragraph 32](#).

²⁵ [Ibid., paragraph 32](#).

²⁶ [Ibid., paragraph 32](#).

²⁷ [Ibid., paragraph 33](#).

²⁸ [Ibid., paragraph 33](#).

²⁹ [Ibid., paragraph 32](#).

³⁰ [United Kingdom \(Scotland\): 2012 visit, paragraph 74](#).

4. Ante-natal, post-natal and child care

The detailed nature of this section should not be understood as an endorsement by the CPT of the imprisonment of pregnant women or mothers, with or without their young children. On the contrary, the Committee has, for instance, specifically recommended that alternatives to detention be imposed in respect of pregnant girls and juvenile mothers.³¹ This section outlines the minimum standards to be observed in the event that such non-custodial alternatives are not applied, and pregnant women or mothers – with or without their children – remain in prison.

- Every effort should be made to meet the specific dietary needs of pregnant women in prison who should be offered a high protein diet, rich in fresh fruit and vegetables.³²
- It is obvious that babies should not be born in prison, and the usual practice in Council of Europe member states seems to be to transfer pregnant women prisoners to outside hospitals.³³ 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 be qualified as inhuman and degrading treatment. Other means of meeting security needs can and should be found.³⁴
- Breastfeeding mothers should be provided with supplementary food according to existing guidelines for this category of women.³⁵
- Many women in prison are primary carers for children or others, whose welfare may be adversely affected by their imprisonment. 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.³⁶
- The governing principle in all cases should be the welfare and the best interests of the child. This implies in particular that any ante- and post-natal care provided in prison should be equivalent to that available in the outside community.³⁷
- In prison, the right to motherhood should not be infringed upon more than is required by security considerations and the safety of the child. Good contact between mother and child is in the interest of both of them. It can assist the rehabilitation of the prisoner and the development of her ability to assume responsibility for herself and her child. Mothers in prison should, therefore, be accommodated together with their babies after delivery and be encouraged to breastfeed (unless there are valid medical reasons to the contrary).³⁸ It could be considered as inhuman and degrading for a child to be removed immediately from a mother after birth. A mother and child should be allowed to stay together for at least a certain period of time.³⁹

³¹ [24th General Report on the CPT's activities, paragraph 117](#). See also Rule 64 of the “Bangkok Rules”.

³² [10th General Report on the CPT's activities, paragraph 26](#).

³³ [Ibid., paragraph 27](#).

³⁴ [France: 1991 visit, paragraph 90](#); [10th General Report on the CPT's activities, paragraph 27](#).

³⁵ [Romania: 2014 visit, paragraph 99](#).

³⁶ [10th General Report on the CPT's activities, paragraph 28](#).

³⁷ [Ibid., paragraph 29](#); [United Kingdom: 1990 visit, paragraph 124](#); [Spain: 1994 \(April\) visit: paragraph 136](#).

³⁸ [Russian Federation: 2001 visit, paragraph 89](#).

³⁹ [Luxembourg: 1993 visit, paragraph 44](#); see also [Czech Republic: 2014 visit, paragraph 82](#).

- For as long as the child remains in prison, the mother should be able to spend an adequate amount of time every day with her child;⁴⁰ they should be accommodated in a suitable, non-carceral setting,⁴¹ in terms of space, furnishings and access to cooking and washing facilities.⁴² Adequate heating/cooling and good access to fresh air and natural light are also very important.⁴³ The specific sanitary and hygiene needs of mothers should be adequately met, including access to good sanitary facilities, and provision of sanitary and hygiene products (nappies, soap, shampoo, washing powder, and clothing, for example) as needed, as well as food suitable for infants.⁴⁴ The equivalent of a nursery or kindergarten should also be provided, together with the support of staff specialised in post-natal care and paediatric nursing.⁴⁵
- There should also be an adequate interface and co-operation between staff employed at prison mother-and-child units and health-care and other prison staff who are in contact with mothers in prison.⁴⁶
- 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, access to nursery or kindergarten facilities could enable women prisoners to participate in work and other activities inside the prison to a greater extent than might otherwise be possible.⁴⁷
- The CPT has encountered situations in which a baby who accompanies his or her mother in prison is not admitted to visits. A mother in prison should be allowed to attend visits from family together with her accompanying baby. Prohibiting such visits is both inappropriate and unjustified. It would hinder the child's relationship with the father or other family members, and would not facilitate the child's eventual transition out of prison.⁴⁸
- Long-term arrangements, in particular the transfer of the child to the community, involving separation from his or her mother, should be determined in each individual case in the light of pedo-psychiatric and medico-social opinion;⁴⁹ after a child has been placed in care outside prison, there should be an on-going involvement of the mother in prison in the upbringing of the child.⁵⁰

5. Gender-sensitive prison management, staffing and training

- It is crucial that any prison accommodation unit holding women has female custodial staff in sufficient numbers at all times.⁵¹ In women's prisons or prison units, the preponderance of staff in contact with prisoners should be female.⁵²

⁴⁰ [Russian Federation: 2001 visit, paragraph 89.](#)

⁴¹ [Italy: 2016 visit, paragraph 73.](#)

⁴² [Ireland: 2014 visit, paragraph 102.](#)

⁴³ [Ibid., paragraph 102.](#)

⁴⁴ [Ibid., paragraph 102.](#)

⁴⁵ [3rd General Report on the CPT's activities, paragraph 66.](#)

⁴⁶ [Russian Federation: 2001 visit, paragraph 89.](#)

⁴⁷ [10th General Report of the CPT's activities, paragraph 29.](#)

⁴⁸ [Romania: 2014 visit, paragraph 100.](#)

⁴⁹ [3rd General Report on the CPT's activities, paragraph 66.](#)

⁵⁰ [Russian Federation: 2001 visit, paragraph 89.](#)

⁵¹ [Georgia: 2012 visit, paragraph 52.](#)

⁵² [Hungary: 2005 visit, paragraph 109.](#)

- Mixed-gender staffing is also 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 any place of detention, including but not limited to establishments for women. Mixed-gender staffing also allows for appropriate staff deployment when carrying out gender-sensitive tasks, such as searches.⁵³
- The CPT has often had to recommend that the management of prisons – including those accommodating women – deliver to custodial staff the clear message that physical ill-treatment, excessive use of force and verbal abuse, as well as other forms of disrespectful or provocative behaviour vis-à-vis prisoners, are not acceptable and will be dealt with severely. In particular, prison managers should demonstrate vigilance and use all means at their disposal to decrease tension.⁵⁴ In addition to investigating any complaints received from women prisoners, managers should be present on a regular basis in the detention areas holding women, and enter into direct contact with them.⁵⁵
- Utmost vigilance is required with regard to inappropriate behaviour and sexual relationships between staff and women in prison. Any allegations in this respect should be taken very seriously.⁵⁶
- In the CPT's view, the development of more specialised training for staff working with women in prison can be instrumental in addressing their specific needs.⁵⁷

6. Gender-sensitive personal searches

- Persons deprived of their liberty should only be searched by staff of the same sex. Any search which requires a prisoner to undress should be conducted out of the sight of custodial staff of the opposite sex.⁵⁸
- Strip searches are a very invasive and potentially degrading measure. When a strip search is considered necessary in a particular case, every reasonable effort should be made to minimise embarrassment. Detained persons who are searched should not normally be required to remove all their clothes at the same time; for example, a person should be allowed to remove clothing above the waist and put the clothes back on before removing further clothing.⁵⁹
- Intrusive searches of the genital area and body cavities carry a high risk of abuse and intimidation. Alternative screening methods, for example, through the use of ultrasound examinations, should be developed. Vaginal searches, in particular, should be conducted exceptionally, when absolutely necessary on the basis of an individual risk assessment,⁶⁰ and surrounded by appropriate safeguards.⁶¹ An intimate internal examination should be conducted by a medical practitioner only, it being understood that this medical practitioner should not be the doctor who would treat the patient with respect to health related issues. Examinations of this intimate nature should be conducted in a way that respects, to the greatest possible extent, the safety and dignity of the woman.⁶² Each examination should also be properly recorded in a special register.⁶³

⁵³ [Slovak Republic: 2013 visit, paragraph 99.](#)

⁵⁴ [Belgium: 2013 visit, paragraph 58;](#) [Georgia: 2007 visit, paragraph 35.](#)

⁵⁵ [Hungary: 2005 visit, paragraph 59.](#)

⁵⁶ [Ireland: 2014 visit, paragraph 93.](#)

⁵⁷ [Hungary: 2013 visit, paragraph 56.](#)

⁵⁸ [10th General Report on the CPT's activities, paragraph 23;](#) [the Netherlands: 2016 visit, paragraph 110.](#)

⁵⁹ [Italy: 2016 visit, paragraph 44.](#)

⁶⁰ [Greece: 2009 visit, paragraphs 91 and 92.](#)

⁶¹ The CPT has noted, e.g., that in both France and Greece such searches are subject to prior approval by a prosecutor (see [France: 2010 visit, paragraph 110;](#) [Greece: 2011 visit, paragraph 50](#)).

⁶² [Greece: 2009 visit, paragraphs 91 and 92.](#)

⁶³ [Ibid., paragraph 92.](#)

7. Contact with the outside world

Due to the limited number of establishments where women can serve their sentences, they are often located far away from their homes, which impacts negatively on contacts with their families and friends.⁶⁴

- In principle, all prisoners should be given the opportunity to maintain their relationships with their family and friends, and especially with their spouses or partners and children. The continuation of such relations can be of critical importance for all concerned, particularly in the context of prisoners' social rehabilitation. The guiding principle should be to promote contact with the outside world as often as possible.⁶⁵
- For example, open visits, allowing physical contact with friends and especially children and partners, should be the norm. A decision to impose closed visits should always be well-founded and reasoned, and based on an individual assessment of potential risks.⁶⁶ Women in prison should be offered the possibility of conjugal visits on an equal footing with men.⁶⁷ It is also important that visits with spouses or partners or other close relatives be made possible even where such persons are also imprisoned, be it in the same or another establishment.⁶⁸
- A high percentage of women in prison are mothers and the primary caretakers in the family. Separation from families and children can have a particularly detrimental effect on both the prisoners and their families, particularly their children.⁶⁹ In view of the critical importance of maintaining family relationships for women in prison, contact with their families, including their children, and their children's guardians and legal representatives, should be encouraged and facilitated by all reasonable means.⁷⁰ Visiting hours should, in particular, allow for contact with school-age children or working relatives who might accompany them.⁷¹ Women prisoners could be permitted to receive longer if less frequent visits, by accumulating visiting time allowances.⁷² Financial assistance might, for example, be provided to those women in prison who do not have the necessary means to maintain regular contact with their dependent children.⁷³

⁶⁴ [Sweden: 1991 visit, paragraphs 109 and 110](#); [Ireland: 2014 visit, paragraph 109](#).

⁶⁵ [Georgia: 2012 visit, paragraph 56](#).

⁶⁶ [Bosnia and Herzegovina: 2012 visit, paragraph 53](#); [Portugal: 2008 visit, paragraph 99](#); [Romania: 2014 visit, paragraph 103](#).

⁶⁷ [Slovenia: 2006 visit, paragraph 87](#).

⁶⁸ [France \(Reunion\): 2004 visit, paragraph 53](#); [Romania: 2014 visit, paragraph 105](#).

⁶⁹ [Ireland: 2014 visit, paragraph 109](#).

⁷⁰ [Ibid., paragraph 110](#). See also Rule 26 of the "Bangkok Rules".

⁷¹ [United Kingdom \(Gibraltar\): 2014 visit, paragraph 56](#).

⁷² [Armenia: 2015 visit, paragraph 107](#).

⁷³ [Ireland: 2014 visit, paragraph 110](#).



Situation of life-sentenced prisoners

*Extract from the 25th General Report of the CPT,
published in 2016*

Preliminary remarks

67. In the 11th General Report on its activities in 2000, the CPT briefly addressed the issue of life-sentenced and other long-term prisoners. In particular, it expressed concern that such prisoners were often not provided with appropriate material conditions, activities and human contact, and that they were frequently subjected to special restrictions likely to exacerbate the deleterious effects of their long-term imprisonment. The Committee considers that the time is ripe to review the situation of life-sentenced prisoners in Europe based upon the experience it has built up on visits over the last 15 years and taking also into consideration developments at the European and universal levels, notably Recommendation Rec (2003) 23 of the Committee of Ministers of the Council of Europe on the management by prison administrations of life sentence and other long-term prisoners.¹

Life sentences

68. For the CPT, a life sentence is an indeterminate sentence imposed by a court in the immediate aftermath of a conviction for a criminal offence which requires the prisoner to be kept in prison either for the remainder of his or her natural life or until release by a judicial, quasi-judicial, executive or administrative process which adjudges the prisoner to no longer present a risk to the public at large. The minimum period required to be served before a prisoner may first benefit from conditional release varies from country to country, the lowest being 12 years (e.g. Denmark and Finland) and 15 years (e.g. Austria, Belgium, Germany, Switzerland) and the highest being 40 years (e.g. Turkey, in the case of certain multiple crimes). The majority of countries imposing life sentences have a minimum period of between 20 and 30 years. In the United Kingdom jurisdictions, the minimum period to be served in prison is determined at the time of sentence by the trial judge; the law does not provide for an absolute minimum period in this regard. Several other countries (e.g. Bulgaria, Lithuania, Malta, the Netherlands and, for certain crimes, Hungary, the Slovak Republic and Turkey) do not have a system of conditional release in respect of life-sentenced prisoners, so that life may literally mean life (see also paragraph 73). On the other hand, it is noteworthy that a number of Council of Europe member states do not have life sentences on the statute book.² Instead, for the most serious crimes they have long determinate sentences usually ranging from 20 to 40 years.

¹ See also the European Prison Rules (2006) and the recently revised United Nations Standard Minimum Rules on the Treatment of Prisoners (*Nelson Mandela Rules* - 2015).

² For example, Andorra, Bosnia and Herzegovina, Croatia, Montenegro, Portugal, San Marino, Serbia, Slovenia and Spain. Further, in practice, life sentences have never been imposed in Iceland and Liechtenstein.

History of the concept of life imprisonment

69. Throughout history, life imprisonment has been intrinsically linked with the death penalty and has progressively become an alternative punishment for the most serious crimes. However, the initial purpose of this substitution was not to mitigate the situation of the convicted person. On the contrary, the medieval view, which persisted for many centuries, was that life-long imprisonment in combination with hard labour and solitary confinement would be seen by offenders as a worse alternative to death. In the same vein, one of the arguments for the retention of the death penalty was precisely that life imprisonment with hard labour was so severe that it would cause more suffering to the individual concerned and be more cruel than capital punishment. From today's perspective, the view that persons serving a life sentence (or for that matter any other sentence) should be additionally punished by the particular severity of conditions in prison is manifestly unacceptable. However, such a view is still deeply entrenched in the public opinion in various European countries.

The concept of life imprisonment was introduced in the 1990s in many member states of the Council of Europe following the ratification of Protocol 6 to the European Convention on Human Rights abolishing the death penalty. The last execution in a Council of Europe member state took place in 1997 and, since 2013, Europe has been a death-penalty free zone in law (with the exception of Belarus).³ However, in many countries it was considered that the public would support the abolition of the death penalty only if its replacement was considered sufficiently punitive. Consequently, persons sentenced to death had their sentences commuted to life imprisonment but little detailed planning appears to have been carried out in relation to the implementation of the life sentences. At the same time, over the 25 years of the CPT's existence, there has been a marked increase in the number of life sentences imposed. This seems mainly to be the result of two factors, the abolition or suspension of the death penalty throughout Europe and sentencing policies across member states in respect of serious crimes. The latest available statistics⁴ show that there were a total of some 27,000 life-sentenced prisoners in Council of Europe member states in 2014. On the basis of a sample of 22 countries in respect of which relevant data are available for a longer period, the number of life-sentenced prisoners had increased by 66% from 2004 to 2014. Further, in 2014, there were about 7,500 inmates held in indeterminate detention for security or public protection reasons in various member states of the Council of Europe (in particular the United Kingdom (England and Wales), Germany, Italy and Switzerland).

70. In the 1990s, the former communist countries of central and eastern Europe specified a period of imprisonment of 20 to 35 years as a blanket minimum for all commuted sentences and new life sentences, without any individual factors being taken into account until this period had elapsed. Equally, many states failed to develop regimes for life-sentenced prisoners tailored to their individual situation. Rather, all such sentenced prisoners were considered to be "dangerous" and in need of ongoing strict control. Now, 20 to 25 years later, as some prisoners start to approach the moment when they may apply for conditional release, there is a realisation that little has been done to give such prisoners a realistic hope of release back into the community. Indeed, long periods of negative treatment in prison, severely restricting the right to maintain relationships with family and friends outside, and a total lack of preparation for release or planning of reintegration are likely to impair seriously the ability of prisoners to function in the outside community.

³ A moratorium has been introduced in the Russian Federation.

⁴ Council of Europe Annual Penal Statistics (SPACE) 2004.8 and 2014.7.

Some of the above-mentioned countries have come to recognise the need to prepare life-sentenced prisoners for release. These countries, as well as those which abolished the death penalty much earlier, have established judicial, quasi-judicial, administrative or executive measures for considering the release of life-sentenced prisoners on an individual basis. Regimes have been developed to address the individual behaviour of the prisoners, offering them education and work. Further, contacts with the outside world, especially with families where possible, have been fostered and outside public and charitable agencies have become involved with them as they progress through their sentence. All this serves both to preserve their “humanity” during the sentence and to prepare them for release. Managing life-sentenced prisoners presents challenges to prison administrations to maintain a positive atmosphere, particularly in the first decade of a life sentence but also as some of these prisoners move into old age. The experience of these states provides a good source of knowledge in proposing techniques to maintain respect for the rights of prisoners facing indeterminate sentences, even though the indeterminacy on its own, no matter how long it may last, creates particular psychological pressures for the prisoner.

The CPT’s findings during visits

71. The CPT has visited a large number of prison establishments across Europe in which life-sentenced prisoners were accommodated. The conditions under which such prisoners were being held varied significantly from one establishment to another. In many countries, life-sentenced prisoners were usually held together with other sentenced prisoners and benefited from the same rights in terms of regime (work, education and recreational activities) and contact with the outside world as other sentenced prisoners.

