# 26 Europe: Monitoring Bodies for the Prevention of Ill Treatment

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## Introduction

The absolute prohibition of torture, inhuman, or degrading treatment or punishment is part of many international treaties, in particular, the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which has been ratified by most countries in the world, including the United States and all European countries (United Nations, 1984). Nonetheless, prisons are not free from torture. Venters' book on the detention conditions at New York City's Rikers Island is a compelling testimony about people tortured and even killed while under the authority of the State (Wolff & Greifinger, 2020).

Independent monitoring bodies play an important role in preventing such events by regular monitoring of respect for human rights in detention. On a global level, the Optional Protocol to the Convention against Torture (OPCAT) sets the frame for national preventive mechanisms (United Nations, 2002). The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) liaises closely with national preventive mechanisms of each country it visits. By the end of 2019, 90 nations/states had ratified OPCAT.

This chapter presents the working methods of one of the most effective correctional monitoring bodies—the CPT—with a focus on health care.

## The CPT

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment of 1987 calls for a preventive monitoring system in all prisons and establishments in which people are held against their will (Council of Europe, 1989). The CPT was created in November 1989, in accordance with Article 1 of the European Torture Convention; it works as a non-judicial mechanism (Council of Europe, n.d.). It complements the judicial control carried out by the European Court of

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Human Rights, which has jurisdiction over crimes of torture committed in Europe by virtue of the 1950 European Convention for the Protection of Human Rights and Fundamental Freedoms prohibiting such practices (Council of Europe 1950).

The CPT carries out its investigations by means of periodic or ad hoc visits. Its mandate extends to any place where individuals are held, whether by administrative, judicial, or military authorities. The committee has unrestricted access to these facilities at any time, has access to all documents, and the right to speak in private with all detained persons in the 47 countries of the Council of Europe.

## Confidentiality and Cooperation

Two working principles determine the work of the CPT: confidentiality and cooperation. *Confidentiality* is achieved by reporting back to the government of the country visited. No information is disclosed without the respective government's authorization. The government decides the moment of publication of the report, along with its response. Most countries accept that the CPT publishes the visit reports on its website. *Cooperation* means regular and constructive interaction with the respective government. After each visit, recommendations are made, and former recommendations and responses are followed up. In the very seldom case of non-cooperation of a country, the CPT can make a public statement (Art. 10.2 of the Convention). By 2020, 455 visits were carried out and only nine public statements were released (Council of Europe, n.d.).

Every member country of the Council of Europe is visited periodically, on average every 5 years. Further ad hoc visits are made on an irregular basis, depending on the issues related to the CPT's mandate. Relevant issues can be brought to the CPT's attention by individuals, human rights organizations, nongovernmental organizations (NGOs), media, or other agencies of the Council of Europe. The CPT's secretariat gathers the information and discusses adequate action with the members to prioritize future visits. Member states are notified 1 year in advance of periodic visits. Ad hoc visits can be organized on short notice. Two weeks before entering a country, its government is notified to prepare relevant credentials, which are needed to enter all facilities without delay. The CPT has the liberty to conduct surprise visits. However, some (but never all) targeted detention facilities are notified and relevant documents requested, for example, the plan of the institution, a list of the detained persons with date of arrival and release, as well as type of offence, registries related to the use of force and security measures. Police stations are visited without prior notice and the choice of the police detention facility depends on the information on the spot, frequently through interviews in pretrial settings with recently arrived detainees. Figure 26.1 presents the organization of CPT's visits and its cooperation with member states.

## Role of the Delegation Physicians

Each visiting delegation has at least one physician who evaluates the prison healthcare unit and assesses the medical files and any visible injuries of detained people who allege ill treatment. One cannot overestimate the importance of medical findings, which is frequently the only proof of injuries and may therefore support allegations of ill treatment. Besides medical "traces," the delegation may also watch video recordings, speak with prison officers and administrative staff, interview the prosecutor in charge of a case, and analyze disciplinary records, administrative files and registries related to the use of force.

