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

3rd General Report on the CPT's activities

covering the period 1 January to 31 December 1992

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Preface

The salient aspects of the CPT's activities during 1992 are summarised in this report. The report contains little concerning the procedural and organisational framework for the conduct of visits. The CPT's Rules of Procedure have not been amended since September 1991. More generally, the working methods established by the Committee at the outset of its activities have proved their worth. The detailed description of these matters set out in the 1st General Report (cf. CPT (91) 3) remains valid.

In its 2nd General Report (cf. CPT/Inf (92) 3), the CPT made reference to some issues relating to police custody of criminal suspects and imprisonment to which it pays attention when carrying out visits. In the present report, the Committee explores in greater depth the question of health care services in prisons. As was the case concerning the CPT's earlier remarks on police custody and imprisonment, the Committee would welcome comments on this "substantive" section of the General Report.

I. ACTIVITIES IN 1992

a. Visits

1. The CPT carried out visits to seven countries during 1992: in chronological order, to Portugal (19 to 27 January 1992), Italy (15 to 27 March 1992), San Marino (25 to 27 March 1992), Finland (10 to 20 May 1992), the Netherlands (30 August to 7 September 1992), Cyprus (2 to 9 November 1992), and Turkey (22 November to 4 December 1992).

The visits were all of a periodic nature. The CPT had planned to make an eighth periodic visit, to Luxembourg, in the course of 1992. However, in the light of workload difficulties within the Committee's Secretariat, it was decided to postpone the visit to 1993¹.

2. The places of detention visited by CPT delegations in 1992 are set out in Appendix 3. Visits to police stations and civil prisons continued to make up the staple diet of the Committee, though an increasing number of psychiatric establishments were visited. A significant extension of the CPT's activities to other types of places where persons are deprived of their liberty can be expected once the Committee has completed its "first round" of periodic visits to all Parties to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter "the Convention").

3. On the whole, visiting delegations received a satisfactory degree of cooperation from both authorities at national (ministerial) level and the authorities in charge of the places visited.

As during 1991, there were some isolated examples of a delegation's access to a place which it wished to visit being delayed (for more than two hours on one occasion). The problem concerned almost exclusively establishments of forces responsible for police functions.

The CPT recognises that at the start of a visit to any place of detention, a short period may be required to check the identity of the members of the visiting delegation. However, this should be a question of minutes, not hours. In order to counter difficulties concerning the implementation in practice of the CPT's right of unlimited access to places of detention, the practice is developing of national authorities providing delegation members with credentials, in addition to the identity papers issued by the Council of Europe.

¹ The visit to Luxembourg took place from 17 to 25 January 1993.

4. In the course of two visits, the activities of delegations were hindered somewhat by prosecuting/judicial authorities.

In one case, a public prosecutor refused to authorise a delegation to interview several persons in police custody, in clear breach of Article 8, paragraph 3, of the Convention. The public prosecutor withheld her authorisation on the grounds that she had received no information concerning the delegation's visit. The matter was subsequently clarified and the delegation met the persons in question on the following day.

In the other case, the delegation's request to have access to a detained person's file was refused by the judge concerned, with the result that the delegation did not have access to the information necessary for it to carry out its task (cf. Article 8.2. d. of the Convention).

5. Reference should also be made to difficulties encountered in two countries by visiting delegations, concerning access to medical files of detainees. In one case, access to such files held by a prison's health service was initially denied; in the other case, it took some considerable time to gain access to medical records of detainees prepared by a forensic medical service.

6. The CPT has no reason to believe that these cases were due to anything other than inadequate knowledge about the CPT on the part of the authorities in question. Nevertheless, they illustrate how important it is for Parties to the Convention to make detailed information on the CPT's terms of reference and the obligations of Parties vis-à-vis the Committee available to all authorities concerned, including the prosecuting and judicial authorities as well as relevant health authorities.

b. Meetings

7. The CPT met in plenary session on four occasions during 1992. Visit reports were adopted on the periodic visits in 1991 to France, Germany, Sweden and Switzerland and to Italy and Portugal in 1992². Further, in the context of the Committee's ongoing dialogue with States which have been the subject of a visit, it forwarded observations to the Maltese, Swedish and United Kingdom authorities on the interim or follow-up reports presented by those countries in response to the Committee's own visit reports³.

² At the plenary session held in February 1993, the CPT adopted its reports on the periodic visits carried out to Finland and San Marino in 1992, and at the plenary session of May 1993, its reports on the periodic visits to Cyprus and the Netherlands in 1992.

³ To date, such observations have been forwarded to the Austrian and French authorities during 1993.

8. In addition to plenary sessions, there were numerous meetings of visiting delegations throughout the year, both on the occasion, and independently, of plenary sessions. Such meetings concern the pre-visit (preparation of the visit) or post-visit (discussion of the draft visit report; preparation of observations on the Party's interim or follow-up report) stages. Indeed, for many Committee members (in particular heads of delegation), their tasks in visiting delegations are just as time-consuming - if not more so - as their work at plenary session level.

c. Public statement on Turkey

9. On 15 December 1992 the CPT had recourse to the power granted to it by Article 10, paragraph 2, of the Convention and adopted a public statement on Turkey (cf. Appendix 4). The statement was issued on 21 December 1992; an embargoed copy was circulated to Permanent Representatives of member States of the Council of Europe on 18 December 1992. This was the first occasion on which the provisions of Article 10, paragraph 2, had been resorted to by the Committee.