However, in a number of countries – including Armenia, Azerbaijan, Bulgaria, Georgia, Latvia, Moldova, Romania, the Russian Federation, Turkey (prisoners sentenced to aggravated life imprisonment only) and Ukraine⁵ – life-sentenced prisoners were as a rule kept separate from other sentenced prisoners. In several countries, the CPT observed that life-sentenced prisoners were also subjected to a very impoverished regime and draconian security measures. By way of example, life-sentenced prisoners were locked up in their cells (alone or in pairs) for 23 hours per day, were not allowed to associate even with life-sentenced prisoners from other cells (including during outdoor exercise), were not allowed to work outside their cell or were not offered any purposeful activities at all. Further, in several countries, life-sentenced prisoners were systematically handcuffed and/or strip-searched whenever they left their cells. In some establishments, the prisoners concerned were additionally escorted by two officers and a guard dog during any movement outside their cell.

Moreover, in a number of establishments visited, prisoners were subjected to anachronistic rules, the sole aim of which was to further punish and humiliate the prisoners concerned (e.g. prohibition to lie down on the bed during the day, obligation to recite the relevant article of the criminal code under which they had been convicted, each time an officer opened the cell door, obligation to wear a prison uniform of a distinct colour, etc.). In the CPT’s view, such practices clearly have a dehumanising humiliating effect and are unacceptable.

It is also noteworthy that, in some countries, the entitlements of life-sentenced prisoners to contacts with the outside world (in particular as regards visits) were extremely limited and significantly lower than those of other sentenced prisoners.

⁵ In some countries (e.g. the Czech Republic, Lithuania and the Slovak Republic), life-sentenced prisoners must serve a certain period (between 10 and 15 years) in a separate unit before they may be transferred to an ordinary detention unit where they can associate with other sentenced prisoners.

72. In some of the above-mentioned countries, steps have been taken in recent years by the prison authorities to alleviate the detention conditions of life-sentenced prisoners, in particular, by offering the prisoners work and other purposeful activities (including more association with other life-sentenced prisoners) and by following a more individualised approach when it comes to the imposition of security measures. However, much remains to be done to render the situation satisfactory. Regrettably, policies regarding the execution of sentences are still all too often based on the presumption that life-sentenced prisoners are by definition particularly dangerous and that the regime applied to such prisoners should in one way or another also have a punitive character.

The CPT wishes to stress once again that there can be no justification for the systematic handcuffing or strip-searching of prisoners, all the more so when it is applied in an already secure environment. The Committee has also repeatedly stated that the use of dogs inside the detention area is unacceptable. In this connection, the Committee wishes to emphasise that the experience in various European countries has shown that *life-sentenced prisoners are not necessarily more dangerous than other prisoners* (see also paragraph 76). Further, as a matter of fact, life-sentenced prisoners – as indeed all prisoners – *are sent to prison as a punishment and not to receive punishment*.

“Life means life”

73. As indicated above, in several Council of Europe member states, a person may be sentenced to life imprisonment without any prospect of conditional release. This is known as an “actual or whole life sentence”. The CPT has criticised the very principle of such sentences in several visit reports, expressing serious reservations regarding the fact that a person sentenced to life imprisonment is considered once and for all to be dangerous and is deprived of any hope of conditional release (except on compassionate grounds or by pardon). The Committee maintains that to incarcerate a person for life without any real prospect of release is, in its view, inhuman. It is also noteworthy that even persons who are convicted by the International Criminal Court (or special international tribunals) of the most serious crimes such as genocide, war crimes and crimes against humanity may in principle benefit at a certain stage from conditional (early) release.

Indeed, the CPT considers that a prison sentence which offers no possibility of release precludes one of the essential justifications of imprisonment itself, the possibility of rehabilitation. While punishment and public protection are important elements of a prison sentence, excluding from the outset any hope of rehabilitation and return to the community effectively dehumanises the prisoner. This is not to say that all life-sentenced prisoners should be released sooner or later; public protection is a crucial issue. However, all such sentences should be subject to a meaningful review at some stage, based on individualised sentence-planning objectives defined at the outset of the sentence, and reviewed regularly thereafter. This would provide not only hope for the prisoner, but also a target to aim for which should motivate positive behaviour. It would thus also assist prison administrations in dealing with individuals who would otherwise have no hope and nothing to lose.

The European Court of Human Rights has in recent years examined a number of cases where domestic courts had imposed life sentences on prisoners with no possibility for early or conditional release and where, barring compassionate or highly exceptional circumstances, a whole life sentence meant precisely that. The most authoritative judgment of the Court to date, delivered by the Grand Chamber in *Vinter and Others v. the United Kingdom*,⁶ states that it was incompatible with human dignity, and therefore contrary to Article 3 of the European Convention on Human Rights, for a state to deprive a person of their freedom without at least giving them a chance one day to regain that freedom.

⁶ See *Vinter and Others v. the United Kingdom* [GC], nos. 66069/09, 130/10 and 3896/10, 9 July 2013.

Three main consequences can be drawn from the existing case-law of the Court. The *legislation* of member states must henceforth provide for a time during the serving of the sentence when there will be a *possibility* to review that sentence. Furthermore, member states must establish a *procedure* whereby the sentence will be reviewed. Finally, detention in prison must be organised in such a way as to enable life-sentenced prisoners to *progress towards their rehabilitation*.

The basic objectives and principles for the treatment of life-sentenced prisoners

74. In the CPT's view, the objectives and principles for the treatment of life-sentenced prisoners enunciated by the Committee of Ministers in Recommendation Rec (2003) 23 on the management by prison administrations of life sentence and other long-term prisoners remains the most pertinent and comprehensive reference document for this group of prisoners. In summary, these principles are:

- *the individualisation principle*: each life sentence must be based on an individual sentence plan, which is tailored to the needs and risks of the prisoner;
- *the normalisation principle*: life-sentenced prisoners should, like all prisoners, be subject only to the restrictions that are necessary for their safe and orderly confinement;
- *the responsibility principle*: life-sentenced prisoners should be given opportunities to exercise personal responsibility in daily prison life, including in sentence planning;
- *the security and safety principles*: a clear distinction should be made between any risks posed by life-sentenced prisoners to the external community and any risks posed by them to other prisoners and persons working in or visiting the prison;
- *the non-segregation principle*: life-sentenced prisoners should not be segregated on the sole ground of their sentence, but be allowed to associate with other prisoners on the basis of risk assessments which take into account all relevant factors;
- *the progression principle*: life-sentenced prisoners should be encouraged and enabled to move through their sentence to improved conditions and regimes on the basis of their individual behaviour and co-operation with programmes, staff and other prisoners.

Establishing these principles in practice

75. Prisons must be safe, secure and ordered, for the sake of all who become involved with them. Since being locked up, especially for an unknown period, is inherently damaging for almost all human beings, steps must be taken to minimise the damage. One important method of achieving this for life-sentenced prisoners is to give them a definite date for the first review for possible release, and a tailored individual programme which provides a realistic series of interventions for each prisoner leading towards that date. Of course, this programme will require regular review, but the objective should always be to engage the prisoner in its development and to provide the prisoner with staging posts and feedback on performance. As a result, such a programme should ensure that all life-sentenced prisoners are given the opportunity to address all aspects of their situation before the date of their first review. This should also entail time spent in less secure conditions, especially on leave in the community towards the end of the period, to ensure that the risk and needs management plan will function outside a secure environment. Continuity of care in the community is crucial to successful re-integration, and a plan for this should be established well before the release date.

Individualisation

76. Meeting these general principles requires individualisation of sentence planning. The CPT proceeds from the knowledge, based on its own experience as well as that of many prison administrations, that life-sentenced prisoners are not necessarily more dangerous than other prisoners (see also paragraph 72); many of them have a long-term interest in a stable and conflict-free environment. Equally, those who start their sentence as dangerous may well become significantly less so, not just with the passage of time during lengthy sentences but also with targeted interventions and humane treatment. After the imposition of the life sentence, individualisation should continue through the process of sentence planning based on an assessment of the individual situation. This requires a lengthy preliminary assessment, preferably conducted in a dedicated place with appropriate staff in the form of experienced and specially trained prison officers, psychologists, educators and social workers. A psychiatrist should also be involved when there are indications of possible mental health issues. The task of that team, working in co-operation with the prisoner, is to develop as full an understanding as possible of the prisoner's situation, both inside a custodial environment and in the community, and the needs the prisoner has for particular interventions to render the stay in prison as beneficial as possible in terms of resolving identified needs and preparation for release. Use should be made of accredited risk and needs assessment instruments, supplemented by professional judgment.⁷ The resulting analysis and plan, which should be shared as far as possible with the prisoner, becomes a source document for all persons working with the prisoner. It should be reviewed on a regular basis, with feedback given to the prisoner.

Implementing the sentence plan

77. *The guiding principles in implementing the sentence plan are very much the same as for all prisoners.* Prisoners should not be subject to any restrictions which are not required for the maintenance of good order, security and discipline within the prison. In particular, the level of security applied to each individual should be proportionate to the risk presented by the person. The nature of the offence is only one factor in assessing this. As a matter of principle, *the imposition of the detention regime of life-sentenced prisoners should lie with the prison authorities and always be based on an individual assessment of the prisoner's situation, and not be the automatic result of the type of sentence imposed* (i.e. the sentencing judge should not determine the regime).

78. Equally, except in the assessment phase, *life-sentenced prisoners should not routinely be kept apart from other sentenced prisoners*, although it would not be objectionable for long-term prisoners to be kept apart from very short-term prisoners. The length of sentence does not necessarily bear any relationship to the level of risk life-sentenced prisoners may represent inside a prison, and the principle of normalisation requires that life-sentenced prisoners can at least associate with other long-term prisoners who have a predetermined release date. The, albeit limited, turnover this can create refreshes the experience of prison for those who are to be incarcerated for a very long time.

Concentrating life-sentenced prisoners in a specialised prison also necessarily results in many such prisoners being kept very far from their families and outside contacts. A life sentence will in any event put a good deal of pressure on these relationships; compounding that by locating the prisoner a significant distance away from home reduces the possibility of maintaining what is a crucial element in promoting resocialisation. Further, no additional restrictions should be imposed on life-sentenced prisoners as compared to other sentenced prisoners when it concerns the

⁷ See Recommendation CM/Rec (2014) 3 of the Committee of Ministers of the Council of Europe to member States concerning dangerous offenders.

possibilities for them to maintain meaningful contact with their families and other close persons. During the first years of imprisonment in particular, restrictions on contacts are likely to disrupt or even destroy such relationships. It is also important that life-sentenced prisoners have genuine access on as regular a basis as possible to visits, telephone calls, letters, newspapers, radio and television to maintain their sense of contact with the outside world.

79. Life-sentenced prisoners should have *access to as full a regime of activities as possible*, and normally in association with other prisoners. Work, education, sports, cultural activities and hobbies not only help pass the time, but are also crucial in promoting social and mental health well-being and imparting transferable skills which will be useful during and after the custodial part of the sentence. The involvement of prisoners in these activities, in addition to their participation in offending behaviour interventions, represents a significant factor in the ongoing assessment of each person's performance. They allow staff of all grades to better understand prisoners and enable the staff to make informed judgments as to when it would be appropriate for the prisoner to progress through the regime and be trusted with lower security conditions. The possibility of such progression is crucial, for the management of the prison and for the prisoner. It motivates and rewards the prisoner, providing staging posts in their otherwise indeterminate world, and ensures a deeper relationship between the assessing staff and the prisoner, which contributes to *dynamic security*.

Indeed, the effective implementation of dynamic security should make a crucial contribution to the process of assessing when it is safe to allow the individual prisoner access to the community, initially in the form of escorted short leave, then moving on to unescorted overnight leave and finally to conditional release into the community. Good staff will have developed an in-depth understanding of the individual, which they can share with decision-making bodies and with those who will take over responsibility for supervision and support in the community. Many existing systems make poor use of staff, especially basic-grade security staff who usually spend by far the most time with the prisoners. They are often discouraged – or forbidden – from getting to know the prisoners and thus a great opportunity for developing positive relationships between staff and prisoners is lost. Such relationships, within appropriate parameters, not only enhance security but can also help motivate prisoners to co-operate with regimes and give staff a much more positive experience of prison work than is available to a prison officer acting purely as a turn-key. Of course, this requires appropriate staff selection, training, supervision and support from other professionals in the system. But the benefits, as experienced by several member states and observed by the CPT, are manifest.

80. There are undoubtedly some life-sentenced prisoners who are very dangerous. However, the approach should be the same as for other sentenced prisoners and includes: detailed assessments of the individual situation of the prisoners concerned; risk management with plans to address the individual's needs and to reduce the likelihood of re-offending in the longer term, while affording the necessary level of protection to others; regular reviews of security measures. The objective, as with all dangerous prisoners, should be to reduce the level of dangerousness by appropriate interventions and return the prisoners to normal circulation as soon as possible.

Conclusion

81. The CPT calls upon member states to review their treatment of life-sentenced prisoners to ensure that this is in accordance with their individual risk they present, both in custody and to the outside community, and not simply in response to the sentence which has been imposed on them. In particular, steps should be taken by the member states concerned to abolish the legal obligation of keeping life-sentenced prisoners separate from other (long-term) sentenced prisoners and to put an end to the systematic use of security measures such as handcuffs inside the prison.

82. Further, all possible efforts should be made to provide life-sentenced prisoners with a regime tailored to their needs and help them reduce the level of risk they pose, to minimise the damage that indeterminate sentences necessarily cause, to keep them in touch with the outside world, offer them the possibility of release into the community under licence and ensure that release can be safely granted, at least in the overwhelming majority of cases. To this end, procedures should be put in place which allow for a review of the sentence. Obviously, having a purely formal possibility to apply for release after a certain amount of time is not sufficient; member states must ensure, notably through the way they treat life-sentenced prisoners, that this possibility is real and effective.



Health care services in prisons

*Extract from the 3rd General Report of the CPT,
published in 1993*

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.²

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.

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.

² 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 possible 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.

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 ³

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.⁴

³ See also "Imprisonment", section "transmissible diseases".

⁴ 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.



Inspection of a prison medical service by a CPT doctor

Checklist

This list is not exhaustive, but rather a tool to be used during CPT visits, and will be reviewed on a regular basis.

I. Initial interview with the doctor in charge

Questions to raise (keep in mind the following general areas of concern): 1. Access to a doctor, 2. Equivalence of care (with special attention to the higher morbidity and the greater health-care needs of prisoners), 3. Patient's consent and confidentiality, 4. Preventive health care (vaccination, addiction, opiate substitution, condoms, needle and syringe exchange, etc.), 5. Vulnerable inmates: elderly, women, disabled, LGBT, juveniles, ethnic minorities, undocumented foreign nationals, 6. Professional independence, 7. Professional competence

A. Medical/nursing team

- Number of doctors (GPs, psychiatrists, dentists), other specialists, psychologists, nurses, auxiliaries (full-time/part-time; other employment) in relation to the number of inmates
- Presence of staff in prison (times of arrival and departure)
- Training, qualifications, remuneration terms
- Involvement of third parties in care: guards, prisoners?

B. Outside medical support

- Back-up hospitals for emergencies/serious conditions?
- Specialist outside consultations (what, who, when, number?)
- Method and conditions of medical transfer of sick prisoners (in particular, emergency cases)

C. Medical care work

1) Volume

- Transmission of health care information / continuity of care
- New prisoners: number per month, content/moment of medical examination upon admission
- Consultations during imprisonment: availability, number and duration of consultations by type of health-care staff, access arrangements respecting confidentiality (oral/written requests, giving reasons for requests to non-medical staff, filtering of requests - by whom?)
- Waiting times by type of health-care service
- Emergencies: procedure during/outside working hours; medical staff on call in prison: who?
- Care provided free of charge / copayment by prisoners? health insurance?
- Medical service also responsible for prison staff/families?

2) Ailments encountered

- Type / specific ailments encountered by the service
- Gender sensitive health care and prevention (pregnant women / mothers and infants / screening for sexual abuse and other forms of violence / screening for breast and gynaecological cancer)
- Groups with special needs: e.g. disabled / LGBT / elderly
- Mental disorders (psychotic disorders, consent to treatment, use of seclusion and restraint)
- List of deaths: causes, autopsies conducted?

3) Prevention, addiction and harm reduction

- Suicide prevention, self-harming
- Transmissible diseases (e.g. Hepatitis, HIV, TB, syphilis, skin infections): screening, counselling, prevention, follow up and treatment
- Condom distribution in a confidential manner?
- Prevention of transmission of diseases through tattooing, piercing and other forms of skin penetration
- Systematic screening for drug, alcohol and tobacco use/abuse upon entry?
- Drug testing (type of tests used, reference lab for supervision?)
- Is opiate substitution treatment offered to prisoners and under what conditions (free of charge / exclusion of undocumented foreign nationals / confidentiality)?
- Are needles and/or syringes found during cell searches? Frequency of needle- and syringe-related problems? Needle and syringe exchange programs (NSP) in the community/in prison?

4) **Medicines**

- Sufficient quantity and range / free of charge / expiry dates?
- Inappropriate use of prescription drugs, e.g. benzodiazepines?
- Proportion of inmates who receive medicines (percentage of psychoactive drugs, percentage of benzodiazepines) (e.g. in general 30-50 percent of inmates receive prescription drugs)
- Distribution of medicines (how? who? confidentiality, supervision of intake)

D. Non-care work / expertise

1) **Ill-treatment**

- Number / type of cases (police, prison guards, fellow prisoners)
- Medical certificates concerning traumatic injuries:
 - procedures for drafting: who may request/consult them?
 - allegations / objective findings / conclusions
 - reporting system (when? to whom?)
 - specific register / involvement of forensic doctor

2) **Disciplinary sanctions / security measures**

- Involvement of health-care staff in decision-making / fit-for-punishment/restraint certificates?
- Medical supervision of disciplinary isolation measures? Frequency?