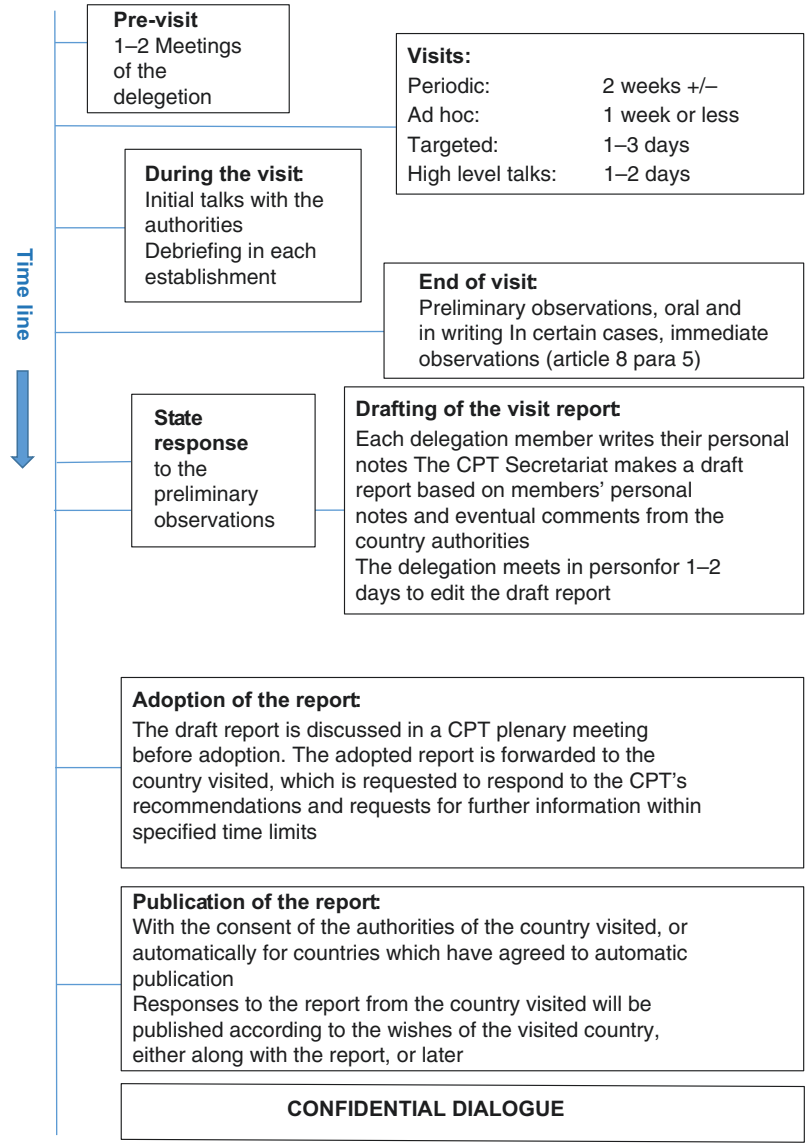


**Fig. 26.1** Organization of CPT's visits and cooperation with member states. (Used with permission from M. Georg Høyer)

## Prevention of Ill Treatment

The CPT has acknowledged that many other aspects related to health care are relevant to its core activities. In its substantive section of the third General Report (Council of Europe, 1993), the CPT set out seven guiding principles for health care in detention:

- Access to a physician
- Equivalence of care (with special attention to the higher morbidity and the greater healthcare needs of detained people)
- Patient consent and confidentiality
- Preventive health care (vaccination, substance use disorders, opioid agonist therapy, access to condoms, needle and syringe exchange, etc.)

- Protection of vulnerable groups: older people, women, disabled persons, lesbian, gay, bisexual, and transgender (LGBT) individuals, juveniles, ethnic minorities, or undocumented foreign nationals
- Professional independence
- Professional competence

Since its creation, the CPT has emphasized the important role of healthcare services, which should combat ill treatment through the methodical recording of injuries and the provision of information to the relevant authorities as recommended by the Istanbul Protocol (United Nations, 2004). The accurate and timely documenting and reporting of such medical evidence greatly facilitates the investigation of cases of possible ill treatment.

## Health-Related Problems

The spectrum of health problems in detention centers is wide and their prevalence is generally greater behind bars than in the general population. The main challenges to health care in prison are substance use, mental illness, and communicable diseases, alongside several other problems such as violence, self-harm, and suicide (Fazel & Baillargeon, 2011). The quality and accessibility of healthcare services in detention centers are therefore of particular importance for the overall quality of life of detained people. This is all the more pertinent since they usually do not have access to a physician of their choice but are fully dependent on the healthcare services provided.

Inadequate provision of health care in detention can rapidly lead to situations falling within the scope of the term "inhuman or degrading treatment" under Article 3 of the European Convention on Human Rights (Council of Europe, 2018). The European Court of Human Rights has based more than 800 judgments on the CPT's findings. The court has determined that the authorities have an obligation to: ensure that a prisoner's state of health is regularly and systematically supervised; maintain a comprehensive record of a detained person's health condition and the treatment received; ensure that diagnosis and care are prompt and accurate; and (where necessary) develop a comprehensive therapeutic strategy.