10. The CPT had decided at its 14th meeting (28 September to 2 October 1992) to set in motion the procedure under Article 10, paragraph 2, following a review of the action taken by the Turkish authorities upon the recommendations made by the Committee in the reports on its ad hoc visits to Turkey in 1990 and 1991.

The Turkish authorities were informed of the conclusion reached by the CPT and, in accordance with the Convention, invited to make known their views. Those views were received on 16 November 1992. The CPT examined the views presented by the Turkish authorities at its 15th meeting, held from 14 to 17 December 1992; on the same occasion, the Committee considered the facts found by the delegation which carried out the periodic visit to Turkey in November/December 1992. By the required majority of two-thirds of its members, the Committee decided to make a public statement.

11. In its statement the CPT concludes, in the light of all the information at its disposal, that the practice of torture and other forms of severe ill-treatment of **persons in police custody** remains widespread in Turkey and that such methods are applied to both ordinary criminal suspects and persons held under anti-terrorism provisions.

The CPT goes on to set out the different types of action which it considers necessary to deal with this problem.

12. The CPT wishes to reiterate that the public statement was made in a constructive spirit. It is hoped that it will facilitate the efforts of the Turkish authorities and the CPT - acting in co-operation - to strengthen the protection of persons deprived of their liberty from torture and inhuman or degrading treatment or punishment.

d. Follow-up of visits

13. At present the CPT is transmitting its report to the State Party concerned some nine months after a periodic visit. This period is too long. The Committee remains firmly committed to sending visit reports not later than six months after the end of a visit. The present situation is due largely to a bottleneck of work at the level of the Committee's Secretariat. The CPT is confident that means will be found of resolving this problem (cf. also paragraphs 26 and 27).

14. However, the CPT would recall that a visiting delegation invariably meets the national authorities at the end of its visit. Consequently, those authorities are informed immediately of any issue of particular concern.

15. The process of ongoing dialogue with States visited has continued in a broadly satisfactory manner throughout 1992. The interim and follow-up reports requested by the CPT are being forwarded by the States concerned, normally within the time-limits requested by the Committee. Some of the reports are very substantial in nature and all of them show that the CPT's recommendations and other advice are being examined seriously.

16. During 1992, two more of the CPT's reports - on the visits to Malta in 1990 and to Sweden in 1991 - have been published, pursuant to Article 11 (2) of the Convention. Subsequently, the Swedish authorities also agreed to the publication of their interim report in response to the CPT's report⁴.

The CPT can only reiterate its appreciation of the attitude adopted by those States which have agreed to the publication of the Committee's reports.

⁴ Further, the CPT's reports on its visits to France and Switzerland in 1991 were published in January 1993, together with the interim reports of the French and Swiss authorities, and the report on the visit to Finland in 1992 was published in April 1993. To date, eight CPT reports have been published: in alphabetical order, on the visits to Austria, Denmark, Finland, France, Malta, Sweden, Switzerland and the United Kingdom. In addition, the follow-up reports of the Swedish and United Kingdom authorities in response to the CPT's visit reports were published, respectively, in March and April 1993.

e. Relations with other bodies

17. The CPT has maintained relations with other bodies, both governmental and non-governmental, which are active in fields falling within the Committee's terms of reference.

The ongoing contacts between the Committee and the International Committee of the Red Cross on matters of mutual interest deserve to be highlighted (cf. also the CPT's 1st General Report; CPT (91) 3, paragraph 44). Further, working relations have now been established between the CPT and the Council on Penological Co-operation.

18. In August 1992 the United Nations Deputy Secretary General for Human Rights invited the CPT to submit observations on the draft Optional Protocol to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which had been proposed by the Costa-Rican Government on 22 January 1991. The observations subsequently forwarded by the CPT are reproduced in Appendix 5.

Further, in October 1992, the CPT's 2nd Vice-President took part in a hearing before the Working Group examining the draft Optional Protocol, in order to explain the CPT's activities.

19. Individual CPT members are increasingly attending seminars and symposia in order to speak about the Committee's work. Particular reference might be made to the Training Forum for Prison Governors from Central and Eastern European countries held in Warsaw in October 1992; the Committee's 1st and 2nd Vice-Presidents participated in this meeting.

20. Finally, the President of the CPT attended a hearing with the Ministers' Deputies on 23 June 1992, in the framework of their consideration of the Committee's 2nd General Report. Such hearings provide an invaluable opportunity for a wide-ranging discussion about the CPT's activities, and the Committee hopes that they will become an annual tradition.