3) **Miscellaneous**

- Certificates indicating prisoners unfit for detention
- Hunger strikes (administrative instructions? written procedures?)
- Biomedical research: staff/prisoners involved; board of ethics; type of consent
- Monitoring of kitchens / checks on food / protection from pathogens / hygiene and temperature of storage rooms, refrigerators / presentation, quality and quantity of meals / variation of menus / inspection reports
- External inspection of health-care provision, by whom (reports, recommendations)?

E. Files / records

- Number and types (electronic file?)
- Confidentiality (access by detained person, lawyer, judicial organs, other medical authorities? what procedure?)
- Quality of medical files (check files of interviewed patients)

F. General atmosphere

- Relations between members of the medical service and prisoners/prison officers
- Confidentiality of consultations
- Relations with doctors/nurses outside the prison system
- Independence of the medical staff (from penitentiary/judicial authorities)? Issues of conflicting loyalties / conflicts of interests

II. Inspection of medical service premises

- Number of rooms / type (e.g. pharmacy, x-ray, laboratory) / general hygiene
- Checking of apparatus/equipment (defibrillator, ECG, sphygmomanometer, steriliser, etc.)
- If infirmary: number of rooms/beds / distribution of patients

III. Final talk with the doctor in charge

- Flag up any contradictions between the statements made by the medical team and:
 - the findings made during the visit to the premises
 - prisoners' complaints (supported by files)
 - the observations of the other members of the delegation



Factsheet

March 2017

CPT/Inf(2017)3

Factsheets are issued under the authority of the Executive Secretary of the CPT.

They aim to present the CPT's standards on key issues. However, they do not claim to be exhaustive, in particular as regards the references to CPT country visit reports.

Immigration detention

Introduction

- Immigration detention is a primary focus of the work of the CPT. It has carried out hundreds of visits to immigration detention facilities, and has developed a detailed set of standards.
- The CPT's standards build on legal principles originating from international (human rights) instruments, such as the European Convention on Human Rights (ECHR),¹ the Committee of Ministers' Twenty Guidelines on Forced Return,² relevant United Nations (UN) treaties, and the 2008 European Union (EU) Return Directive.³
- A foreign national may be deprived of his/her liberty following a(n) (alleged) violation of the legislation related to aliens, such as illegal entry, illegal residence, etc. Frequently, such detention is referred to as 'immigration detention', which is a form of administrative detention in most Council of Europe member states.
- Under the terms of Article 5 of the ECHR, this form of deprivation of liberty is permitted, provided that action is being taken either with a view to deportation, or in order to prevent unauthorised entry into the country. Deprivation of liberty of irregular migrants shall be neither arbitrary nor the automatic consequence of an (alleged) violation of aliens legislation. In other words, immigration detention should be exceptional, proportionate and, by consequence, an individual measure necessary in order to prevent unlawful immigration.
- In line with its administrative nature, immigration detention must not be punitive in character: it is not a sanction or a punishment. Therefore, immigration detainees should be afforded both a regime and material conditions appropriate to their legal situation.
- "Asylum seekers" are not "immigration detainees", although the persons concerned may become so should their asylum application be rejected and their leave to stay in a country rescinded.

¹ In particular Articles 3, 5 and 8.

² CM(2005)40 final, 9 May 2005; in particular Guidelines 10 and 11.

³ Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals.

The Directive applies to all European Union Member States except the United Kingdom and Ireland. To the extent that it applies to those who enter the territory without authorisation, it applies to Denmark and the Schengen associates (Iceland, Liechtenstein, Norway and Switzerland).

1. Detention as a last resort

- Deprivation of liberty under aliens legislation should only be a measure of last resort, after a careful and individual examination of each case. In addition, the continued need for it should be the subject of periodic review. Alternative (non-custodial) measures should be developed and used wherever possible.⁴
- Whenever asylum seekers are deprived of their liberty, as an exceptional measure, 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 and should be kept separately from foreign nationals who have not lodged an application for international protection.⁵
- If members of the same family are detained under aliens legislation, every effort should be made to avoid splitting up the family.⁶
- The CPT is of the view that the prolonged detention of persons under aliens legislation, without a time limit and with unclear prospects for release, could easily be considered as amounting to inhuman treatment.⁷

2. Safeguards during detention

- 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.⁸
- 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.⁹
- 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.¹⁰
- All newly arrived detainees should be promptly examined by a doctor or by a fully-qualified nurse reporting to a doctor.¹¹
- 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 have access to them.¹²

⁴ [Malta: 2004 visit, paragraph 14; Serbia and Montenegro: 2004 visit, paragraph 65.](#)

⁵ [19th General Report on the CPT's activities, paragraph 76; Spain: 2014 visit, paragraph 9.](#)

⁶ [Germany: 2005 visit, paragraph 56; 19th General Report on the CPT's activities, paragraph 87.](#)

⁷ [Bulgaria: 2008 visit, paragraph 29.](#)

⁸ [19th General Report on the CPT's activities, paragraph 85.](#)

⁹ [19th General Report on the CPT's activities, paragraph 81.](#)

¹⁰ [19th General Report on the CPT's activities, paragraph 82.](#)

¹¹ [19th General Report on the CPT's activities, paragraph 82.](#)

¹² [19th General Report on the CPT's activities, paragraph 82.](#)

- In addition to these three basic safeguards, international law recognises 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.¹³
- Detained irregular migrants should be expressly informed, without delay and in a language they understand, of their rights and the procedure applicable to them. To this end, all immigration detainees should be systematically provided with a document setting out this information; the document should be available in the languages most commonly spoken by those concerned and, if necessary, the services of an interpreter should be made available. The persons concerned should confirm in writing that they have been informed of their rights, in a language they can understand.¹⁴
- Foreign nationals should receive, when necessary, the assistance of qualified interpreters. The use of fellow detainees as interpreters should, in principle, be avoided.¹⁵
- Detained irregular migrants should have every opportunity to remain in meaningful contact with the outside world, and should have regular access to a telephone or to their mobile phones.¹⁶
- Arrangements should be made to enable detained irregular migrants to consult a lawyer or a doctor on an ongoing basis, to receive visits from NGO representatives, family members or other persons of their choice, and to have telephone contact with them.¹⁷
- It is in the interests of both immigration detainees 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.¹⁸
- 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.¹⁹

3. Suitable premises

- A prison is by definition not a suitable place in which to detain someone who is neither suspected nor convicted of a criminal offence.²⁰
- Immigration detainees are frequently initially held at “point of entry holding facilities”, airport transit zones and police stations. Clearly, these places are often inadequate places in which to accommodate persons, in particular for extended stays. Consequently, the period of time spent by immigration detainees in such establishments should be kept to the absolute minimum²¹ (i.e. less than 24 hours).

¹³ [19th General Report on the CPT's activities, paragraph 83.](#)

¹⁴ [Netherlands \(Antilles\): 2007 visit, paragraph 36; Romania: 2006 visit, paragraph 61.](#)

¹⁵ [Bulgaria: 2010 visit, paragraph 53.](#)

¹⁶ [Hungary: 2015 visit, paragraph 70; 19th General Report on the CPT's activities, paragraph 79; Serbia and Montenegro: 2004 visit, paragraph 78.](#)

¹⁷ [19th General Report on the CPT's activities, paragraph 87.](#)

¹⁸ [19th General Report on the CPT's activities, paragraph 88.](#)

¹⁹ [19th General Report on the CPT's activities, paragraph 86.](#)

²⁰ [Ireland: 2014 visit, paragraph 19.](#)

²¹ [7th General Report on the CPT's activities, paragraph 27.](#)

- Persons detained under aliens legislation should be accommodated in centres specifically designed for that purpose, offering material conditions and a regime appropriate to their legal situation. Care should be taken in the design and layout of such premises to avoid, as far as possible, any impression of a carceral environment.²²
- Female detainees should be held in an area which is separated from that accommodating male detainees, and their privacy should be guaranteed.²³

4. Adequate material conditions for longer stays (over 24 hours)²⁴

- Immigration detention 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.²⁵
- These centres should have adequate lighting (including daylight), ventilation and heating.²⁶
- Call bells should be installed in all detention areas where staff are not continuously present.²⁷
- All detained persons should:
 - be provided with a bed or plinth, and a clean mattress and clean blankets;²⁸
 - have ready access to toilet facilities, including at night;²⁹
 - be provided, on a regular basis, with a basic sanitary kit (including adequate rations of soap, washing powder, toilet paper, shampoo, shaving utensils and toothpaste, and a toothbrush) free of charge;³⁰
 - have access to a shower and to hot water;³¹
 - be offered the possibility to wear their own clothes during their stay if those are suitable and, if necessary, to have them washed and repaired;³²
 - be provided with the necessary products and equipment to keep their accommodation clean;³³
 - be provided with lockable space in which to keep personal belongings;³⁴
 - have access to food and drinking water.³⁵ Meals should take into account the religious requirements and dietary habits of foreign nationals.³⁶

²² [Malta: 2008 visit, paragraph 51.](#)

²³ [Greece: 2011 visit, paragraph 38.](#)

²⁴ [Greece: 2013 visit, paragraph 51.](#)

²⁵ ["The former Yugoslav Republic of Macedonia": 2014 visit, paragraph 113.](#)

²⁶ [Ukraine: 2002 visit, paragraph 62.](#)

²⁷ [Greece: 2011 visit, paragraph 38.](#)

²⁸ [Greece: 2007 visit, paragraph 25.](#)

²⁹ [Greece: 2011 visit, paragraph 38.](#)

³⁰ [Greece: 2011 visit, paragraph 38.](#)

³¹ [Greece: 2013 visit, paragraph 51.](#)

³² [Croatia: 2007 visit, paragraph 37.](#)

³³ ["The former Yugoslav Republic of Macedonia": 2014 visit, paragraph 120.](#)

³⁴ [Croatia: 2007 visit, paragraph 35.](#)

³⁵ [Hungary: 2005 visit, paragraph 53.](#)

³⁶ ["The former Yugoslav Republic of Macedonia": 2014 visit, paragraph 120.](#)

5. Open regime

- 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. Within the detention facility, detained persons should be restricted in their freedom of movement as little as possible.³⁷
- Detained irregular migrants should in principle have free access to outdoor exercise throughout the day (i.e. considerably more than one hour per day) and outdoor exercise areas should be appropriately equipped (benches, shelters, etc.).³⁸
- The longer the period for which persons are held, the more developed should be the activities which are offered to them.³⁹ Purposeful activities, in an immigration detention context, can include, *inter alia*, language classes, IT/computer classes, gardening, arts and crafts, cookery skills and so-called “cultural kitchens”.⁴⁰
- Immigration detention centres should include 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, sports),⁴¹ a library and a prayer room.⁴² All multiple occupancy rooms should be equipped with tables and chairs commensurate with the number of persons detained.⁴³
- The presumption should be in favour of open visits for detained foreign nationals. Visiting rooms should enable immigration detainees to meet under open conditions with family and friends visiting them, and the environment should be child-friendly (including a play area for children). If, exceptionally, it is considered necessary to impose restrictions on a particular foreign national, this should be done on the basis of an individual risk assessment.⁴⁴
- Immigration detainees should be offered the possibility to have visits several times per week. As a minimum, they should be allowed to receive at least one visit of one hour per week.⁴⁵
- Immigration detainees should have access to computers along with Voice over Internet Protocol or Skype facilities and basic internet access.⁴⁶

³⁷ [19th General Report on the CPT's activities, paragraph 79.](#)

³⁸ [Hungary: 2015 visit, paragraph 42; France : 2010 visit, paragraph 43; Ukraine: 2009 visit, paragraph 62.](#)

³⁹ [Cyprus: 2013 visit, paragraph 45.](#)

⁴⁰ [Denmark: 2014 visit, paragraph 78; United Kingdom: 2012 visit, paragraph 120.](#)

⁴¹ [“The former Yugoslav Republic of Macedonia”: 2014 visit, paragraph 113.](#)

⁴² [“The former Yugoslav Republic of Macedonia”: 2014 visit, paragraph 120.](#)

⁴³ [Greece: 2013 visit, paragraph 72.](#)

⁴⁴ [Czech Republic: 2014 visit, paragraph 41; The Netherlands: 2011 visit, paragraph 72; Hungary: 2009 visit, paragraph 44; Austria: 2014 visit, paragraph 49.](#)

⁴⁵ [Germany: 2010 visit, paragraph 44.](#)

⁴⁶ [Denmark: 2014 visit, paragraph 82; “The former Yugoslav Republic of Macedonia”: 2014 visit, paragraph 133.](#)

6. Qualified staff

- Custodial staff in detention centres for immigration detainees should be carefully selected and receive appropriate training.⁴⁷
- Staff should possess well-developed qualities in the fields of interpersonal communication and cultural sensitivity, given the diverse backgrounds of the detainees. Further, at least some of them should have relevant language skills.⁴⁸
- They should also be taught to recognise possible symptoms of stress reaction displayed by detained persons and to take appropriate action.⁴⁹
- 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.⁵⁰ The presence of female custodial staff members should be guaranteed in all establishments accommodating female detainees.⁵¹
- The ethos of an immigration detention setting should not be carceral, which means that staff working within immigration detention facilities should not be equipped with batons, handcuffs or pepper spray.⁵²

7. Discipline, segregation and means of restraint

- As regards discipline, clear procedures should be formally established and applied in practice; any grey areas involve the risk of an unofficial (and uncontrolled) system developing.⁵³ In this context, the CPT recommends that:
 - formal disciplinary regulations be drafted for holding centres for foreign nationals detained under aliens legislation. These regulations should provide detainees with a right to be heard on the subject of the offences which they are alleged to have committed, and to appeal to a higher authority against any sanctions imposed;
 - a clear disciplinary procedure be adopted, affording detained persons the rights to be informed in writing of the charges against them, and to call witnesses on their own behalf.⁵⁴
- If segregation is imposed (e.g. for security reasons), the foreign nationals concerned should be provided with a copy of the relevant decision and information on the possibilities to appeal the measure to an outside authority, segregation should be time-limited and a separate register should be established (setting out full information, such as date and time of entering and leaving, grounds for segregation, etc.).⁵⁵

⁴⁷ [Luxembourg: 2015 visit, paragraph 111](#); [Czech Republic: 2014 visit, paragraph 37](#).

⁴⁸ [Luxembourg: 2015 visit, paragraph 111](#); [Czech Republic: 2014 visit, paragraph 37](#).

⁴⁹ [Luxembourg: 2015 visit, paragraph 111](#); [Czech Republic: 2014 visit, paragraph 37](#).

⁵⁰ [Greece: 2013 visit, paragraph 79](#).

⁵¹ [Malta: 2004 visit, paragraph 61](#).

⁵² [Norway: 2011 visit, paragraph 38](#); [Latvia: 2011 visit, paragraph 36](#).

⁵³ [Malta: 2004 visit, paragraph 64](#).

⁵⁴ [19th General Report on the CPT's activities, paragraph 88](#); [Ukraine: 2009 visit, paragraph 71](#); [Bulgaria: 2008 visit, paragraph 44](#); [France: 2006 visit, paragraph 76](#).

⁵⁵ [19th General Report on the CPT's activities, paragraph 88](#); [Ukraine: 2009 visit, paragraph 71](#); [Bulgaria: 2008 visit, paragraph 44](#); [France: 2006 visit, paragraph 76](#).

- Detainees in segregation should have a means of rest at their disposal, ready access to toilet facilities, and regular access to a shower, as well as at least one hour of outdoor exercise every day and access to reading matter.⁵⁶
- Applying handcuffs as a matter of routine to immigration detainees whenever they leave their detention facility, such as on hospital transfers, is disproportionate; the use of means of restraint should be considered on individual grounds and based on the principle of proportionality.⁵⁷

8. Monitoring and complaints mechanisms

- 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.).⁵⁸
- Effective complaints procedures are basic safeguards against ill-treatment in immigration detention. As regards complaints procedures, immigration detainees should have avenues open to them, both internally and externally, and be entitled to confidential access to an appropriate complaints authority.⁵⁹

9. Adequate health care

- Medical screening of all newly-arrived detainees is in the interests of both detainees and staff, in particular for identifying those at risk of self-harm, screening for transmissible diseases and the timely recording of any injuries.⁶⁰
- All newly-arrived detainees should benefit from comprehensive medical screening (including screening for transmissible diseases) by a doctor or a fully-qualified nurse reporting to a doctor as soon as possible after their admission.⁶¹
- The record drawn up after a medical examination of a detainee, whether newly-arrived or not, should contain:
 - (i) a full account of objective medical findings based on a thorough examination;
 - (ii) an account of statements made by the person concerned which are relevant to the medical examination, including any allegations of ill-treatment made by him/her;
 - (iii) the doctor's observations in the light of (i) and (ii), indicating the consistency between any allegations made and the objective medical findings.

In addition, the results of every examination, including the above-mentioned statements and the doctor's observations, should be made available to the detainee and his/her lawyer.⁶²

⁵⁶ [Ukraine: 2009 visit, paragraph 71](#); [Bulgaria: 2008 visit, paragraph 44](#).

⁵⁷ [Netherlands: 2011 visit, paragraph 56](#); [Malta: 2004 visit, paragraph 67](#).

⁵⁸ [19th General Report on the CPT's activities, paragraph 89](#).

⁵⁹ [United Kingdom: 2012 visit, paragraph 136](#); [Spain: 2011 visit, paragraph 97](#).

⁶⁰ [Sweden: 2015 visit, paragraph 37](#).

⁶¹ [Sweden: 2015 visit, paragraph 37](#).

⁶² [Austria: 2014 visit, paragraph 46](#).