The CPT has emphasized that prisoners are entitled to the same level of medical care as persons living in the community at large. It attaches to the principle of equivalence of care. This principle is also recognized by many other organizations and is reflected in the legislation and policies of several states. In light of the disproportionately high level of health problems amongst detained people, a growing body of opinion questions whether the aim should instead ensure the equivalence of objectives or results. In many cases, this would involve a higher standard of care for people in detention. Proponents of the principle of "equity of care" argue that, quite apart from the legal and ethical considerations, it is often the only real way to achieve larger public health objectives.

## Assessment of a Medical Service in Prison

The delegation physician assesses the quality of the healthcare service using a checklist (Box 26.1). This checklist is not exhaustive and may be adapted according the specific aim of the visit.

**Box 26.1 A CPT Physician's Inspection Checklist for Assessing Medical Services in a Detention Center**

I. ***Initial Interview with the Doctor-in-Charge***

A. *Medical/Nursing Team*

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

B. *Outside Medical Support*

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

C. *Medical Care Work*

1. *Volume*

- Transmission of healthcare information/continuity of care
- Newly arrived detained persons: 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, eventually by whom?)
- Waiting times by type of healthcare service
- Emergencies: procedure during/outside working hours; medical staff on call in detention: who?
- Care provided free of charge/copayment by detained persons? health insurance?
- Medical service also responsible for staff/families working in the detention center?

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 and screening for breast and gynecological cancer)
- Groups with special needs: for example, disabled/LGBT/elderly
- Mental disorders (e.g., psychotic disorders, consent to treatment, use of seclusion, and restraint)
- List of deaths: causes, autopsies conducted?

3. *Prevention, Addiction, and Harm Reduction*

- Suicide prevention, and self-harming
- Transmissible diseases: (e.g., Hepatitis, HIV, TB, syphilis, skin infections; screening, counseling, 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/use disorder upon entry?
- Drug testing (type of tests used, reference lab for supervision? and who tests?)
- Is opioid agonist treatment offered to detained persons and under what conditions (free of charge? exclusion of undocumented migrants? confidentiality?)
- Are needles and/or syringes found during cell searches? Frequency of needle- and syringe-related problems? Needle and syringe exchange programs in the community/in prison?

4. *Medicines*

- Sufficient quantity and range/free of charge/expiry dates/distribution/who and how?
- Inappropriate use of prescription drugs, for example, benzodiazepines?
- Proportion of detained persons who receive medicines (percentage of psychoactive drugs, percentage of benzodiazepines)
- Distribution of medicines (how? who? confidentiality, supervision of intake)

D. *Non-care Work/Expertise*

1. *Ill Treatment*

- Number/type of cases (e.g., police, detention officers, and 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 healthcare staff in decision-making/fit-for-punishment/restraint certificates?
- Medical supervision of disciplinary isolation measures? Frequency?

3. *Miscellaneous*

- Certificates indicating persons unfit for detention?
- Hunger strikes (administrative instructions? written procedures?)
- Biomedical research: staff/detained persons 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 by public health authorities
- External inspection of healthcare 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 detained persons/detention officers
- Confidentiality of medical 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, and laboratory)/general hygiene
- Checking of apparatus/equipment [defibrillator, electrocardiogram (ECG), sphygmomanometer, sterilizer, 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
  - detained persons' complaints (supported by files)
  - the observations of the other members of the delegation

## Conclusion

The quality of health care in places of deprivation of liberty is important for the prevention of inhuman and degrading treatment. The CPT thoroughly assesses all elements related to potential violation of human rights in these places.

The state has the responsibility to ensure access to health care that is equivalent to care delivered in the outside community. The European Court of Human Rights has repeatedly qualified non-access to essential medical treatment as inhuman and degrading treatment. In this regard, as an example, Germany has been found guilty because it did not allow a person to receive opioid agonist treatment in prison (Junod et al., 2018).

All items assessed by the CPT's medical members are relevant for the provision of health care and therefore relevant for the respect of human rights in places of deprivation of liberty. In particular, the timely screening for healthcare problems at entry and the detection and reporting of injuries are key elements for the prevention of ill treatment. Healthcare professionals must be trained to identify, record, and report injuries in places of deprivation of liberty (Pont et al., 2015).

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