II. ORGANISATIONAL AND LEGAL ISSUES

a. Signatures and ratifications of the Convention

21. The number of Parties to the Convention remained stable during 1992, at twenty-three. The Convention was signed by Czechoslovakia on 23 December 1992, shortly before that State ceased to exist⁵. The question of whether that signature will have any effect vis-à-vis the newly-formed Czech and Slovak Republics, in the event of their becoming Members of the Council of Europe (both Republics have applied for membership of the Organisation), remains to be clarified.

b. CPT membership

22. Four new members of the CPT were elected by the Committee of Ministers during 1992: Mr Jón Bjarman in respect of Iceland, Mr Arnold Oehry (Liechtenstein), Mrs Nora Staels-Dompas (Belgium) and Mr José Vieira Mesquita (Portugal). At the end of 1992 the CPT had 22 members, the seat in respect of San Marino remaining vacant (see Appendix 2A for the full list of members)⁶.

23. In its 2nd General Report, the CPT emphasised the importance of increasing the number of members who possess specialist practical knowledge of penitentiary systems or are medical doctors with relevant experience (cf. CPT/Inf (92) 3, paragraphs 26 and 27). The CPT is grateful to the Committee of Ministers for the action subsequently taken by it in relation to this matter.

24. Another issue raised in the CPT's 2nd General Report was that of the expiry dates of members' terms of office (cf. CPT/Inf (92) 3, paragraph 16). The Committee is again grateful to the Committee of Ministers for having requested the Steering Committee for Human Rights to look into the question of the advisability of placing each member of the CPT in one of two groups, with a view to ensuring an orderly renewal of one half of the Committee's membership every two years.

⁵ Further, the Convention was signed by Hungary on 9 February 1993 (cf. Appendix 1 for the state of signatures and ratifications of the Convention).

⁶ On 3 May 1993, Mr Léopoldo Torres Boursault was elected as the member of the CPT in respect of Spain, following the resignation of Mr José Maria Mohedano on 15 February 1993.

25. That action is required is clear from the list of CPT members in Appendix 2A. Of the existing 22 members, 10 have the same term of office expiry date. However, among the other 12 there are no less than 9 different expiry dates, spanning a period of approximately three years. Under the existing provisions of the Convention, there is no means of regrouping the terms of office of the latter members. Further, the terms of office of members elected in the future in respect of new Parties to the Convention will expire on different dates. Even the existing group of 10 members with the same term of office expiry date shall no doubt in time be gradually broken up, as individual members in that group fail, for one reason or another, to complete a term of office.

Unless appropriate measures are taken, the profusion of different term of office expiry dates will in due course become the source of considerable inconvenience from an organisational standpoint. The CPT very much hopes, therefore, that a Protocol to the Convention tackling this issue will be adopted at the earliest possible opportunity, and that it will include provisions designed to ensure its rapid entry into force.

c. Budgetary questions

26. The CPT's budgetary requests for 1993 in respect of visits and meetings were approved by the Committee of Ministers. However, the resources of the CPT's Secretariat in 1993 shall be somewhat weaker than had been envisaged when the 1993 visit programme was drawn up in the middle of 1992. Faced with this situation, and taking into account also a certain backlog of work as regards drawing up visit reports and the pursuit of the ongoing dialogue with States visited, the CPT has had to cut the visit programme originally foreseen for 1993. Nevertheless, the Committee still hopes to have completed the first round of periodic visits to States which are currently Parties to the Convention by the end of 1993⁷.

27. The Secretariat is due to be reinforced by the arrival of an additional administrative officer some time in 1993, and it is hoped that a further administrative officer shall be available at the outset of 1994. This should enable the CPT to increase its visiting activities and at the same time to remain on schedule with the drawing up of visit reports and with follow-up procedures.

⁷ At the beginning of 1993, the following Parties to the Convention had not yet received a periodic visit: Belgium, Greece, Iceland, Ireland, Liechtenstein, Luxembourg and Norway.

d. Other issues

28. In previous General Reports, the CPT drew attention to certain legal issues which had arisen concerning the interpretation of the Convention i.e. the application of visa requirements to members of CPT visiting delegations, the giving of reasons when Article 14 (3) of the Convention is invoked (objections to an expert, or other person assisting the Committee, taking part in a visit), and the legal status of the Explanatory Report on the Convention.

29. The Committee of Ministers has declassified the documents exchanged between it and the CPT on these subjects. Consequently, the documents concerned can be obtained from the CPT's Secretariat.

III. HEALTH CARE SERVICES IN PRISONS

30. Health care services for persons deprived of their liberty is a subject of direct relevance to the CPT's mandate. 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.

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.

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.

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

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.

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.

IV. CONCLUDING REMARKS

78. 1992 was a year of consolidation for the CPT. Seven countries were visited by CPT delegations, a small increase as compared to the previous year. By the end of 1992, sixteen of the twenty-three Parties to the Convention had been visited by the Committee on a periodic basis.

The remaining Parties to the Convention should receive periodic visits during the course of 1993. Consequently, some four years after its inaugural meeting, the CPT will have completed its first round of visits. This will provide an appropriate opportunity to take stock of the Committee's work. In this connection, the CPT intends to organise a meeting of all the liaison officers appointed by States Parties under Article 15 of the Convention.

79. The possible extension of the CPT's activities beyond the framework of the Council of Europe remains under consideration.