- Whenever injuries are recorded which are consistent with allegations of ill-treatment made by a detained person (or which, even in the absence of the allegations, are indicative of ill-treatment), the information should be immediately and systematically brought to the attention of the relevant prosecutor, regardless of the wishes of the person concerned.⁶³
- 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.⁶⁴
- 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.⁶⁵
- Whenever members of the medical and/or nursing staff are unable to make a proper diagnostic evaluation due to language problems, they should be able to benefit without delay from the services of a qualified interpreter.⁶⁶
- Detained irregular migrants should be fully informed about the treatment being offered to them.⁶⁷
- Adequate access to psychological assistance and psychiatric care should be provided to detainees.⁶⁸ Further, procedures and training should be in place to prevent acts of self-harm and suicides.⁶⁹

10. Care of vulnerable persons (in particular children)

- Specific screening procedures aimed at identifying victims of torture and other persons in situation of vulnerability should be put in place and appropriate care should be provided. In this context, the CPT considers that there should be meaningful alternatives to detention for certain vulnerable categories of person. These categories include *inter alia* victims of torture, victims of trafficking, pregnant women and nursing mothers, children, families with young children, elderly persons and persons with disabilities.⁷⁰
- The CPT wishes to recall its position that every effort should be made to avoid resorting to the deprivation of liberty of an irregular migrant who is a child.⁷¹

⁶³ [Austria: 2014 visit, paragraph 46.](#)

⁶⁴ [19th General Report on the CPT's activities, paragraph 92.](#)

⁶⁵ [19th General Report on the CPT's activities, paragraph 91.](#)

⁶⁶ [19th General Report on the CPT's activities, paragraph 92.](#)

⁶⁷ [19th General Report on the CPT's activities, paragraph 92.](#)

⁶⁸ [Finland: 2014 visit, paragraph 36.](#)

⁶⁹ [Greece: 2015 visit, paragraph 117.](#)

⁷⁰ [Hungary: 2015 visit, paragraph 51; Denmark: 2014 visit, paragraphs 77-79; Cyprus: 2013 visit, paragraph 33; United Kingdom: 2012 visit \(September\), paragraphs 132 and 133; 19th General Report of the CPT's activities, paragraphs 75 and 76; Malta: 2008 visit, paragraph 68.](#)

⁷¹ [19th General Report on the CPT's activities, paragraph 97.](#)

- When, exceptionally, children are held with their parents in a detention centre, the deprivation of liberty should be for the shortest possible period of time. Mother (or any other primary carer) and child should be accommodated together in a facility catering for their specific needs.⁷²
- The CPT concurs with the United Nations Committee on the Rights of the Child which considers that “[i]n application of article 37 of the Convention [on the Rights of the Child] and the principle of the best interest of the child, unaccompanied or separated children should not, as a general rule, be detained. Detention cannot be justified solely on the basis of the child being unaccompanied or separated, or on their migratory or residence status, or lack thereof”.⁷³ Further, other Council of Europe bodies, such as the Parliamentary Assembly⁷⁴ and the Commissioner for Human Rights,⁷⁵ have stated that unaccompanied children should not be detained.⁷⁶
- As soon as possible after the presence of an unaccompanied minor becomes known to the authorities, a professional 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).⁷⁷ Every effort should be made to facilitate their immediate release from a detention facility and their placement in more appropriate care.⁷⁸
- Any unaccompanied or separated child 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 representative⁷⁹ who keeps them informed of their legal situation and effectively protects their interests. Review mechanisms should also be introduced to monitor the ongoing quality of the guardianship.⁸⁰
- Children should only be held in centres designed to cater for their specific needs and staffed with properly trained men and women.⁸¹
- 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.⁸²
- Children deprived of their liberty should be offered a range of constructive activities (with particular emphasis on enabling a child to continue his/her education).⁸³

⁷² [Cyprus: 2013 visit, paragraph 36](#); [Czech Republic: 2014 visit, paragraph 32](#).

⁷³ Committee on the Rights of the Child, General Comment no. 6 (2005) on the Treatment of unaccompanied and separated children outside their country of origin, CRC/GC/2005/6, 1 September 2005, paragraph 61

⁷⁴ Parliamentary Assembly of the Council of Europe, Resolution 1707 (2010) on detention of asylum seekers and irregular migrants in Europe, 28 January 2010, paragraph 9.1.9, and Resolution 2020 (2014) on the alternatives to immigration detention of children, 3 October 2014, paragraph 3

⁷⁵ Commissioner for Human Rights, Positions on the rights of minor migrants in an irregular situation, CommDH/PositionPaper(2010)6, 25 June 2010.

⁷⁶ [Finland: 2014 visit, paragraph 29](#).

⁷⁷ [19th General Report on the CPT’s activities, paragraph 98](#).

⁷⁸ [Denmark: 2014 visit, paragraph 77](#).

⁷⁹ [“The former Yugoslav Republic of Macedonia”: 2014 visit, paragraph 122](#).

⁸⁰ [19th General Report on the CPT’s activities, paragraph 98](#).

⁸¹ [Greece: 2015 visit, paragraph 108](#).

⁸² [19th General Report on the CPT’s activities, paragraph 100](#).

⁸³ [19th General Report on the CPT’s activities, paragraph 99](#).



Foreign nationals detained under aliens legislation

*Extract from the 7th General Report of the CPT,
published in 1997*

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.

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

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.

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 of the CPT,
published in 2009*

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

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

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 continent⁵ 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.

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

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.

⁵ 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.

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.⁶ 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,⁷ 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.

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.

⁶ 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.

⁷ “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.



Deportation of foreign nationals by air

*Extract from the 13th General Report of the CPT,
published in 2003*

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 escort¹, 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.

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 asphyxia².

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.

² 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).

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 periods³.

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.

³ 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.

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.

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.



Involuntary placement in psychiatric establishments

*Extract from the 8th General Report of the CPT,
published in 1998*

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 described¹. 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.

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.

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

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.



Strasbourg, 21 March 2017

CPT/Inf(2017)6

**Means of restraint
in psychiatric establishments for adults**
(Revised CPT standards)

In the light of previous publications¹ on this subject matter and its findings during many visits in recent years to civil and forensic psychiatric establishments in various European countries, the CPT has decided to review its standards regarding the use of means of restraint and to consolidate them in the present document.

¹ See paragraphs 47 to 50 of the 8th General Report on the CPT's activities (CPT/Inf (98) 12) and paragraphs 36 to 54 of the 16th General Report on the CPT's activities (CPT/Inf (2006) 35), as well as document CPT (2012) 28 on "the use of restraints in psychiatric institutions".

Introduction

Given their intrusive nature and the potential for abuse and ill-treatment, the CPT has always paid particular attention to the use of various types of restraint vis-à-vis psychiatric patients.

At the outset, the CPT wishes to stress that the ultimate goal should always be to prevent the use of means of restraint by limiting as far as possible their frequency and duration. To this end, it is of paramount importance that the relevant health authorities and the management of psychiatric establishments develop a strategy and take a panoply of proactive steps, which should *inter alia* include the provision of a safe and secure material environment (including in the open air), the employment of a sufficient number of health-care staff, adequate initial and ongoing training of the staff involved in the restraint of patients, and the promotion of the development of alternative measures (including de-escalation techniques).

In most countries visited by the CPT, one or more of the following types of restraint may be used:

- (a) physical restraint (i.e. staff holding or immobilising a patient by using physical force – “manual control”);
- (b) mechanical restraint (i.e. applying instruments of restraint, such as straps, to immobilise a patient);
- (c) chemical restraint (i.e. forcible administration of medication for the purpose of controlling a patient’s behaviour);
- (d) seclusion (i.e. involuntary placement of a patient alone in a locked room).

1. General principles

- 1.1. The restraint of violent psychiatric patients who represent a danger to themselves or others may exceptionally be necessary.²
- 1.2. Means of restraint should always be applied in accordance with the principles of legality, necessity, proportionality and accountability.
- 1.3. All types of restraint and the criteria for their use should be regulated by law.
- 1.4. Patients should only be restrained as a measure of last resort (*ultimo ratio*) to prevent imminent harm to themselves or others and restraints should always be used for the shortest possible time. When the emergency situation resulting in the application of restraint ceases to exist, the patient should be released immediately.
- 1.5. Means of restraint are security measures and have no therapeutic justification.
- 1.6. Means of restraint should never be used as punishment, for the mere convenience of staff, because of staff shortages or to replace proper care or treatment.

² See also Article 27 of Recommendation Rec(2004)10 of the Committee of Ministers to member States concerning the protection of the human rights and dignity of persons with mental disorder, as well as the judgments of the European Court of Human Rights in *Bureš v. the Czech Republic* (18 October 2012; application no. 37679/08; paragraph 86) and *M.S. v. Croatia* (19 February 2015; application no. 75450/12; paragraph 97).

- 1.7. 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 be aimed at preventing as far as possible the resort to means of restraint and 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; recording; internal and external reporting mechanisms; debriefing; and complaints procedures. Further, patients should be provided with relevant information on the establishment's restraint policy.

2. Authorisation

Every resort to means of restraint should always be expressly ordered by a doctor after an individual assessment, or immediately brought to the attention of a doctor with a view to seeking his/her approval. To this end, the doctor should examine the patient concerned as soon as possible. No blanket authorisation should be accepted.

3. Application of means of restraint

- 3.1. Means of restraint should always be applied with skill and care, in order to minimise the risk of harming or causing pain to the patient and to preserve as far as possible his/her dignity. Staff should be properly trained before taking part in the practical application of means of restraint.
- 3.2. When recourse is had to physical (manual) restraint, staff should be specially trained in holding techniques that minimise the risk of injury. Neck holds and techniques that may obstruct the patients' airways or inflict pain should be prohibited.
- 3.3. For the purpose of mechanical restraint, only equipment designed to limit harmful effects (preferably, padded cloth straps) should be used in order to minimise the risk of the patient sustaining injury and/or suffering pain. Handcuffs or chains should never be used to immobilise a patient. Patients under restraint should always be face up with the arms positioned down. Straps must not be too tight and should be applied in a manner that allows for the maximum safe movement of the arms and legs. The vital functions of the patient, such as respiration and the ability to communicate, must not be hampered. Patients under restraint should be properly dressed and, as far as possible, be enabled to eat and drink autonomously and to comply with the needs of nature in a sanitary facility.
- 3.4. The use of net (or cage) beds should be prohibited under all circumstances.
- 3.5. Patients should not be subjected to mechanical restraint in view of other patients (unless the patient explicitly expresses a wish to remain in the company of a certain fellow patient); visits by other patients should only take place with the express consent of the restrained patient.
- 3.6. Staff should not be assisted by other patients when applying means of restraint to a patient.
- 3.7. If recourse is had to chemical restraint, only approved, well-established and short-acting drugs should be used. The side-effects that 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.
- 3.8. As regards seclusion, the room in which patients are placed should be specially designed for that specific purpose. In particular, it should ensure the safety of the patient and provide a calming environment for the patient concerned.

4. Duration

- 4.1. The duration of the use of means of mechanical restraint and seclusion should be for the shortest possible time (usually minutes rather than hours), and should always be terminated when the underlying reasons for their use have ceased. Applying mechanical restraint for days on end cannot have any justification and could, in the CPT's view, amount to ill-treatment.
- 4.2. If, exceptionally, for compelling reasons, recourse is had to mechanical restraint or seclusion of a patient for more than a period of hours, the measure should be reviewed by a doctor at short intervals. Consideration should also be given in such cases and where there is repetitive use of means of restraint to the involvement of a second doctor and the transfer of the patient concerned to a more specialised psychiatric establishment.

5. Selection of type(s) of restraint

In cases where the use of restraint is considered, preference should be given to the least restrictive and least dangerous restraint measure. When choosing among available restraint measures, factors such as the patient's opinion (including any preferences expressed in advance) and previous experience should as far as possible be taken into account.

6. Concurrent use of different types of restraint

Sometimes seclusion, mechanical or physical restraint may be combined with chemical restraint. Such a practice may only be justified if it is likely to reduce the duration of the application of restraint or if it is deemed necessary to prevent serious harm to the patient or others.

7. Supervision

Every patient who is subjected to mechanical restraint or seclusion should be subjected to continuous supervision. In the case of mechanical restraint, a qualified member of staff should be permanently present in the room in order to maintain a therapeutic alliance with the patient and provide him/her with assistance. If patients are held in seclusion, the staff member may be outside the patient's room (or in an adjacent room with a connecting window), provided that the patient can fully see the staff member and the latter can continuously observe and hear the patient. Clearly, video surveillance cannot replace continuous staff presence.

8. Debriefing

Once the means of restraint have been removed, it is essential that a debriefing of the patient take place, to explain the reasons for the restraint, reduce the psychological trauma of the experience and restore the doctor-patient relationship. This also provides an opportunity for the patient, together with staff, to find alternative means to maintain control over him/herself, thereby possibly preventing future eruptions of violence and subsequent restraint.

9. Use of means of restraint at the patient's own request

Patients may sometimes ask to be subjected to means of restraint. In most cases, such requests for "care" suggest that the patients' needs are not being met and that other therapeutic measures should be explored. If a patient is nevertheless subjected to any form of restraint at his/her own request, the restraint measure should be terminated as soon as the patient asks to be released.

10. Use of means of restraint vis-à-vis voluntary patients

In case the application of means of restraint to a voluntary patient is deemed necessary and the patient disagrees, the legal status of the patient should be reviewed.

11. Recording and reporting of instances of means of restraint

- 11.1. 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. To this end, a specific register should be established to record all instances of recourse to means of restraint (including chemical restraint). This should supplement 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 entitlement; at their request, they should receive a copy of the full entry.
- 11.2. The frequency and duration of instances of restraint should be reported on a regular basis to a supervisory authority and/or a designated outside monitoring body (e.g. health-care inspectorate). This will facilitate a national or regional overview of existing restraint practices, with a view to implementing a strategy of limiting the frequency and duration of the use of means of restraint.

12. Complaints procedures

Effective complaints procedures are basic safeguards against ill-treatment in all psychiatric establishments. Psychiatric patients (as well as their family members or legal representatives) should have avenues of complaint open to them within the establishments' administrative system and should be entitled to address complaints – on a confidential basis – to an independent outside body. Complaints procedures should be simple, effective and user-friendly, particularly regarding the language used. Patients should be entitled to seek legal advice about complaints and to benefit from free legal assistance when the interests of justice so require.

Checklist for the evaluation of a psychiatric hospital

by Andres Lehtmetts and Pétur Hauksson

This list is not exhaustive, but rather an *aide memoire* to be used during a CPT visit.

I. The comprehensive evaluation of a psychiatric hospital involves the completion of the following steps:

- a. analysis of the legal basis of the mental health services (Mental Health Act etc) and the regulations within the hospital (guidelines etc).
- b. an initial interview with the head of the hospital (and his deputies)
- c. a visit to all the establishments facilities
- d. examination of a number of medical files and other documentation related to the medical service provision (court rulings, registers, reports of outside monitoring bodies)
- e. interviews (in private) with a number of patients
- f. interviews with the staff (doctors, nurses, specialists)
- g. a final talk with the head of the hospital and his deputies (to provide first impressions, and – if needed – to ask for supplementary information)

Other activities might be necessary, depending on the situation: visits to external medical units, surprise visits during night hours etc.

II. Attention should be paid to the following matters:

1. Issues to be addressed on the management level

- 1.1. official capacity of the establishment and the number of patients on the day of the visit
- 1.2. different categories of patients (children, juveniles, elderly patients, patients with substance abuse problems, forensic patients)
- 1.3. number on involuntarily admitted patients (if relevant, breakdown of different categories according to the law)
- 1.4. ward structure of the hospital (including the supportive / paraclinical services – X-ray, EEG, clinical laboratory etc)
- 1.5. staffing: breakdown by different specialist categories, numbers of posts, vacancies, persons working for more than one full post
- 1.6. external support : security companies, consultants from outside, cooperation with general hospitals, discharge and transfer to social care homes etc
- 1.7. financial issues : budgeting principles, out-of-pocket payments related to service provision

- 1.8. medical statistics : number of admissions per year, main pathologies, deaths (including suicides), autopsies
- 1.9. special treatments : ECT, psychosurgery, special programs for sexual offenders etc.
- 1.10. medical documentation (registers, standards and rules for taking medical notes and filing the documentation)
- 1.11. plans for future developments (renovations, reconstructions, new treatment options)
- 1.12. guidelines for addressing certain medical issues (treatment guidelines)
- 1.13. training and supervision of the staff

2. Issues to be addressed on the ward level

- 2.1. admission of patients – procedures, regulations
- 2.2. placement of patients in the rooms
- 2.3. different regimes of observation
- 2.4. daily activities provided for the patients
- 2.5. presence of medical and paramedical staff
- 2.6. treatment plans and teamwork
- 2.7. medication (availability, possible excessive use, chemical restraints)
- 2.8. availability of psychotherapeutic treatments and psychosocial interventions
- 2.9. interpatient violence

3. Special issues

- 3.1. use of restraints and seclusion
- 3.2. outdoor exercise
- 3.3. categories of patients under special regimes
- 3.4. restrictions concerning possessions, searches
- 3.5. ECT
- 3.6. vulnerable categories (including juveniles and children, long-term patients, physically handicapped persons)
- 3.7. contacts with the outside world (visits, access to telephone)
- 3.8. prevention of suicides
- 3.9. biomedical research

4. Assessment of material conditions

- 4.1. living conditions in different wards – layout of the rooms (privacy issues), access to light, temperature
- 4.2. clothing and personal items
- 4.3. food
- 4.4. hygiene (toilets, showers)

5. Legal issues

- 5.1. involuntary placement procedure
- 5.2. review of placement decisions
- 5.3. consent to treatment
- 5.4. information on rights and access to legal aid
- 5.5. complaints procedure
- 5.6. visits by outside bodies (monitoring bodies, NGO's, ombudsman etc)



Strasbourg, 22 May 2015

CPT/Inf (2015) 23

Checklist
for visits to social care institutions
where persons may be deprived of their liberty
by Jari Pirjola and Vytautas Raškauskas

This list is not exhaustive, but rather a tool to be used during CPT visits, and will be reviewed on a regular basis.

A. General information

- Which body is responsible for the institution (national, regional or local authority; church, charity association, private structure)?
- Official capacity? Based on how many square-metres per person? Number of residents at the time of the visit (male, female, age groups)?
- Categories of residents?
- Does the law provide for an involuntary placement procedure? Who decides on the placement of persons who do not consent (court, social welfare authority, mayor)?
- Number of residents who are formally deprived of their liberty?
- How many residents are deprived of their legal capacity/under guardianship?
- Is there a unit where residents are subjected to special protective measures (“closed regime”)?
- What action is taken when residents leave the institution without permission? Is the police called to search for them and bring them back to the institution?
- Staffing: breakdown of posts by category with an indication of full- and part-time employment and vacancies (including general practitioners/psychiatrists/psychologists/nurses/nursing assistants/caretakers)? Working hours of staff? Number of staff present on different shifts, including at night and during weekends? Training and supervision of staff?
- External support: Co-operation with external consultants/hospitals? Private security companies?
- Interventions by police after security incidents?
- Major incidents in recent years?
- Deaths in recent years (number and causes)?