The CPT has referred in its 1st and 2nd General Reports to the possibility of opening the Convention to accession by non-member States, and in particular to States members of the Conference on Security and Co-operation in Europe (CSCE) which are not members of the Council of Europe.

The Committee of Ministers has now instructed the Steering Committee for Human Rights to prepare a draft Protocol to the Convention permitting such an opening. The CPT is grateful to the Committee of Ministers for having stipulated that the CPT should be associated with work on the draft Protocol.

80. Further, in its Recommendation 1183 (1992) adopted on 5 May 1992, the Parliamentary Assembly of the Council of Europe recommended inter alia that the Committee of Ministers "enable European States which are members of the CSCE but not of the Council of Europe to invite the European Committee for the Prevention of Torture to visit places of detention in these countries."

The CPT understands this recommendation is designed to take into account that the adoption and entry into force of the draft Protocol opening the Convention to accession by non-member States (a step also recommended by the Assembly) would inevitably take several years.

81. The CPT welcomes the initiative taken by the Assembly; in principle it is in favour of the Assembly's recommendation. Such an extension of the monitoring and preventive action carried out by the Committee could only be beneficial for the cause of human rights.

However, the additional resources required by such activities would have to be clearly identified in advance and made available. On no account should the carrying out of visits to non-member States outside the framework of the Convention be allowed to jeopardise the Committee's activities under the Convention.

APPENDIX 1

**Signatures and ratifications of the
European Convention for the Prevention of Torture
and Inhuman or Degrading Treatment or Punishment (*)**

MEMBER STATES	Date of signature	Date of ratification	Date of entry into force
AUSTRIA	26.11.87	06.01.89	01.05.89
BELGIUM	26.11.87	23.07.91	01.11.91
BULGARIA			
CYPRUS	26.11.87	03.04.89	01.08.89
CZECHOSLOVAKIA(**)	23.12.92		
DENMARK	26.11.87	02.05.89	01.09.89
FINLAND	16.11.89	20.12.90	01.04.91
FRANCE	26.11.87	09.01.89	01.05.89
GERMANY	26.11.87	21.02.90	01.06.90
GREECE	26.11.87	02.08.91	01.12.91
HUNGARY	09.02.93		
ICELAND	26.11.87	19.06.90	01.10.90
IRELAND	14.03.88	14.03.88	01.02.89
ITALY	26.11.87	29.12.88	01.04.89
LIECHTENSTEIN	26.11.87	12.09.91	01.01.92
LUXEMBOURG	26.11.87	06.09.88	01.02.89
MALTA	26.11.87	07.03.88	01.02.89
NETHERLANDS	26.11.87	12.10.88	01.02.89
NORWAY	26.11.87	21.04.89	01.08.89
POLAND			
PORTUGAL	26.11.87	29.03.90	01.07.90
SAN-MARINO	16.11.89	31.01.90	01.05.90
SPAIN	26.11.87	02.05.89	01.09.89
SWEDEN	26.11.87	21.06.88	01.02.89
SWITZERLAND	26.11.87	07.10.88	01.02.89
TURKEY	11.01.88	26.02.88	01.02.89
UNITED KINGDOM	26.11.87	24.06.88	01.02.89

(*) The Convention is open for signature by the member States of the Council of Europe.

(**) Czechoslovakia ceased to exist on 31 December 1992. The newly-formed Czech and Slovak

Republics have applied to become members of the Council of Europe.

APPENDIX 2

**A. Members of the CPT listed in order of precedence
(as at 15 May 1993*)**

Name	Nationality	Term of office expires
Mr Antonio CASSESE, President	Italian	19.9.1995
Mr Bent SØRENSEN, 1st Vice-President	Danish	19.9.1993
Mr Jacques BERNHEIM, 2nd Vice-President	Swiss	19.9.1993
Mr Love KELLBERG	Swedish	19.9.1993
Mrs Lydie DUPUY	French	19.9.1993
Mr Stefan TERLEZKI	British	19.9.1993
Mr Rudolf MACHACEK	Austrian	19.9.1993
Ms Astrid HEIBERG	Norwegian	19.9.1993
Mr Ergun ÖZBUDUN	Turkish	19.9.1993
Mr Petros MICHAELIDES	Cypriot	19.9.1995
Mr Michael MELLETT	Irish	19.9.1995
Mrs Nadia GEVERS LEUVEN-LACHINSKY	Dutch	19.9.1993
Mr Claude NICOLAY	Luxemburger	19.9.1993
Mr Günther KAISER	German	21.6.1994
Mr Tonio BORG	Maltese	21.6.1994
Mrs Pirkko LAHTI	Finnish	20.6.1995
Mr Constantin ECONOMIDES	Greek	1.12.1995
Mrs Nora STAELS-DOMPAS	Belgian	8.1.1996
Mr Jón BJARMAN	Icelandic	26.3.1996
Mr José VIEIRA MESQUITA	Portuguese	24.9.1996
Mr Arnold OEHRYS	Liechtensteiner	22.10.1996
Mr Léopoldo TORRES BOURSAULT	Spanish	3.5.1997

* At this date, the seat in respect of San Marino was vacant.

B. Secretariat of the CPT

Mr Trevor STEVENS,	Committee Secretary
Mrs Geneviève MAYER,	Administrative Officer
Mr Fabrice KELLENS,	Administrative Officer
Mr Mark KELLY,	Administrative Officer
Mrs Florence DURING,	Principal Administrative Assistant (administrative and budgetary questions)
Mrs Joëlle BOUTEILLER	Principal Administrative Assistant (documentation and information)
Miss Mireille MONTI,	Senior Clerk
Ms Gráinne GALVIN,	Secretary
Ms Marie O'KANE,	Secretary

APPENDIX 3

Places of detention visited by delegations of the CPT in 1992

A. CYPRUS

Famagusta District

- Ayia Napa Police Station
- Xylotymbou Police Station
- Xylophagou Police Station

Larnaca District

- Larnaca Airport Police Station and Transit Room for foreigners
- Larnaca Town Police Station
- Kiti Police Station
- Kophinou Police Station
- Oroklini Police Station

Limassol District

- Limassol Town Police Station
- Yermasoyia Police Station

Nicosia District

- Athalassa Psychiatric Hospital
- Nea Eleoussa Home for Severely Mentally Retarded Persons (Athalassa area)
- Nicosia Central Prisons
- Nicosia Police Prison
- Ayios Dhometios Police Station
- Deftera Police Station
- Klirou Police Station
- Lykavitos Police Station
- Omorphita Police Station
- Strovolos Police Station
- Holding room at Nicosia Assize Court

Paphos District

- Kouklia Police Station
- Paphos Town Police Station.

B. FINLAND

Helsinki:

- Central Prison
- Central Police Department
- Police Detoxification Centre

Hämeenlinna:

- Central and Local Prisons
- City Police Department

Kerava:

- Juvenile Prison

Turku:

- Mental Hospital for Prisoners
- City Police Department

C. ITALY

Milan:

- District Prison (Casa Circondariale), San Vittore
- Police Headquarters, Via Fatabenefratelli
- Operational Department of the Carabinieri, Via Moscova

Naples:

- Judicial Psychiatric Hospital (Ospedale Psichiatrico Giudiziario)
- Police Headquarters, Via Medina
- Carabinieri Headquarters, Corso Vittorio Emanuele
- Stella District Carabinieri Headquarters, Piazzetta Stella

Rome:

- District Prison for women, Rome-Rebibbia
- District Prison New Complex (Nuovo Complesso), Rome-Rebibbia
- District Prison, Rome-Regina Coeli
- Police Headquarters, Via di S. Vitale
- Trevi Police Station, Piazza del Collegio Romano
- Operational Department of the Carabinieri, Via In Selci
- Piazza Dante Carabinieri Station, Via Tasso

D. THE NETHERLANDS

Almelo:

- Alexandra Youth Detention Centre
- Headquarters of the Municipal Police

Amsterdam:

- Over-Amstel Prisons (Demersluis, De Singel and Het Veer)
- Headquarters and 1st, 2nd and 4th Districts of the Municipal Police
- Het Nieuwe Lloyd Youth Detention Centre
- Grenshospitium Holding Centre for Asylum Seekers and Illegal Immigrants

Rotterdam:

- De Schie Prison
- 5th district of the Municipal Police

Volendam:

- National Police Station

E. PORTUGAL

Alcoentre:

- Vale de Judeus Prison.

Almada:

- Alfeite Naval Prison
- Headquarters of the National Republican Guard
- Almada Division of the Public Security Police

Lisbon:

- Judicial Police Group Prison
- Headquarters of the Judicial Police
- Headquarters of the Public Security Police
- Public Security Police Station at Praça da Alegria

Santarem:

- Headquarters of the Public Security Police
- Headquarters of the National Republican Guard.

Sintra:

- Linhó Prison
- Public Security Police Station at Rua Dr Guilherme Fernandes

F. SAN MARINO

- San Marino Prison
- Headquarters of the Civilian Police
- Headquarters of the Gendarmerie

G. TURKEY

Adana

- Police Headquarters
- Adana Prison
- Closed Unit for Prisoners, Numune General Hospital

Ankara:

- Police Headquarters
- Çankaya District Central Police Station
- Eltik District Central Police Station
- Mamak District Central Police Station
- Ankara Central Closed Prison

Diyarbakır:

- Police Headquarters
- Interrogation Centre of the 1st Section of the Diyarbakır Police
- Central Interrogation Centre of the Departmental Command of the Diyarbakır Gendarmerie Regiment
- Dicle University Police Station
- Diyarbakır -1 Prison
- Diyarbakır -2 Prison

Istanbul:

- Police Headquarters
- Beyoğlu District Central Police Station
- Eminönü District Central Police Station
- Eyüp District Central Police Station
- Bayrampaşa Prison
- Bakirköy Mental and Psychological Health Hospital

APPENDIX 4

Public statement on Turkey

(Adopted on 15 December 1992)

Introduction

1. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has to date organised three visits to Turkey. The first two visits, carried out from 9 to 21 September 1990 and 29 September to 7 October 1991, were of an ad hoc nature. They were visits which appeared to the Committee "to be required in the circumstances" (Article 7, paragraph 1, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment). The circumstances in question were essentially the considerable number of reports received by the Committee, from a variety of sources, containing allegations of torture or other forms of ill-treatment of persons deprived of their liberty in Turkey. The reports related in particular to persons held in police custody. The third visit took place from 22 November to 3 December 1992, and formed part of the CPT's programme of periodic visits for that year.