B. Ill-treatment

- Ill-treatment by staff (physical and/or verbal)?
- Inter-resident violence? Do members of staff react and intervene promptly in case of incidents? Are measures taken to protect particularly vulnerable residents?

C. Living conditions

- Allocation of different groups of residents: Placement policies? Are persons with mental disorders and those with a learning disability accommodated separately? Are minors and adult residents accommodated separately?
- Possibilities for spouses to be accommodated together?
- Material conditions in bed rooms/dormitories and communal rooms, sanitary facilities, etc.? Living space per person? Does every resident have his/her own bed? Access to natural light and artificial lighting? Ventilation? Heating?
- Physical structure of buildings adapted to the special needs of the residents?

- Hygiene: Availability of diapers/disposable pads for incontinent residents and sufficiently frequent diaper change? Special mattresses? Toilet and washing/shower facilities accessible and adapted for residents with physical impairments?
- Leisure activities? Outdoor exercise every day? For how long? Assistance provided for residents suffering from physical/walking impairments to access outdoor areas?
- Residents' privacy: Individual wardrobes? Lockable space for personal belongings? Can residents keep personal belongings in their room? Any restrictions applied? Do residents have access to their rooms during the day?
- Clothes and footwear adequate (also for cold season)? : Possibility to wear own clothes?
- Food:¹ Quality and quantity, provision for special diets (e.g. for diabetes)? Feeding assistance provided when necessary?

D. Health care

- Equivalence of somatic and psychiatric care compared to the care available in the outside community?
- Dental care? Is conservative treatment available free of charge for indigent residents?
- Sufficient supply of medicines?
- Provision of psychological care (e.g. to address anxiety, grief, depression)?
- Management of acute psychiatric and somatic conditions? Transfer to a hospital when necessary?
- Are all newly-admitted residents subjected to a medical examination upon admission (including check of weight)?
- Periodic medical examination of residents?
- Therapeutic, occupational and rehabilitative activities? Physiotherapy?
- Care plan drawn up for each resident? Are residents personally involved in this process? Regular review?
- Does a personal medical file exist for every resident?
- Who has access to medical files (medical confidentiality)?
- Use of contraceptives? Policy regarding abortions?
- How many bedridden residents?
- Arrangements for persons who are not able or refuse to take food themselves? Artificial feeding?
- Suicide prevention measures in place?
- Any biomedical research? If yes, examine procedures and safeguards (including consent)
- Clear protocol for dealing with unexpected deaths? Autopsy carried out unless clear diagnosis of fatal disease? Records kept of the clinical causes of residents' deaths?

E. Means of restraint

- What types of restraint are used? Seclusion? Physical restraint? Mechanical restraint (straps, straitjacket, bed sides, net bed, etc)? Chemical restraint? Other types?
- Legal basis for use of restraints?
- Is there a clearly-defined restraint policy regarding the procedures and modalities?
- Who decides on the use of restraint? Possible to give authorisation in advance ("*pro re nata*")?
- Are there rules regarding the maximum duration of restraint? Longest duration in practice?
- Staff properly trained (including in non-physical de-escalation techniques)?
- Are all instances of restraint, including chemical restraint, recorded in a specific register?

Mechanical restraint:

- Always ordered by a doctor or immediately brought to the attention of a doctor in order to seek his/her approval?
- Application exclusively by health-care staff or other staff? Are other residents on occasion involved in restraining an agitated resident?
- Always continuously and directly monitored (human contact)? Supervision through CCTV?
- Application always out of sight of other residents?

¹ For methods to identify undernutrition, calculating quantity and quality of food and the CPT's role in assessing if undernutrition and the risk of it are appropriately monitored and addressed, see "Preliminary remarks on the development of some tools for assessing the nutritional status of some groups of persons deprived of their liberty" by Veronica Pimenoff (document CPT (2005) 6).

F. Safeguards in the context of involuntary placement²

1. Initial placement procedure

- Who decides on the involuntary placement? According to what procedure?
- Does an involuntary placement order issued by a non-judicial body have to be approved by a court?
- Is the person concerned heard by the decision-making body? Where does the hearing take place? At the institution?
- Is the placement decision based on objective medical expertise, including of a psychiatric nature?
- Is a second (independent) doctor always/in some cases involved?
- Is the placement order limited in time or for an indefinite period?
- Written notification? Information on reasons for placement?
- Appeal procedures? To an independent body? Are residents informed about the possibility and modalities of lodging an appeal? Are they heard in the context of the appeal procedure?
- If admitted on a voluntary basis, is the consent properly recorded (special form requiring resident's signature)?
- Transformation of voluntary into involuntary stay: Is an involuntary civil placement procedure initiated in the event that a resident who has been admitted on a voluntary basis withdraws his/her previous consent to the placement and is prevented from leaving the institution or that the person concerned is no longer capable of giving his/her valid consent? Do the same safeguards apply to such "retained" residents and those who have been admitted on an involuntary basis?

2. Review procedures

- Regular reviews of the involuntary placement decision? Automatic (*ex officio*) and/or at the request of the resident or his/her representative?
- In which intervals is the placement decision reviewed? Involvement of a court or another independent body?
- Is the resident heard in person? At the institution?

G. Safeguards in the context of involuntary treatment

- Consent to treatment distinguished from consent to admission?
- Consent free and informed?
- Involvement of a second (independent) doctor/decision-making body or court in all/some involuntary treatment decisions?
- Exceptions to the possibility to refuse treatment only based on law and relating to clearly-defined exceptional circumstances?
- Possibilities of withdrawal of previous consent to treatment and appeal against involuntary treatment decision?
- Consent properly recorded? Are there situation in which the written consent of the resident is required?
- Regular reviews of involuntary treatment orders? Automatic and/or upon the request of the resident or his/her representative? Independence of review? Frequency of review?

²

Safeguards in the context of involuntary placement should apply to all residents of social care institutions who are deprived of their liberty. This also includes residents who are formally regarded as "voluntary", but who are in practice not free to leave the institution and who are thus *de facto* deprived of their liberty.

H. Safeguards regarding persons who are deprived of their legal capacity

1. Procedure for the deprivation of legal capacity and appointment of a guardian

- Does the court which decides on the (partial) deprivation of legal capacity also decide on the nomination of a guardian or is the guardian appointed by another body (e.g. social welfare authority)?
- Is the resident heard in person in the process of deprivation of his/her legal capacity and the appointment of a guardian?
- Are the persons concerned given a copy of the decisions and informed (verbally and in writing) of the possibility and modalities for appealing against the decisions to deprive them of their legal capacity and to appoint a guardian?
- Are the decisions on deprivation of legal capacity subject to a regular court review? How frequently? Can the person concerned initiate proceedings to restore the legal capacity? Does the person have effective access to legal assistance in the context of these procedures?
- Who are the guardians (relatives, private associations, public officials, staff of the social care institution)?

2. Safeguards in the context of admission

- Who decides on the placement?
- Does the guardian have to sign a private-law contract with the institution?
- Which safeguards apply for the admission of legally incapacitated persons in a social care institution?
- Is the admission of a person on the basis of consent given by his/her guardian considered to be voluntary or involuntary?
- Is an additional approval by an outside body required in such cases?

3. Safeguards in the context of treatment and the use of means of restraint

- Which safeguards apply for the treatment of legally incapacitated persons? To what extent is the guardian involved in treatment measures? Are there situations where additional safeguards are required, e.g. approval by a court or another outside body?
- Which safeguards apply for the use of means of restraint vis-à-vis legally incapacitated persons? To what extent is the guardian involved in decisions on the use of restraint measures? Are there situations where additional safeguards are required (e.g. approval by a court or another outside body)?

I. Other issues

- Residents' contact with the outside world (correspondence, telephone, visits)
- Regular inspections/monitoring by an independent outside body?
- Complaints procedures? Is there a system of legal counselling in place (such as "residents' advocates")?
- Information of residents: Are residents informed of the institution's routine and their rights including of complaints procedures e.g. in the context of involuntary placement or treatment and of discharge procedures? Is this information part of the admission contracts signed by the resident (or his/her legal representative)?



Juveniles deprived of their liberty under criminal legislation

*Extract from the 24th General Report of the CPT,
published in 2015*

1. Preliminary remarks

96. In 1998, in its 9th General Report, the CPT set out the criteria which guide its work when visiting places where “juveniles” (i.e. persons under the age of 18¹) are deprived of their liberty. In particular, it identified a number of safeguards which should be offered to all juveniles deprived of their liberty under criminal legislation and the conditions which should obtain in detention centres specifically designed for juveniles. The Committee considers that the time is ripe to review these standards based upon its visit experience since 1998 and taking into consideration developments at the European and universal levels, focusing at this stage on the deprivation of liberty of juveniles in the criminal law context.

At the outset, the CPT reiterates that its standards should be viewed as complementary to those set out in international instruments, notably the 1989 United Nations Convention on the Rights of the Child and Recommendation CM/Rec (2008) 11 of the Committee of Ministers of the Council of Europe to member states on the European Rules for juvenile offenders subject to sanctions or measures (“European rules for young offenders”), which provides a detailed set of rules for the treatment of juvenile offenders in Europe.² The Committee subscribes wholeheartedly to the cardinal principles enshrined in Articles 3 and 37.b of the Convention on the Rights of the Child and in Rules 5 and 10 of the European Rules for juvenile offenders, namely that in all action concerning juveniles, their best interests shall be a primary consideration and that they should only be deprived of their liberty as a last resort and for the shortest possible period of time.

¹ In the majority of Council of Europe member states, the minimum age of criminal responsibility is fixed at the age of 14 or 15 years, while, in a few countries, the minimum age ranges from eight to 13 years.

² See also the 1985 United Nations Standard Minimum Rules for the Administration of Juvenile Justice (“Beijing Rules”), the 1990 United Nations Rules for the Protection of Juveniles Deprived of their Liberty (“Havana Rules”), the 1990 United Nations Guidelines for the Prevention of Juvenile Delinquency (“Riyadh Guidelines”) and the 2010 Guidelines of the Committee of Ministers of the Council of Europe on child friendly justice.

2. Juveniles held in police custody

97. Bearing in mind its preventive mandate, the CPT's priority during visits is to seek to establish whether juveniles deprived of their liberty have been subjected to ill-treatment. Regrettably, deliberate ill-treatment of juveniles by law enforcement officials has by no means been eradicated and remains a real concern in a number of European countries. CPT delegations continue to receive credible allegations of detained juveniles being ill-treated. The allegations often concern kicks, slaps, punches or blows with batons at the time of apprehension (even after the juvenile concerned has been brought under control), during transportation or subsequent questioning in law enforcement establishments. It is also not uncommon for juveniles to become victims of threats or verbal abuse (including of a racist nature) whilst in the hands of law enforcement agencies.

98. It is the period immediately following apprehension when persons are most at risk of ill-treatment. Therefore, the CPT has advocated three fundamental safeguards (namely the rights of detained persons to notify a close relative or another person of their detention and to have access to a lawyer and a doctor), which should apply from the very outset of deprivation of liberty (i.e. from the moment a person is first obliged to remain with a law enforcement agency). Given their particular vulnerability, the CPT considers that juveniles held in police custody should always benefit from the following additional safeguards against ill-treatment:

- law enforcement officials should be under a formal obligation to ensure that a relative or another adult person trusted by the juvenile is notified of the fact that a juvenile has been detained (regardless of whether the juvenile requests that this be done);
- a detained juvenile should never be subjected to police questioning or be requested to make any statement or to sign any document concerning the offence(s) he/she is suspected of having committed without the presence of a lawyer and, in principle, a trusted adult person (the option "does not wish to see a lawyer" should not apply to juveniles);
- a specific information sheet setting out the above-mentioned safeguards should be given to all juveniles taken into custody immediately upon their arrival at a law enforcement establishment. The information sheet must be child-friendly, written in simple and clear language and available in a variety of languages. Special care should be taken to ensure that juveniles fully understand the information.

99. The CPT considers that nobody should be held in law enforcement establishments for prolonged periods as such establishments normally do not provide suitable conditions and an appropriate regime. Moreover, experience has shown that persons in police custody are more vulnerable and often run a higher risk of being subjected to torture or other forms of ill-treatment. It follows that even greater efforts should be made to keep the detention in law enforcement establishments to a minimum for juveniles. In some countries, juveniles continue to be held in police stations for periods of ten days or more; such practices are unacceptable. The CPT considers that, as a rule, juveniles should not be held in a law enforcement establishment for more than 24 hours. Further, every effort should be made to avoid placing juveniles in ordinary police cells but rather to hold them in a juvenile-friendly environment. To this end, it would be highly desirable for separate police units for juveniles to be established so that juveniles can be removed as quickly as possible from the general population of persons in police custody and accommodated in a specialised holding facility.

Regrettably, the Committee continues to find juveniles in police custody being accommodated together with adults in the same cells. Such a state of affairs is not acceptable. The vulnerability of juveniles means that as a matter of principle they should be accommodated separately from adults.

100. Further, law enforcement officials who frequently or exclusively deal with juveniles or who are primarily engaged in the prevention of juvenile delinquency should receive specialised initial and ongoing training.

3. Detention centres for juveniles

a. introduction

101. The CPT has long advocated that all detained juveniles who are suspected or convicted of a criminal offence should be held in detention centres specifically designed for persons of this age, offering a non-prison-like environment and regimes tailored to their needs and staffed by persons trained in dealing with the young. Regrettably, this is still far from being the case in many Council of Europe member states. There has been progress in ensuring that juveniles who are sent to prison are not held together with adults but in juvenile-only units. However, all too often these units offer not only poor material conditions but, due to a lack of trained staff, juvenile inmates are also provided with an impoverished regime, and support and supervision remain inadequate. This means that juveniles do not benefit from purposeful activities and training in life skills which are beneficial for reintegration into the community upon release.

On the other hand, the Committee has visited a number of juvenile establishments in several countries, which are indeed juvenile-centred and based on the concept of living units. These establishments are composed of small well-staffed units, each comprising a limited number of single rooms (usually no more than ten) as well as a communal area. Juveniles are provided with a range of purposeful activities throughout the day, and staff promote a sense of community within the unit. The CPT considers that this type of centre represents a model for holding detained juveniles in all European countries.

102. As indicated above, juveniles (whether on remand or sentenced) should as a rule not be held in institutions for adults but in facilities specially designed for this age group. The CPT considers that when, exceptionally, they are held in prisons for adults, juveniles should always be accommodated separately from adults, in a distinct unit. Further, adult prisoners should not have access to this unit. That said, the Committee acknowledges that there can be arguments in favour of juveniles participating in out-of-cell activities with adult prisoners, on the strict condition that there is appropriate supervision by staff. Such situations occur, for example, when there are very few or only one juvenile offender in an establishment; steps need to be taken to avoid juveniles being placed *de facto* in solitary confinement.

103. Juveniles detained under criminal legislation should, in principle, not be held with juveniles deprived of their liberty on other grounds. Male and female juveniles who are placed in the same institution should be accommodated in separate units, although they may associate for organised activities during the day, under appropriate supervision. Special attention should be paid to the allocation of juveniles belonging to different age groups in order to accommodate their needs in the best way. Appropriate measures should also be taken to ensure adequate separation between these age groups in order to prevent unwanted influence, domination and abuse.

The European Rules for young offenders state that young adult offenders may, where appropriate, be regarded as juveniles and dealt with accordingly. This practice can be beneficial to the young persons involved but requires careful management to prevent the emergence of negative behaviour. In this respect, the CPT considers that a case-by-case assessment should be carried out in order to decide whether it is appropriate for a particular inmate to be transferred to an adult institution after reaching the age of majority (i.e. 18 years), taking into consideration the remaining term of his/her sentence, his/her maturity, his/her influence on other juveniles, and other relevant factors.

b. material conditions

104. A well-designed juvenile detention centre should provide positive and personalised conditions of detention for young persons, respecting their dignity and privacy. All rooms should be appropriately furnished and provide good access to natural light and adequate ventilation.

Juveniles should normally be accommodated in individual bedrooms; reasons should be provided explaining why it is in the best interests of the juvenile to share sleeping accommodation with another inmate. Juveniles should be consulted before being required to share sleeping accommodation and should be able to state with whom they would wish to be accommodated.

Every effort should be made to avoid placing juveniles in large dormitories as the CPT's experience is that this puts juveniles at a significantly higher risk of violence and exploitation. Indeed, establishments with large dormitories should be phased out.

105. Further, juveniles should have ready access to sanitary facilities that are hygienic and respect privacy. In particular, attention should be paid to ensuring that female juveniles are provided with ready access to sanitary and washing facilities as well as to hygiene items, such as sanitary towels.

106. Juvenile offenders should also be allowed to wear their own clothing if it is suitable. Those who do not have suitable clothing of their own should be provided with non-uniform clothing by the establishment.

c. regime

107. Although a lack of purposeful activities is detrimental for any prisoner, it is especially harmful for juveniles, who have a particular need for physical activity and intellectual stimulation. Juvenile inmates should be provided throughout the day with a full programme of education, sport, vocational training, recreation and other purposeful out-of-cell activities.

108. Physical exercise should constitute an important part of the juveniles' daily programme. All juveniles should be allowed to exercise regularly, for at least two hours every day, of which at least one hour should be in the open air and, preferably, considerably more. Outdoor exercise yards should be spacious and suitably equipped to give juveniles a real opportunity to exert themselves physically (e.g. to practise sports); they should also be equipped with shelter against inclement weather.

109. Upon admission, an individualised plan should be drawn up for every juvenile, specifying the objectives, the time-frame and the means through which the objectives should be attained, in order to best utilise the time that the juvenile concerned spends in the detention centre, to develop skills and competences that assist him/her to reintegrate into society.