2. Throughout 1991 and 1992 an ongoing dialogue has been maintained between the Turkish authorities and the CPT on matters of concern, based on the reports drawn up by the Committee after its first and second visits and the reports provided by the Turkish authorities in response. This dialogue culminated in a number of meetings between the Turkish authorities and a delegation of the CPT held in Ankara from 22 to 24 September 1992.

Subsequently, at its 14th meeting (28 September to 2 October 1992), the CPT reviewed the action taken by the Turkish authorities upon the recommendations made by the Committee in its visit reports. The Committee concluded that the continuing failure of the Turkish authorities to improve the situation in the light of its recommendations concerning (i) the strengthening of legal safeguards against torture and other forms of ill-treatment in police (and gendarmerie) establishments and (ii) the activities of the Anti-Terror Departments of the Ankara and Diyarbakır Police, justified resort to Article 10, paragraph 2, of the Convention.

3. The Turkish authorities were informed of the conclusion reached by the CPT and, in accordance with the Convention, invited to make known their views. Those views were received on 16 November 1992. The CPT examined the views presented by the Turkish authorities at its 15th meeting, held from 14 to 17 December 1992; on the same occasion, the Committee considered the facts found by the delegation which carried out the periodic visit to Turkey in November/December 1992, in particular insofar as they related to matters of police and gendarmerie custody. By the required majority of two-thirds of its members, the Committee decided to make a public statement.

The ad hoc visits

a) first visit

4. In the report drawn up following its first visit to Turkey in 1990, the CPT reached the conclusion that torture and other forms of severe ill-treatment were important characteristics of police custody in that country. More specifically, in the light of all the information gathered concerning the Anti-Terror Departments of the Ankara and Diyarbakır Police, the CPT concluded that detectives in those departments frequently resorted to torture and/or other forms of severe ill-treatment, both physical and psychological, when holding and questioning suspects. A variety of elements led the Committee to those conclusions.

5. In the first place, the CPT was struck by the extremely large number of allegations of torture and other forms of ill-treatment by the police received in the course of the visit, the wide range of persons making those allegations, and their consistency as regards the particular types of torture and ill-treatment said to have been inflicted. It should be noted that the allegations emanated from persons suspected or convicted of offences under anti-terrorism provisions and from persons suspected or convicted of ordinary criminal offences. As regards the latter, the number of allegations was especially high among persons detained for drug-related offences, offences against property (burglary, robbery, theft) and sex offences. Concerning the types of ill-treatment involved, the following forms were alleged time and time again: suspension by the arms; suspension by the wrists, which were fastened behind the victim (so-called "palestinian hanging", a technique apparently employed in particular in anti-terror departments); electric shocks to sensitive parts of the body (including the genitals); squeezing of the testicles; beating of the soles of the feet ("falaka"); hosing with pressurised cold water; incarceration for lengthy periods in very small, dark and unventilated cells; threats of torture or other forms of serious ill-treatment to the person detained or against others; severe psychological humiliation.

6. The CPT's medical findings must also be emphasised. Indeed, a considerable number of persons examined by doctors in the CPT's visiting delegation displayed physical marks or conditions consistent with their allegations of torture or ill-treatment by the police. The delegation also met several persons in police custody who, while not stating openly that they had been ill-treated, displayed clear medical signs consistent with very recent torture or other severe ill-treatment of both a physical and psychological nature. Some specific cases were described in the Committee's report.

7. Other on-site observations in police establishments visited (relating in particular to the often extremely poor material conditions of detention, the interrogation facilities and the general attitude and demeanour of police officers) did nothing to reassure the CPT's delegation about the fate of persons taken into custody. The same can be said of the circumstances under which certain of the visits took place, in particular at Ankara Police Headquarters, where the delegation was subjected to a series of delays and diversions (and on several occasions given false information) and a number of detainees were removed in order to prevent the delegation from meeting them.

8. In its report the CPT recommended a series of measures to the Turkish authorities designed to combat the problem of torture and other forms of ill-treatment. These measures related in part to the introduction or reinforcement of formal safeguards against such methods (shortening of the maximum periods of custody by the police or gendarmerie; notification of a person's custody to his next of kin or a third party of his choice; access to a lawyer; medical examination of detained persons; a code of practice for the conduct of interrogations).

The Committee also placed considerable emphasis on the need for a major and sustained effort by the Turkish authorities in the areas of education on human rights matters and professional training for law enforcement officials. It is axiomatic that the best possible guarantee against ill-treatment of persons deprived of their liberty is for its use to be unequivocally rejected by such officials.

As for the Anti-Terror Departments of the Ankara and Diyarbakır Police, the Committee recommended that appropriate steps be taken immediately to remedy the situation identified in those services.