110. Education and vocational training offered to juveniles in detention should be similar to that in the community, provided by professional teachers/trainers, and juveniles in detention should obtain the same types of diploma or certificate (after successfully completing their education) as juveniles who attend educational establishments in the community. Measures should be taken to avoid that school-leaving certificates bear any indication of the juvenile's institutional affiliation. Given the particularly difficult backgrounds of many juveniles, efforts need to be made to encourage and motivate them to attend educational classes/vocational training and to participate in workshops where they can learn skills to assist them upon their release. In a number of countries, the CPT has observed the practice of training juveniles in using computers (including the Internet) and/or of allowing selected detained juveniles to attend schools in the outside community. Such practices should be encouraged.

111. The CPT also wishes to stress that female juveniles should under no circumstances receive less care, protection, assistance and training than male juveniles, despite the fact that their numbers are much lower and that detention centres are nearly always designed for male inmates. If necessary, additional measures should be taken to ensure equal treatment.

112. In various establishments visited, the CPT observed the existence of a differentiated incentive-based regime in which progress is rewarded to juveniles who are co-operative and display good behaviour, while inmates who display negative behaviour are demoted and subjected to various restrictions. In the CPT's view, a behavioural approach can be beneficial in encouraging juvenile inmates to abide by the norms of living within a group and pursue constructive paths of self-development. However, withdrawal of incentives due to non-compliance can quickly reach a level of deprivation which is incompatible with minimum requirements. In particular, steps should be taken to avoid the juveniles concerned being subjected to a regime which is akin to solitary confinement. In addition, there should be formal and transparent procedures in order to avoid "educational measures" becoming or being perceived as arbitrary.

d. health care

113. When examining the issue of health-care services in prisons, the CPT has been guided in its work by a number of general criteria (access to a doctor; equivalence of care; patient's consent and confidentiality; preventive health care; professional independence and professional competence). Moreover, in its 23rd General Report, the Committee set out in detail its standards regarding the role of prison health-care services in preventing ill-treatment (notably through the systematic recording of injuries and the provision of information to the relevant authorities). Naturally, all the aforementioned standards apply equally to detention centres for juveniles.

114. Having said that, the CPT always 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 upon admission all juveniles should benefit from a comprehensive individual medical, psychological and social needs assessment and that there is always close co-ordination between the work of an establishment's health-care team (doctors, nurses, psychologists, etc.) and that of other professionals, including specialised educators, social workers and teachers, who have regular contact with inmates. The goal should be to ensure that the health care delivered to juvenile inmates forms part of a seamless web of support and therapy.

115. All juveniles should be properly interviewed and physically examined by a medical doctor, or a qualified nurse reporting to a doctor, as soon as possible after their admission to the detention centre; preferably, on the day of arrival. 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, sexual abuse and 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.

116. It is also widely recognised that detained juveniles have a tendency to engage in risk-taking behaviour, especially with respect to drugs, alcohol and sexual practices, and that they are more likely to engage in self-harm. In consequence, in every detention centre for juveniles, there should be a comprehensive strategy for the management of substance abuse (including prevention and treatment) and the prevention of self-harm and suicide. The provision of health education about transmissible diseases is another important element of a preventive health-care programme. Juveniles with mental-health problems should be cared for by psychiatrists and psychologists specialising in the mental health of children and adolescents.

117. Particular attention should always be paid to the health-care needs of female juveniles: access to gynaecologists and education on women's health care should be provided. Pregnant juvenile girls and juvenile mothers in detention should receive appropriate support and medical care; as far as possible, alternatives to detention should be imposed. In this regard, the relevant standards on women deprived of their liberty which the CPT elaborated in its 10th General Report apply equally to detained female juveniles.³

118. Health-care staff should also play an active role in monitoring the quality and quantity of food. The juveniles' nutritional state should be assessed through, inter alia, drawing up a growth chart for those juveniles who are still in the growth phase.

e. staffing issues

119. The custody and care of juveniles deprived of their liberty is a particularly challenging task. It should be taken into account that many of them have suffered physical, sexual or psychological violence. The staff called upon to fulfil this task should be carefully selected for their personal maturity, professional integrity and ability to cope with the challenges of working with – and safeguarding the welfare of – this age group. More particularly, steps should be taken to ensure the regular presence of specialised educators, psychologists and social workers in detention centres for juveniles. They should be committed to working with young people, and be capable of guiding and motivating them. With a view to avoiding a prison-like environment, staff working in direct contact with juveniles should as a rule not carry batons, incapacitating sprays or other means of restraint. The practice observed by the CPT in a number of juvenile detention centres of custodial staff not wearing a prison uniform is to be encouraged. Mixed-sex staffing can have a beneficial effect in terms of the custodial ethos and foster a more caring and relaxed atmosphere.

120. All staff, including those with custodial duties, who are in direct contact with juveniles 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. Particular attention should be given to staff training in the management of violent incidents, especially in verbal de-escalation to reduce tension and professional restraint techniques.

121. It is the responsibility of the establishments' administration to take special precautions to protect juveniles from all forms of abuse, including sexual or other kinds of exploitation. Staff members should be alert to signs of bullying (including physical and sexual assault, verbal abuse, extortion, and theft of other juveniles' belongings) and should know how to respond accordingly and adopt a pro-active attitude to prevent such incidents from occurring.

f. contact with the outside world

122. The active promotion of good contact with the outside world 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. Every effort should be made to ensure that all juvenile inmates are afforded the possibility to have contact with their families and other persons from the moment they are admitted to the detention centre. The concept of family should be interpreted liberally, so as to include contacts with persons with whom the juvenile has established a relationship comparable to that of a family member, even if the relationship has not been formalised. For the purpose of their social integration, juveniles should as far as possible also be allowed regular periods of leave (either escorted or alone).

³ See CPT/Inf (2000) 13, paragraphs 26 to 33.

123. Juveniles should benefit from a visiting entitlement of more than one hour every week, and they should also be able to receive visits at weekends. Short-term visits should be allowed, as a rule, under open conditions.

The CPT has observed in some countries that juveniles are authorised to benefit from long-term unsupervised visits. Except for cases when it is not in the juveniles' best interests, such an approach is particularly welcome in order to foster the family life of the juvenile and his/her close relatives and the juvenile's reintegration into society.

124. All juveniles, including those on remand, should have frequent access to a telephone and the opportunity to exercise their right to correspondence at all times. If there are security concerns, particular telephone calls and correspondence could be monitored, and exceptionally prohibited. Any such decision should be based on a substantiated risk of collusion or other illegal activity, and be for a specified period.

In some establishments visited by the CPT, juveniles are allowed to communicate with family members on a regular basis by using free-of-charge Voice over Internet Protocol (VoIP) services. Such practices are highly welcome; however, they should not be considered as a substitute for visits.

125. Information on transfers, release, disciplinary sanctions and protective and security measures applied to a juvenile, as well as concerning any illness, injury or death, should be provided without delay to the parents or legal representative of the juvenile concerned.

g. discipline and security

126. Restorative conflict resolution should be given priority over formal disciplinary procedures and sanctions. Disciplinary sanctions, if applied, should be governed by the principle of proportionality and imposed in full compliance with the relevant formal disciplinary rules and procedures, and not take the form of an unofficial punishment. Any form of collective punishment is unacceptable.

In a number of establishments visited by the CPT, it was not uncommon for staff to administer a so-called "pedagogic slap" or other forms of physical chastisement to juveniles who misbehaved. In this regard, the CPT recalls that corporal punishment is likely to amount to ill-treatment and must be strictly prohibited.

127. The CPT wishes to stress that a juvenile's contact with the outside world should never be denied as a disciplinary measure; nor should it be limited unless the disciplinary offence relates to such contact.

128. Any form of isolation of juveniles is a measure that can compromise their physical and/or mental well-being and should therefore be applied only as a means of last resort.

In the CPT's view, solitary confinement as a disciplinary measure should only be imposed for very short periods and under no circumstances for more than three days. Whenever juveniles are subject to such a measure, they should be provided with socio-educational support and appropriate human contact. A member of the health-care staff should visit the juvenile immediately after placement and thereafter on a regular basis, at least once per day, and provide him/her with prompt medical assistance and treatment.⁴

129. As regards solitary confinement for protection or preventive purposes, the CPT recognises that such a measure may, in extremely rare cases, be required in order to protect particularly vulnerable juveniles or to prevent serious risks to the safety of others or the security of the prison, provided that absolutely no other solution can be found. Every such measure should be decided by a competent authority, based on a clear procedure specifying the nature of the confinement, its duration, the grounds on which it may be imposed and providing a regular review process, as well as the possibility for the juvenile concerned to appeal against the decision to an independent external authority. The juveniles concerned should always be provided with appropriate human contact and benefit from daily visits by a member of the health-care staff.

Likewise, the placement of a violent and/or agitated juvenile in a calming-down room should be a highly exceptional measure. Any such measure should not last for more than a few hours and should never be used as an informal punishment. Mechanical restraint should never be used in this context. Every placement of a juvenile in a calming-down room should be immediately brought to the attention of a doctor in order to allow him/her to look after the health-care needs of the juvenile concerned. In addition, every such placement should be recorded in a central register as well as in the juvenile's individual file.

h. information on rights

130. Upon admission, all juveniles should be given a copy of the rules governing everyday life in the institution and a written description of their rights and obligations in a language and manner they can understand. Juveniles should also be given information on how to lodge a complaint, including the contact details of the authorities competent to receive complaints, as well as the addresses of any services which provide legal assistance.

For those juveniles who are illiterate or who cannot understand the language in the written form, the above-mentioned information should be conveyed in a manner enabling full comprehension.

⁴ Note [by the Secretariat of the CPT; in 2017]:

In recent years, the CPT has observed an increasing trend at the international level to promote the abolition of solitary confinement as a disciplinary sanction in respect of juveniles. The Committee fully endorses this approach. Particular reference is made in this regard to Rule 45 (2) of the United Nations Standard Minimum Rules on the Treatment of Prisoners (Nelson Mandela Rules, 2015). For more details on this subject, see, for instance, the CPT's reports on the 2015 visit to France ([CPT/Inf\(2017\)7](#), paragraph 95), on the 2015 visit to Germany ([CPT/Inf\(2017\)13](#), paragraph 70) and on the 2016 visit to Latvia ([CPT/Inf\(2017\)16](#), paragraph 96).

i. complaints and inspection procedures

131. Effective complaints and inspection procedures are basic safeguards against ill-treatment in all places of detention, including detention centres for juveniles.

Juveniles (as well as their parents or legal representatives) should have avenues of complaint open to them within the establishments' administrative system and should be entitled to address complaints – on a confidential basis – to an independent authority. Complaints procedures should be simple, effective and child-friendly, particularly regarding the language used. Juveniles (as well as their parents or legal representatives) should be entitled to seek legal advice about complaints and to benefit from free legal assistance when the interests of justice so require.

132. The CPT also attaches particular importance to regular visits to all detention centres for juveniles by an independent body, such as a visiting committee, a judge, the children's Ombudsman or the National Preventive Mechanism (established under the Optional Protocol to the United Nations Convention against Torture – OPCAT) with authority to receive – and, if necessary, take action on – juveniles' complaints or complaints brought by their parents or legal representatives, to inspect the accommodation and facilities and to assess whether these establishments are operating in accordance with the requirements of national law and relevant international standards. Members of the inspection body should be proactive and enter into direct contact with juveniles, including by interviewing inmates in private.



Factsheets are issued under the authority of the Executive Secretary of the CPT.

They aim to present the CPT's standards on key issues. However, they do not claim to be exhaustive, in particular as regards the references to CPT country visit reports.

Women in prison

Introduction

- In fulfilling its mandate, the CPT endeavours to examine the treatment and conditions of all categories of incarcerated persons, including women. Women usually make up a very small minority of the overall prison population, albeit a growing one in some countries.¹ Importantly, they are characterised by having particular needs and vulnerabilities which differ from those of men. In combination with these differences, the fact that women are far fewer in number poses a variety of challenges for prison administrations, often resulting in less favourable treatment as compared to imprisoned men. This stems from the fact that prison rules and facilities have been developed for a prison population in which the male prisoner is considered to be the norm.
- Whether or not they are imprisoned, women must enjoy the fundamental right not to be discriminated against – directly or indirectly – on the grounds of their biological sex or gender. Substantive equality may require the adoption of special measures in order to address existing inequalities. As in the community, particular measures may be required by prison administrations in order to ensure that women enjoy equal rights with men. The growing recognition of the benefits of fully embracing substantive gender equality in all areas of policy-making should extend to the prevention of ill-treatment in prison. Greater efforts are therefore needed in order to ensure a gender-sensitive monitoring of prisons, attuned to the potential compounding of problems women face in prison.
- Women in prison constitute a group with distinctive needs, biological as well as gender-specific. Some female prisoners also have particular vulnerabilities due to their social situation and cultural roles. There is a risk that the specific needs of women will be disregarded, especially as they are a minority category of prisoners. It is important that a number of factors are taken into account when dealing with women prisoners, notably any physical, sexual or psychological form of violence, including domestic violence, they might have suffered before the imprisonment, a high level of mental health-care needs, a high level of drug or alcohol dependency, specific (for example, reproductive) health-care needs, caretaking responsibilities for their children and/or their families, and the high likelihood of post-release victimisation and abandonment by their families.²

¹ SPACE I 2015 reported a median proportion of 5.2% female inmates in the total prison population, up from 4.7% in 2013, notwithstanding a decrease in absolute numbers over the same period. In 2015 very few Council of Europe countries had overall female prison populations of more than 7%.

² [Ireland: 2014 visit, paragraph 86](#). See also, for example, Rules 41, 42 and 44 of the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the “Bangkok Rules”).

- Women should be held in an environment suited to their needs. However, the challenges involved in making separate provision for the small numbers of women in prison often result in their being held at a limited number of locations (on occasion, far from their homes and families, including dependent children³), in premises which were originally designed for (and may be shared by⁴) male prisoners.⁵
- This factsheet presents the main standards which the CPT has developed so far, as regards adult women in prison. It is not intended to cover the full range of standards applicable generally to all imprisoned persons, including women. Many of the issues addressed may also apply by analogy to other categories of detained persons, such as transgender or female juvenile prisoners.
- The CPT's standards in this area are evolving. They should not be seen in isolation from international instruments such as the European Convention on Human Rights and the relevant case-law of the European Court of Human Rights, the Council of Europe's European Prison Rules,⁶ the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the "Bangkok Rules")⁷ and the United Nations Standard Minimum Rules for the Treatment of Prisoners (the "Nelson Mandela Rules").⁸

1. Appropriate accommodation

- The CPT has recommended that prison administrations move away from large-capacity accommodation formats, in favour of smaller living units. Women are no exception: smaller living units allow for an approach which is better tailored to their particular needs.⁹
- In the CPT's experience, although violence among women in prison can certainly occur, violence against women by men (and, more particularly, sexual harassment, including verbal abuse with sexual connotations) is a much more common phenomenon. Women in prison should, therefore, as a matter of principle, be held in accommodation which is physically separate from that occupied by any men being held at the same establishment.¹⁰
- The CPT has encountered some specific situations in which prisons permit men and women to share an accommodation unit in pursuit of "normalcy", i.e. promoting conditions of living that approximate as far as possible those in the community, with prisoners taking responsibility for their own lives. Nevertheless, great care should be taken in establishing and following the criteria for assigning both male and female prisoners to such units, and in ensuring rigorous supervision of relations between the inmates concerned. Clearly, persons likely to abuse others, or who are particularly vulnerable to abuse, should not be placed in such a unit. Whatever the arrangements, it is essential that proactive measures be taken to prevent sexual exploitation where male and female prisoners come into contact in a prison environment.¹¹

³ [Ireland: 2014 visit, paragraph 110.](#)

⁴ See, for example, [Ukraine: 2000 visit, paragraph 77.](#)

⁵ Extract from the [10th General Report on the CPT's activities, paragraph 21.](#)

⁶ Recommendation (2006) 2 of the Committee of Ministers of the Council of Europe, adopted on 11 January 2006.

⁷ United Nations General Assembly Resolution 65/229, adopted on 21 December 2010.

⁸ United Nations General Assembly Resolution 70/175, annex, adopted on 17 December 2015.

⁹ [Georgia: 2003-2004 visits, paragraph 86](#); [Slovenia: 2006 visit, paragraphs 52 and 55](#); [United Kingdom \(Scotland\): 2012 visit, paragraph 44.](#)

¹⁰ [10th General Report on the CPT's activities, paragraph 24.](#)

¹¹ [Denmark: 2014 visit, paragraph 31.](#)

- The CPT has encountered numerous women in prison who, for a variety of reasons, are not provided with adequate accommodation. The small number of facilities for women are at times overcrowded. Yet early release measures envisaged in the event of overcrowding are not offered to women who have nowhere to go, for example, where no homeless shelter is available.¹² The lack of capacity¹³ or of appropriate specialised facilities for women,¹⁴ the requirement to separate detention categories (remand/sentenced; short/long sentences; preventive detention), or the fact that an establishment holds only one woman, may result in a woman being accommodated for extended periods in a detention unit subject to an unduly restrictive regime,¹⁵ or she may *de facto* be subjected to a regime akin to solitary confinement.¹⁶ In such cases, the authorities should seek to transfer the woman to appropriate accommodation; if such transfer is not possible, the authorities should make the necessary efforts to provide the woman with purposeful out-of-cell activities and appropriate human contact.¹⁷

2. Equal access to activities

- Women in prison should enjoy access to a comprehensive programme of meaningful activities (work, training, education and sports) on an equal footing with men. CPT visiting delegations find all too often that female prisoners are offered activities deemed “appropriate” for them (such as sewing or handicrafts), and are excluded from far more vocational training reserved for men. The small number of women may mean that it is not considered viable to establish a workshop exclusively for them. However, such a discriminatory approach can only serve to reinforce outmoded stereotypes of the social role of women.¹⁸
- Consideration might also be given to offering activities in prison – including access to outdoor exercise – in which both men and women may participate together,¹⁹ provided those involved consent to such arrangements and the persons are carefully selected and adequately supervised.²⁰

¹² [Ireland: 2014 visit, paragraphs 89 and 91.](#)

¹³ [Ibid., paragraph 97; United Kingdom \(Scotland\): 2012 visit, paragraph 44.](#)

¹⁴ [Spain: 2007 visit, paragraph 100; United Kingdom \(Scotland\): 2012 visit, paragraph 64.](#)

¹⁵ [Luxembourg: 2015 visit, paragraph 43.](#)

¹⁶ [Latvia: 2007 visit, paragraphs 70 and 72; Germany: 2013 visit, paragraphs 26 and 28.](#)

¹⁷ [Liechtenstein: 2016 visit, paragraph 36](#); on alleviating the effects of *de facto* solitary confinement through regime activities, see also part 2 below.

¹⁸ [Montenegro: 2013 visit, paragraph 53; the Netherlands \(Caribbean Part\): 2014 visit, paragraph 158; Switzerland: 2011 visit, paragraph 62.](#)

¹⁹ [United Kingdom \(Gibraltar\): 2014 visit, paragraph 32.](#)

²⁰ [10th General Report on the CPT's activities, paragraph 24; Czech Republic: 2006 visit, paragraph 68; Liechtenstein: 2016 visit, paragraph 36.](#)

3. Adequate hygiene and health care

Hygiene

- Women's specific hygiene needs should be adequately addressed. Ready access to sanitary and washing facilities, adequate quantities of essential hygiene products, such as sanitary towels and tampons, and safe disposal arrangements for blood-stained articles, are of particular importance. The failure to provide women in prison with such items can amount, in itself, to degrading treatment.²¹
- All prisoners should have access to toilets at all times. It is not acceptable, in the absence of in-cell sanitation, to fail to provide ready access to toilets due to low staffing levels. Ready access to sanitation is all the more important for women, given their special needs during menstrual periods.²² Positive differentiation in terms of additional access to washing facilities may also be necessary.²³

Health care

- The health care provided to persons deprived of their liberty should be of a standard equivalent to that enjoyed by the population in the outside community.²⁴ Ensuring that this principle of equivalence of care is respected as regards women in prison will require that health care is provided by medical practitioners and nurses who have specific training in women's health issues, including in gynaecology.²⁵
- 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 in prison.²⁶
- Adequate supplies of medication specifically required by women should be available in prison, allowing women who have begun a course of treatment before being incarcerated to continue it in prison.²⁷
- The contraceptive pill, for whatever reason it has been prescribed, should not be withheld from women wishing to take it.²⁸ A woman's right to bodily integrity is not diminished by virtue of her imprisonment. Where the abortion pill and/or other forms of abortion at later stages of a pregnancy are available to women in the outside community, they should be available under the same conditions to women in prison.²⁹
- The CPT has encountered many women prisoners who suffer from severe personality and behavioural disorders, and/or have a history of self-harming, abuse and abandonment. Where such prisoners are not eligible for transfer to a psychiatric hospital, a multifaceted approach should be adopted, involving clinical psychologists in the design of individual programmes, including psycho-social support, counselling and treatment. The absence of such programmes may bring about an increase in incidents of self-harm and an excessive use of prolonged segregation.³⁰

²¹ [10th General Report on the CPT's activities, paragraph 31](#); [Estonia: 2012 visit, paragraph 60](#).

²² [Bulgaria: 2006 visit, paragraph 85](#).

²³ [Ibid., paragraph 55](#).

²⁴ [10th General Report on the CPT's activities, paragraph 32](#).

²⁵ [Ibid., paragraph 32](#).

²⁶ [Ibid., paragraph 32](#).

²⁷ [Ibid., paragraph 33](#).

²⁸ [Ibid., paragraph 33](#).

²⁹ [Ibid., paragraph 32](#).

³⁰ [United Kingdom \(Scotland\): 2012 visit, paragraph 74](#).

4. Ante-natal, post-natal and child care

The detailed nature of this section should not be understood as an endorsement by the CPT of the imprisonment of pregnant women or mothers, with or without their young children. On the contrary, the Committee has, for instance, specifically recommended that alternatives to detention be imposed in respect of pregnant girls and juvenile mothers.³¹ This section outlines the minimum standards to be observed in the event that such non-custodial alternatives are not applied, and pregnant women or mothers – with or without their children – remain in prison.

- Every effort should be made to meet the specific dietary needs of pregnant women in prison who should be offered a high protein diet, rich in fresh fruit and vegetables.³²
- It is obvious that babies should not be born in prison, and the usual practice in Council of Europe member states seems to be to transfer pregnant women prisoners to outside hospitals.³³ 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 be qualified as inhuman and degrading treatment. Other means of meeting security needs can and should be found.³⁴
- Breastfeeding mothers should be provided with supplementary food according to existing guidelines for this category of women.³⁵
- Many women in prison are primary carers for children or others, whose welfare may be adversely affected by their imprisonment. 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.³⁶
- The governing principle in all cases should be the welfare and the best interests of the child. This implies in particular that any ante- and post-natal care provided in prison should be equivalent to that available in the outside community.³⁷
- In prison, the right to motherhood should not be infringed upon more than is required by security considerations and the safety of the child. Good contact between mother and child is in the interest of both of them. It can assist the rehabilitation of the prisoner and the development of her ability to assume responsibility for herself and her child. Mothers in prison should, therefore, be accommodated together with their babies after delivery and be encouraged to breastfeed (unless there are valid medical reasons to the contrary).³⁸ It could be considered as inhuman and degrading for a child to be removed immediately from a mother after birth. A mother and child should be allowed to stay together for at least a certain period of time.³⁹

³¹ [24th General Report on the CPT's activities, paragraph 117](#). See also Rule 64 of the “Bangkok Rules”.

³² [10th General Report on the CPT's activities, paragraph 26](#).

³³ [Ibid., paragraph 27](#).

³⁴ [France: 1991 visit, paragraph 90](#); [10th General Report on the CPT's activities, paragraph 27](#).

³⁵ [Romania: 2014 visit, paragraph 99](#).

³⁶ [10th General Report on the CPT's activities, paragraph 28](#).

³⁷ [Ibid., paragraph 29](#); [United Kingdom: 1990 visit, paragraph 124](#); [Spain: 1994 \(April\) visit: paragraph 136](#).

³⁸ [Russian Federation: 2001 visit, paragraph 89](#).

³⁹ [Luxembourg: 1993 visit, paragraph 44](#); see also [Czech Republic: 2014 visit, paragraph 82](#).

- For as long as the child remains in prison, the mother should be able to spend an adequate amount of time every day with her child;⁴⁰ they should be accommodated in a suitable, non-carceral setting,⁴¹ in terms of space, furnishings and access to cooking and washing facilities.⁴² Adequate heating/cooling and good access to fresh air and natural light are also very important.⁴³ The specific sanitary and hygiene needs of mothers should be adequately met, including access to good sanitary facilities, and provision of sanitary and hygiene products (nappies, soap, shampoo, washing powder, and clothing, for example) as needed, as well as food suitable for infants.⁴⁴ The equivalent of a nursery or kindergarten should also be provided, together with the support of staff specialised in post-natal care and paediatric nursing.⁴⁵
- There should also be an adequate interface and co-operation between staff employed at prison mother-and-child units and health-care and other prison staff who are in contact with mothers in prison.⁴⁶
- 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, access to nursery or kindergarten facilities could enable women prisoners to participate in work and other activities inside the prison to a greater extent than might otherwise be possible.⁴⁷
- The CPT has encountered situations in which a baby who accompanies his or her mother in prison is not admitted to visits. A mother in prison should be allowed to attend visits from family together with her accompanying baby. Prohibiting such visits is both inappropriate and unjustified. It would hinder the child's relationship with the father or other family members, and would not facilitate the child's eventual transition out of prison.⁴⁸
- Long-term arrangements, in particular the transfer of the child to the community, involving separation from his or her mother, should be determined in each individual case in the light of pedo-psychiatric and medico-social opinion;⁴⁹ after a child has been placed in care outside prison, there should be an on-going involvement of the mother in prison in the upbringing of the child.⁵⁰

5. Gender-sensitive prison management, staffing and training

- It is crucial that any prison accommodation unit holding women has female custodial staff in sufficient numbers at all times.⁵¹ In women's prisons or prison units, the preponderance of staff in contact with prisoners should be female.⁵²

⁴⁰ [Russian Federation: 2001 visit, paragraph 89.](#)

⁴¹ [Italy: 2016 visit, paragraph 73.](#)

⁴² [Ireland: 2014 visit, paragraph 102.](#)

⁴³ [Ibid., paragraph 102.](#)

⁴⁴ [Ibid., paragraph 102.](#)

⁴⁵ [3rd General Report on the CPT's activities, paragraph 66.](#)

⁴⁶ [Russian Federation: 2001 visit, paragraph 89.](#)

⁴⁷ [10th General Report of the CPT's activities, paragraph 29.](#)

⁴⁸ [Romania: 2014 visit, paragraph 100.](#)

⁴⁹ [3rd General Report on the CPT's activities, paragraph 66.](#)

⁵⁰ [Russian Federation: 2001 visit, paragraph 89.](#)

⁵¹ [Georgia: 2012 visit, paragraph 52.](#)

⁵² [Hungary: 2005 visit, paragraph 109.](#)

- Mixed-gender staffing is also 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 any place of detention, including but not limited to establishments for women. Mixed-gender staffing also allows for appropriate staff deployment when carrying out gender-sensitive tasks, such as searches.⁵³
- The CPT has often had to recommend that the management of prisons – including those accommodating women – deliver to custodial staff the clear message that physical ill-treatment, excessive use of force and verbal abuse, as well as other forms of disrespectful or provocative behaviour vis-à-vis prisoners, are not acceptable and will be dealt with severely. In particular, prison managers should demonstrate vigilance and use all means at their disposal to decrease tension.⁵⁴ In addition to investigating any complaints received from women prisoners, managers should be present on a regular basis in the detention areas holding women, and enter into direct contact with them.⁵⁵
- Utmost vigilance is required with regard to inappropriate behaviour and sexual relationships between staff and women in prison. Any allegations in this respect should be taken very seriously.⁵⁶
- In the CPT's view, the development of more specialised training for staff working with women in prison can be instrumental in addressing their specific needs.⁵⁷

6. Gender-sensitive personal searches

- Persons deprived of their liberty should only be searched by staff of the same sex. Any search which requires a prisoner to undress should be conducted out of the sight of custodial staff of the opposite sex.⁵⁸
- Strip searches are a very invasive and potentially degrading measure. When a strip search is considered necessary in a particular case, every reasonable effort should be made to minimise embarrassment. Detained persons who are searched should not normally be required to remove all their clothes at the same time; for example, a person should be allowed to remove clothing above the waist and put the clothes back on before removing further clothing.⁵⁹
- Intrusive searches of the genital area and body cavities carry a high risk of abuse and intimidation. Alternative screening methods, for example, through the use of ultrasound examinations, should be developed. Vaginal searches, in particular, should be conducted exceptionally, when absolutely necessary on the basis of an individual risk assessment,⁶⁰ and surrounded by appropriate safeguards.⁶¹ An intimate internal examination should be conducted by a medical practitioner only, it being understood that this medical practitioner should not be the doctor who would treat the patient with respect to health related issues. Examinations of this intimate nature should be conducted in a way that respects, to the greatest possible extent, the safety and dignity of the woman.⁶² Each examination should also be properly recorded in a special register.⁶³

⁵³ [Slovak Republic: 2013 visit, paragraph 99.](#)

⁵⁴ [Belgium: 2013 visit, paragraph 58;](#) [Georgia: 2007 visit, paragraph 35.](#)

⁵⁵ [Hungary: 2005 visit, paragraph 59.](#)

⁵⁶ [Ireland: 2014 visit, paragraph 93.](#)

⁵⁷ [Hungary: 2013 visit, paragraph 56.](#)

⁵⁸ [10th General Report on the CPT's activities, paragraph 23;](#) [the Netherlands: 2016 visit, paragraph 110.](#)

⁵⁹ [Italy: 2016 visit, paragraph 44.](#)

⁶⁰ [Greece: 2009 visit, paragraphs 91 and 92.](#)

⁶¹ The CPT has noted, e.g., that in both France and Greece such searches are subject to prior approval by a prosecutor (see [France: 2010 visit, paragraph 110;](#) [Greece: 2011 visit, paragraph 50](#)).

⁶² [Greece: 2009 visit, paragraphs 91 and 92.](#)

⁶³ [Ibid., paragraph 92.](#)

7. Contact with the outside world

Due to the limited number of establishments where women can serve their sentences, they are often located far away from their homes, which impacts negatively on contacts with their families and friends.⁶⁴

- In principle, all prisoners should be given the opportunity to maintain their relationships with their family and friends, and especially with their spouses or partners and children. The continuation of such relations can be of critical importance for all concerned, particularly in the context of prisoners' social rehabilitation. The guiding principle should be to promote contact with the outside world as often as possible.⁶⁵
- For example, open visits, allowing physical contact with friends and especially children and partners, should be the norm. A decision to impose closed visits should always be well-founded and reasoned, and based on an individual assessment of potential risks.⁶⁶ Women in prison should be offered the possibility of conjugal visits on an equal footing with men.⁶⁷ It is also important that visits with spouses or partners or other close relatives be made possible even where such persons are also imprisoned, be it in the same or another establishment.⁶⁸
- A high percentage of women in prison are mothers and the primary caretakers in the family. Separation from families and children can have a particularly detrimental effect on both the prisoners and their families, particularly their children.⁶⁹ In view of the critical importance of maintaining family relationships for women in prison, contact with their families, including their children, and their children's guardians and legal representatives, should be encouraged and facilitated by all reasonable means.⁷⁰ Visiting hours should, in particular, allow for contact with school-age children or working relatives who might accompany them.⁷¹ Women prisoners could be permitted to receive longer if less frequent visits, by accumulating visiting time allowances.⁷² Financial assistance might, for example, be provided to those women in prison who do not have the necessary means to maintain regular contact with their dependent children.⁷³

⁶⁴ [Sweden: 1991 visit, paragraphs 109 and 110](#); [Ireland: 2014 visit, paragraph 109](#).

⁶⁵ [Georgia: 2012 visit, paragraph 56](#).

⁶⁶ [Bosnia and Herzegovina: 2012 visit, paragraph 53](#); [Portugal: 2008 visit, paragraph 99](#); [Romania: 2014 visit, paragraph 103](#).

⁶⁷ [Slovenia: 2006 visit, paragraph 87](#).

⁶⁸ [France \(Reunion\): 2004 visit, paragraph 53](#); [Romania: 2014 visit, paragraph 105](#).

⁶⁹ [Ireland: 2014 visit, paragraph 109](#).

⁷⁰ [Ibid., paragraph 110](#). See also Rule 26 of the "Bangkok Rules".

⁷¹ [United Kingdom \(Gibraltar\): 2014 visit, paragraph 56](#).

⁷² [Armenia: 2015 visit, paragraph 107](#).

⁷³ [Ireland: 2014 visit, paragraph 110](#).



Women deprived of their liberty

*Extract from the 10th General Report of the CPT,
published in 2000*

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.

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.



Complaints mechanisms

*Extract from the 27th General Report of the CPT,
published in 2018*

For the purpose of this section, the term “complaints” refers to all formal complaints lodged by, or sometimes on behalf of, persons deprived of their liberty against decisions, actions or lack of official action on a variety of issues, in particular: staff misconduct, inadequate protection from other persons deprived of liberty who may cause them harm, poor material conditions, lack of activities or insufficient provision of health care. “Complaints” qualify as such irrespective of the seriousness of the issues complained of and whether or not they could amount to ill-treatment. As is the case in several countries, the term “complaints” may include actions aimed at challenging decisions taken by the relevant complaints bodies. The right to complain or to challenge these decisions is often referred to as an “appeal”. At the same time, legal action aimed at challenging decisions on deprivation of liberty/placement is not covered in this section.

Introduction

68. In the CPT’s view, complaints mechanisms constitute a fundamental safeguard against torture and inhuman or degrading treatment of persons deprived of their liberty by a public authority, regardless of the place or situation concerned (police stations, prisons, penal institutions for juveniles, immigration detention centres, psychiatric hospitals, social care homes, military detention facilities, forced return flights, etc.). Such mechanisms can not only allay tensions between persons deprived of their liberty and staff but also, by ensuring that complaints are taken seriously, contribute to building positive relationships.

69. However, on a number of occasions, the CPT has found that complaints mechanisms were either non-existent or displayed major shortcomings. These concerned in particular an insufficient legal basis, lack of, or inadequate, provision of information about complaints bodies or procedures, undue delays in initiating the examination/ investigation of complaints, lack of thoroughness in the examination/investigation of complaints, lack of independence or impartiality of the officials dealing with complaints, or insufficient protection against intimidation and reprisals.

During its visits, the Committee has encountered many persons deprived of their liberty who were unaware that they had the possibility to complain, who had found it very difficult to make complaints or who had refrained from making a complaint out of fear of reprisals. Others lacked trust that their complaints would be considered credible and/or be examined in a fair manner.

Type, capacity and nature of complaints mechanisms

70. It is crucially important that, in each place of deprivation of liberty, there is an effective **internal complaints mechanism**. This can help not only to identify and resolve problems as soon as they arise but can also assist the management and frontline staff to prevent abuses. Such a mechanism should be immediately accessible. Complaints may initially be made orally, and recorded by a member of staff on duty to whom the complaint is made, unless the complaint is about that member of staff (in which case it should be made confidentially to the senior member of staff on duty or the next available supervisor). Such a complaint should be responded to quickly, i.e. within a narrowly defined time span. If not resolved, the complaint should be formulated in writing by the complainant and taken to the next hierarchical level of staff who should also respond in writing. All decisions should indicate the subsequent steps to be taken if the complainant is not satisfied. More sensitive and/or serious complaints should be submitted, by a separate internal procedure, directly to the person in charge of the establishment. It is also important for managers to enter into direct contact with persons deprived of their liberty on a regular basis in order to provide them with opportunities to complain to them freely and confidentially. In the CPT's view, it is also advisable that external complaints bodies maintain oversight on internal complaints mechanisms.