9. The implementation of these recommendations was the subject of numerous exchanges between the Turkish authorities and the CPT during 1991. However, by the time of the Committee's second visit, few tangible results had been achieved, with the exception of the drawing up and subsequent revision of Regulations for the conduct of interrogations.

b) second visit

10. In the course of its second visit to Turkey in the Autumn of 1991, the CPT found that no progress had been made in eliminating torture and ill-treatment by the police. Many persons alleged that they had received such treatment during the previous twelve months. The types of ill-treatment alleged remained much the same; however, an increasing number of allegations were heard of forcible penetration of bodily orifices with a stick or truncheon. Once again, a number of the persons who claimed to have been ill-treated were found, on medical examination, to display marks or conditions consistent with their allegations. The delegation also had access to a considerable number of reports drawn up during the previous twelve months, at the end of periods of police custody, by doctors belonging to Forensic Institutes; many of them contained findings consistent with particular forms of torture or severe ill-treatment. As regards more specifically the Anti-Terror Departments of the Ankara and Diyarbakır Police, the only conclusion that could be reached in the light of all the information gathered was that torture and other forms of severe ill-treatment continued unabated in those services.

11. In the report on its second visit to Turkey, the CPT reiterated the previously-made recommendations designed to prevent torture and other forms of ill-treatment. Further, the Committee recommended that a body composed of independent persons be set up immediately, with terms of reference to carry out a thorough investigation of the methods used by police officers of the Anti-Terror Departments of the Ankara and Diyarbakır Police when holding and questioning suspects. In the light of the information gathered in the course of the CPT's second visit, it was also pointed out that it would be appropriate for the terms of reference of that body to include the Anti-Terror Department of the Istanbul Police.

Review of action taken on the ad hoc visit reports

12. One year after submission of the CPT's second report, at its meeting of September/October 1992, the Committee reviewed the action taken by the Turkish authorities upon all the recommendations set out in the reports drawn up after its two visits. It was noted that some progress had been made on certain issues. Measures of both a legal and practical nature had been taken in response to the CPT's recommendations on material conditions of detention in police and gendarmerie establishments. The dialogue between the Turkish authorities and the Committee on prison matters also appeared to be bearing fruit. However, implementation of the central recommendations concerning torture and other forms of ill-treatment in police establishments was clearly at a standstill.

13. Legislation going in the direction of the recommendations made by the CPT on the strengthening of legal safeguards against torture and other forms of ill-treatment had been approved by the Turkish Grand National Assembly on 21 May 1992. However, it was subsequently returned by the President of the Republic to the Assembly for reconsideration; and at the time of the Committee's review of the situation, the fate of that legislation was a matter of conjecture.

14. Further, no satisfactory action had been taken on the CPT's recommendation concerning the Anti-Terror Departments of the Ankara and Diyarbakır Police. The Human Rights Inquiry Commission of the Grand National Assembly - to which the task of carrying out the investigation recommended by the Committee was entrusted - had failed to act expeditiously. It was only on 29 June 1992 that the relevant Sub-Committee of the Commission visited Ankara Police Headquarters for the first time (apparently a second visit was carried out on 7 July 1992). Further, at the time of the meetings between the Turkish authorities and a delegation of the CPT held in Ankara towards the end of September 1992, the Sub-Committee had still not apprised the Human Rights Inquiry Commission of its findings. Nor had the Sub-Committee carried out any visits to the Anti-Terror Department of the Diyarbakır Police (or for that matter the Anti-Terror Department of the Istanbul Police). Moreover, from the information provided to the CPT's delegation by a member of the Sub-Committee, it was clear that the visits carried out to the Ankara Police Headquarters had been of a quite perfunctory nature. Furthermore, it was also clear that the Sub-Committee possessed neither the powers nor the relevant professional competence necessary to carry out a "thorough investigation" as envisaged in the recommendation made by the CPT in its second report.

15. It should be added that in the course of the above-mentioned meetings in Ankara in September 1992, information received from officials of the Ministry of the Interior indicated that no credible action had been taken at the internal administrative level in response to the successive recommendations of the CPT concerning the Anti-Terror Departments of the Ankara and Diyarbakır Police. The only investigations instigated had been entrusted to the very police forces which the Committee had concluded were resorting to torture. Not surprisingly, they had led nowhere.

16. In short, more than two years after the CPT's first visit, very little had been achieved as regards the strengthening of legal safeguards against torture and ill-treatment and no concrete steps capable of remedying the situation found by the Committee in the Anti-Terror Departments of the Ankara and Diyarbakır Police had been taken. At the same time, the Committee continued to receive reports of torture and other forms of severe ill-treatment in those departments, as well as in many other police establishments in Turkey.

It was under those conditions that the CPT decided on 2 October 1992 to set in motion the procedure provided for in Article 10, paragraph 2, of the European Convention for the Prevention of Torture.

The periodic visit

17. The information gathered in the course of the CPT's periodic visit to Turkey, from 22 November to 3 December 1992, shows that the problem of torture and other forms of ill-treatment of persons in police custody has not been resolved, despite the importance which had been attached to this subject by the present government when it came to power at the end of 1991. The Committee's delegation was inundated with allegations of such treatment, from both ordinary criminal suspects and persons detained under anti-terrorism provisions. Further, numerous persons examined by the delegation's doctors displayed marks or conditions consistent with their allegations.