71. Naturally, complainants should be able to turn to **external complaints bodies** directly. There is a variety of models in Council of Europe member states, ranging from general complaints bodies (e.g. national ombudsman institutions, administrative courts) to specialised agencies (e.g. independent police complaints bodies, prosecutors or judges specialised in penitentiary matters, prisons ombudsman institutions, special complaints boards or commissions).¹ Their powers may also vary considerably and their decisions may or may not be binding. In the context of its visits, the CPT has often found that complaints bodies which were not empowered to make binding decisions faced problems in having their recommendations or opinions followed up by the relevant authorities.

72. It should also be stressed that the **capacity** of complaints bodies to carry out their task depends largely on the allocation of adequate resources to their functioning, including human resources. Staff working for these bodies should receive appropriate training and be sufficient in number. Where necessary, they should be able to call on consultants or independent specialised support staff.

73. In the CPT's experience, it is inadvisable for **national preventive mechanisms or other similar monitoring bodies** also to deal directly with formal complaints. Where the same institution is designated to handle complaints and to monitor places of deprivation of liberty, both functions should preferably be kept separate and performed by clearly distinct entities, each with its own staff.

74. Complaints bodies should also be conceived as offering **supplementary protection**. They should not be considered as a substitute for criminal and other legal remedies that should be available to persons deprived of their liberty.

¹ An overview of prison complaints mechanisms is provided by Dirk Van Zyl Smit and Sonia Snacken, *Principles of European Prison Law and Policy. Penology and Human Rights*, New York: Oxford University Press 2008, pp. 308-310.

Basic principles

75. The proper handling of complaints made by persons deprived of their liberty, irrespective of the place or situation in which they are held and the legal framework applicable to their deprivation of liberty, requires the observance of certain basic principles: availability, accessibility, confidentiality/safety, effectiveness and traceability. The presentation of these principles is mainly based on views expressed by the CPT in its visit reports, in the light of its findings on the ground. It does not aim at establishing an exhaustive set of standards on all aspects of the operation of complaints mechanisms.²

1. Availability

76. It is widely recognised that every person deprived of his or her liberty should be **legally entitled to lodge formal complaints with bodies designated for this purpose**. It is crucial that both internal and external complaints mechanisms are genuinely available.

77. **Other interested parties** (such as close relatives and friends) should be able to act on behalf of the person concerned, as a rule with her or his consent and close co-operation.

78. Complaints which do not concern ill-treatment or other serious human rights violations may be dealt with through **alternative dispute resolution mechanisms** such as mediation, subject to the complainant's agreement.

2. Accessibility

79. Persons deprived of their liberty should promptly receive **information, both orally and in writing, about all avenues of complaint** (including appeal procedures), both internal and external to the places in which they are being held. They should also have a clear understanding of the modalities for exercising their right to lodge a complaint. For this purpose, appropriate information tools should be developed (e.g. posters in communal areas, a section on complaints procedures in the establishment's house rules, information leaflets issued by complaints bodies, information videos) and made available to them, in straightforward, user-friendly and non-legalistic formats.

80. All **information provided about avenues of complaint** – whether upon arrival in a place of deprivation of liberty or at a later stage – should also be available **in a language which persons deprived of their liberty understand**. In this context, written information on complaints bodies and procedures should be available in the languages most commonly spoken.

81. In order to facilitate access to external complaints mechanisms, it would be highly desirable that **appropriate standard complaints forms** be made available. Nevertheless, the fact that a complaint has been lodged on a non-standard form should not prevent it from being examined.

82. As regards **indigent persons**, measures should be taken to provide them with **writing material, envelopes and postage free of charge**.

83. Specific regard should be had to the age, gender, state of health, any disability, or any circumstances which render certain persons deprived of their liberty particularly vulnerable.

² For more details about police complaints systems in particular, see also the Opinion of the Commissioner for Human Rights of the Council of Europe concerning independent and effective determination of complaints against the police ([CommDH\(2009\)4](#)).

This implies that special measures should be taken to make complaints mechanisms more accessible for persons with particular needs, such as **juveniles**,³ **persons with psychosocial and/or learning disabilities**,⁴ or persons having problems with understanding, speaking, reading or writing the official language(s) of the country concerned, including foreigners.

It should also be stressed that access to the complaints bodies should not be contingent on **legal competence**. For instance, the fact that a person benefits from legal representation should not affect his or her own right to make complaints. Like any other complainant, he or she should be heard in person. It is also important that, whenever necessary, **appropriate support** is provided. In particular, it is advisable that juveniles, persons with disabilities, including psychosocial and/or learning disabilities, or foreigners deprived of their liberty have the possibility of being assisted by a person or body that can help them understand and exercise their rights. In addition, it is important that the professionals concerned receive **specialised training** in the handling of such complaints.

3. Confidentiality / safety

84. **Direct and confidential access** to complaints bodies should be secured (e.g. by installing locked complaint boxes accessible to complainants in appropriate locations, to be opened only by persons specially designated to ensure the confidentiality of the complaints). Staff who have persons deprived of their liberty directly in their charge should not be in a position to filter complaints.

85. The necessary efforts should also be made to ensure that complainants remain **free from intimidation and reprisals**. In this connection, staff at all levels should receive the clear message that any kind of threats, attempts to prevent complaints from reaching the relevant complaints bodies, or intimidatory or retaliatory action will not be tolerated and will be the subject of appropriate sanctions.

4. Effectiveness

86. Effective complaints mechanisms should process complaints **promptly, thoroughly and expeditiously**. They should also contribute to preventing further rights violations and, where appropriate, may offer compensation.

Complaints that are upheld should lead to any rights violations identified being **remedied, responsibility** for any such violations being determined and, if necessary, a **suitable sanction** imposed upon those responsible. When required, **legal assistance** should be provided to complainants. Complaints bodies should also be entitled to initiate **ex officio proceedings** (i.e. without a formal complaint being lodged) whenever there are indications of serious rights violations. In this context, the adequacy of the investigations into complaints (or any other information indicative) of torture and other forms of ill-treatment has been the subject of an extensive case-law of the European Court of Human Rights and has been dealt with at length in the CPT's 14th General Report.

87. In the CPT's experience, the **perceived fairness of a complaints system** is also crucial to its effectiveness in combating impunity and promoting a safe environment in the institutions concerned. The system should inspire public confidence and its operation should not dissuade the persons in question from making complaints. In this context, **independent** complaints bodies

³ See also paragraph 131 of the CPT's [24th General Report](#) and [Recommendation CM/Rec \(2008\) 11](#) of the Committee of Ministers of the Council of Europe on the European Rules for juvenile offenders subject to sanctions or measures.

⁴ See, in this connection, paragraph 76 of the judgment of 19 February 2015 of the European Court of Human Rights in the case of [M. S. v. Croatia \(No. 2\)](#), which became final on 19 May 2015.

should be unconnected and separate from the agencies responsible for persons deprived of their liberty. It is essential that they are, and are seen to be, independent. In several countries, the CPT reached the conclusion that it was necessary to set up an independent agency specialising in the investigation of complaints against police or prison officers, which is demonstrably separate from the authorities having the complainants under their responsibility and from the prosecution services.

88. Whenever a **complaint is considered inadmissible**, complainants should be informed of the reasons by the competent complaints body and, where applicable, provided with further options for addressing their concerns.

89. Regardless of the outcome of the complaint, it is also important to ensure that complainants are not subjected to **any financial or legal sanctions**.

5. Traceability

90. Each establishment concerned should keep a **record of complaints** in a specific register, giving due consideration to the above-mentioned principles of confidentiality and safety. Such a register should include the names of the complainants, the type and the subject of complaints, the outcome of the complaints procedure and of any appeal procedure, follow-up action taken to remedy the situation complained of and any compensation provided to the complainants. These records should serve as a management tool; for instance, it may be the case that many of the complaints relate to the same members of staff, or that certain categories of persons deprived of their liberty hardly ever lodge formal complaints.

91. In each area of competence (police, prisons, immigration detention, psychiatric and social care, etc.), a national **system for compiling statistics** on complaints, relevant proceedings and outcomes should be established. If the data are correctly gathered and analysed, it becomes possible to identify trends and develop future policies aimed at improving the functioning of the complaints mechanisms and the accountability of the authorities entrusted with the supervision and care of persons deprived of their liberty. In this context, the absence of complaints should not be necessarily considered as positive. On the contrary, in the CPT's experience, this is often indicative of an unsafe environment in the establishments concerned or of a lack of trust in the complaints system.



Combating impunity

*Extract from the 14th General Report of the CPT,
published in 2004*

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.



Documenting and reporting medical evidence of ill-treatment

*Extract from the 23rd General Report of the CPT,
published in 2013*

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 authorities¹. 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.

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

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

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 whole². 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.

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,

² 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 or Degrading Treatment or Punishment).

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 doctor³. 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.

³ 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.



Factsheets are issued under the authority of the Executive Secretary of the CPT.

They aim to present the CPT's standards on key issues. However, they do not claim to be exhaustive, in particular as regards the references to CPT country visit reports.

Transport of detainees

Introduction

- Whatever the grounds for transferring persons deprived of their liberty from a place of detention to another place (e.g. from a police station to a prison, from a prison to another prison, a courthouse or a hospital, or from a border point of entry to an immigration detention centre), the CPT considers that transportation should always be carried out in a humane, secure and safe manner.
- On a number of occasions, CPT delegations have inspected vehicles intended for the transport of detainees, such as road and railway vehicles.¹ They frequently found that conditions were substandard or that basic safety requirements were not being met. The Committee has also come across practices which called for criticism (e.g. overreliance on means of restraint; unnecessarily long periods of confinement in prisoner transport vehicles).
- In this context, the CPT has observed positive change in light of its recommendations (e.g. decisions to put an end to the use of vehicles unsuitable for the transportation of detainees; acquisition of new fleets of vehicles allowing transportation of detainees in conditions advocated by the Committee; building of holding cells in courthouses in order to avoid prolonged detention in prisoner transport vans).
- This factsheet presents the CPT's main standards on this subject which have been developed over several decades. It covers the transport of persons in police custody, prisoners and immigration detainees, whenever transportation is organised by law enforcement, prison or other criminal justice services, or private contractors. It does not cover transportation carried out by health-care services, and it is not intended to cover transportation in the context of transfers of prisoners outside the national territory or return operations by air or other means.
- Finally, the standards presented in this factsheet should not be seen in isolation from international instruments such as the European Convention on Human Rights and the relevant case-law of the European Court of Human Rights, the Council of Europe's European Prison Rules² and European Rules for juvenile offenders subject to sanctions or measures³, or the United Nations Standard Minimum Rules for the Treatment of Prisoners ("the Nelson Mandela Rules"⁴).

¹ More rarely, CPT delegations have inspected vessels/boats and aircrafts used for domestic transfers of prisoners.

² Recommendation Rec(2006)2 of the Committee of Ministers adopted on 11 January 2006.

³ Recommendation Rec(2008)11 of the Committee of Ministers adopted on 5 November 2008.

⁴ United Nations General Assembly Resolution 70/175 adopted on 17 December 2015.

1. Material conditions

- When vehicles are equipped with secure compartments, **individual cubicles** measuring less than 0.6 m² should not be used for transporting a person, no matter how short the duration. Individual cubicles measuring some 0.6 m² can be considered as acceptable for short journeys/distances; however, cubicles used for longer journeys/distances should be much larger.⁵
- **Compartments or cubicles intended to transport more than one detainee** for short journeys/distances should offer no less than 0.4 m² of space per person, and preferably more. As regards longer journeys/distances, compartments should offer at least 0.6 m² of personal space.⁶
- Compartments or cubicles used for transporting detainees should be of a **reasonable height**.⁷
- All transport vehicles should be **clean**,⁸ sufficiently **lit** and **ventilated**, and **heated** appropriately.⁹
- Transport vehicles should be equipped with suitable means of **rest** (such as appropriate benches or seats).¹⁰
- For **overnight transport by train**, compartments should be equipped with **beds or sleeping platforms**, and inmates should be provided with **mattresses and sheets/blankets** during the journey.¹¹
- The necessary arrangements should be made to provide detainees with **drinking water** as required and, for long journeys/distances, with **food** at appropriate intervals.¹²
- In the context of long journeys, arrangements should be made to allow detainees to have access to **sanitary facilities** or to **satisfy the needs of nature** in conditions offering sufficient privacy, hygiene and dignity. When travelling by road, this implies the organisation of regular stops.¹³
- Detainees brought before a court following a long journey should be placed under conditions which guarantee respect for their dignity. In particular, they should be offered appropriate **rest** and the opportunity to **wash** and **change their clothes**.¹⁴

⁵ [Ukraine: Visit 2009, § 44](#), [Lithuania: Visit 2008, § 31](#), [Azerbaijan: Visit 2006, § 41](#), [Lithuania: Visit 2004, §§ 44-45](#), [Azerbaijan: Visit 2002, § 152](#), [United Kingdom: Visit 2001, § 30](#), [Ukraine: Visit 2000, § 129](#), [Lithuania: Visit 2000, § 118](#), [Ukraine: Visit 1998, § 189](#)

⁶ [Greece: Visit 2005, § 134](#), [Slovenia: Visit 2001, § 95](#), [Ukraine: Visit 2000, § 131](#), [Lithuania: Visit 2000, § 118](#)

⁷ [Moldova: Visit 2007, §§ 73 and 76](#)

⁸ [Lithuania: Visit 2000, § 111](#)

⁹ [Slovenia: Visit 2012, § 72](#), [Azerbaijan: Visit 2006, § 41](#), [Ireland: Visit 2006, § 101](#), [Romania: Visit 2006, § 151](#), [Greece: Visit 2005, § 134](#), [Spain: Visit 2003, § 34](#), [Slovenia: Visit 2001, § 95](#), [Ukraine: Visit 1998, § 189](#), [Bulgaria: Visit 1995, §§ 176-177](#)

¹⁰ [Azerbaijan: Visit 2006, § 41](#)

¹¹ [Azerbaijan: Visit 2002, § 154](#)

¹² [Greece: Visit 2013, § 150](#), [Greece: Visit 2009, § 153](#), [Ukraine: Visit 2000, § 131](#)

¹³ [Greece: Visit 2013, § 150](#), [Greece: Visit 2009, § 153](#), [United Kingdom: Visit 2005 \(November\), § 23](#), [Lithuania: Visit 2000, § 118](#)

¹⁴ [Lithuania: Visit 2000, §§ 117-118](#)

2. Safety measures

- Detained persons should be transported in vehicles **suitably designed for that purpose**, taking due account of all relevant safety requirements in order to protect detainees.¹⁵
- The number of detainees transported should not exceed the **capacity** of the vehicles used for that purpose.¹⁶
- Detainees should not have to stand up during a journey due to a **lack of seating space**.¹⁷
- Detainees should not **remain inside the escort van during a boat crossing**, if this contravenes the safety rules of the ferry authorities.¹⁸
- All vehicles which are used for the transportation of detained persons should be equipped with **appropriate safety devices** (such as safety belts).¹⁹
- Detainees who are being transferred should **always be escorted**, however long the journey and whichever mode of transport is used.²⁰ Transport vehicles should be equipped with means to enable detainees to **communicate with escort staff**.²¹
- Doors of secure cubicles/compartments should be equipped with a **device that automatically (and/or rapidly) unlocks the doors** in the event of an emergency.²²
- Steps should be taken to **prevent violence, intimidation or theft** being perpetrated by detainees against their fellow passengers.²³

3. Security measures

- The application of **handcuffs** and/or **body belts** to detainees during transportation should only be resorted to when the risk assessment in an individual case clearly warrants it. When the use of such means is considered absolutely necessary, it should be done in such a way as to minimise any risk of injury to the detained person.²⁴
- Such means should not be used when detainees are **locked inside secure cubicles or compartments**.²⁵
- Given the potential for discomfort to the person concerned and the risk of injury in the case of accident, the practice of **handcuffing detainees behind their back** during transportation should be avoided.²⁶
- **Stun belts** should never be used; alternative means of restraint can and must be found in the context of movements of detainees.²⁷

¹⁵ [Lithuania: Visit 2000, §§ 117 and 118](#)

¹⁶ [Romania: Visit 2006, § 151](#)

¹⁷ [Greece: Visit 2013, § 150](#)

¹⁸ [Malta: Visit 2015, § 32](#)

¹⁹ [Netherlands: Visit 2016, § 29](#), [United Kingdom: Visit 2012 \(Scotland\), § 88](#), [Andorra: Visit 2011, § 25](#), [Poland: Visit 2009, § 80](#), [Slovenia: Visit 2001, § 95](#)

²⁰ [Switzerland: Visit 1996, §§ 116-117](#)

²¹ [Serbia: Visit 2015, § 53](#), [United Kingdom: Visit 2012 \(Scotland\), § 88](#), [Slovenia: Visit 2001, § 95](#)

²² [Lithuania: Visit 2000, § 115](#), [Bulgaria: Visit 1995, § 176-177](#), [Spain: Visit 1994 \(April\), § 27](#)

²³ [Lithuania: Visit 2004, §§ 44-45](#)

²⁴ [Serbia: Visit 2015, § 53](#), [Ireland: Visit 2014, § 85](#), [Slovenia: Visit 2012, § 73](#)

²⁵ [Ireland: Visit 2006, § 101](#), [United Kingdom: Visit 2005 \(November\), § 23](#), [Hungary: Visit 2005, § 126](#)

²⁶ [Serbia: Visit 2015, § 53](#)

²⁷ [Hungary: Visit 2009, § 120](#)

- The practice of using **devices on detainees to block their vision** (for example, by means of glasses blacking out their vision or blindfolding them) while they are being transported from one location to another should be abolished.²⁸

4. Health issues

- The **means of transport** employed for taking detainees to and from a hospital should **take into account their medical condition**.²⁹
- The **confidentiality of medical data** should be respected during transfers of detainees.³⁰
- Any practice of segregating **HIV-positive detainees** should be discontinued.³¹

²⁸ [Belgium: Visit 2017, §§ 19-20](#), [Netherlands \(Curaçao\): Visit 2014, § 125](#), [Belgium: Visit 2013, § 38](#)

²⁹ [Spain: Visit 1991, § 150](#)

³⁰ [Lithuania: Visit 2004, § 46](#)

³¹ [Lithuania: Visit 2004, § 46](#)