18. By way of illustration, reference might be made to the following cases:

- several prisoners charged with offences against property, encountered in the reception unit of Bayrampaşa Prison (Istanbul), who bore fresh haematomas consistent with their allegations that they had recently been subjected to falaka and to beating on the palm of the hands and ventral face of the wrists;
- a prisoner charged with a drug-related offence being held for observation in a forensic section at Bakirköy Hospital (Istanbul), who had a fresh rounded mark on his penis (reddish-brown and slightly swollen edge, whitish centre without induration), consistent with his allegation that an electrode had been placed by the police on that part of his body some five days earlier in order to deliver electric shocks;

- a prisoner charged with smuggling examined at Adana Prison, who displayed haematomas on the soles of his feet and a series of vertical violet stripes (10 cm long/2 cm wide) across the upper part of his back, consistent with his allegation that he had recently been subjected to falaka and beaten on the back with a truncheon while in police custody.

19. Comparable cases in Ankara and Diyarbakır could also have been described, including of persons who had been held by the Anti-Terror Departments of the Ankara and Diyarbakır Police (in particular, cases of motor paralysis of the arms and severe sensory loss consistent with allegations of suspension).

However, the CPT shall instead draw attention to highly incriminating material evidence found in police establishments in those cities.

20. Acting in each case on concordant information independently received from several different sources, the Committee's delegation carried out two impromptu visits to specific rooms situated on the top floors of both the Ankara Police Headquarters (new building) and the Diyarbakır Police Headquarters. The rooms in question were located within the areas occupied by the Law and Order Departments, which deal with ordinary criminal suspects. In the room at the Ankara Police Headquarters, the delegation discovered a low stretcher-type bed equipped with eight straps (four each side), fitting perfectly the description of the item of furniture to which persons had said they were secured when electric shocks were administered to them. No credible explanation could be proffered for the presence of this bed in what was indicated by a sign as being an "interrogation room".

In Diyarbakır, the delegation found the equipment necessary for suspension by the arms in place and ready for use (i.e. a three metre long wooden beam which was mounted on heavily-weighted filing cabinets on opposite sides of the room and fitted with a strap made of strong material securely tied to the middle). On both occasions, the delegation's discoveries caused considerable consternation among police officers present; some expressed regret, others defiance.

Conclusions based on the ad hoc and periodic visits

21. **In the light of all the information at its disposal, the CPT can only conclude that the practice of torture and other forms of severe ill-treatment of persons in police custody remains widespread in Turkey and that such methods are applied to both ordinary criminal suspects and persons held under anti-terrorism provisions. The words "persons in police custody" should be emphasised.**

22. The Committee has heard very few allegations of ill-treatment by prison staff in the different prisons visited over the last two years, and practically none of torture. Certainly, there are problems which need to be addressed in Turkish prisons, but the phenomenon of torture is not one of them. As already indicated, the CPT's dialogue with the Turkish authorities on prison matters is on the whole progressing satisfactorily.

23. Further, in the course of its third visit to Turkey, the CPT visited the largest psychiatric establishment in the country, namely the Bakirköy Mental and Psychological Health Hospital. No allegations of torture or other forms of ill-treatment by hospital staff were heard by the Committee's delegation in the course of that visit; nor was any other evidence of such treatment found. In fact, the delegation was favourably impressed by staff-patient relations.

24. As for the gendarmerie (which is responsible for police functions in rural areas), the CPT has heard allegations that suspects are frequently handled roughly and on occasion even beaten by members of the gendarmerie, in particular when apprehended. Further, the CPT has reason to believe that from time to time, ill-treatment occurs in the course of the transport of prisoners (which is another task performed by the gendarmerie). However, the CPT has heard fewer allegations - and found less medical evidence - of torture or other forms of premeditated severe ill-treatment by members of the gendarmerie.

25. To sum up, as far as the CPT can judge, the phenomenon of torture and other forms of ill-treatment of persons deprived of their liberty in Turkey concerns at the present time essentially the police (and to a lesser extent the gendarmerie). All the indications are that it is a deep-rooted problem.

Action required

26. Action is required on several fronts if this problem is to be addressed effectively. Legal safeguards against torture and other forms of ill-treatment need to be reinforced and new safeguards introduced. At the same time, education on human rights matters and professional training for law enforcement officials must be intensified. In this respect, the recent arrangements to send some 20 Turkish police officers to various other European countries in order to study police methods there are to be welcomed, and the CPT trusts that they represent part of an ongoing process.

Furthermore, public prosecutors must react expeditiously and effectively when confronted with complaints of torture and ill-treatment. On this point, the recent annulment by the Constitutional Court of section 15 (3) of the Law to Fight Terrorism of 12 April 1991 (which severely curtailed the possibilities for public prosecutors to proceed against police officers alleged to have ill-treated persons in the performance of duties relating to the suppression of terrorism) is a very positive development. In order to facilitate effective action by public prosecutors, the medical examinations of persons in police and gendarmerie custody carried out by the Forensic Institutes should be broadened in scope (medical certificates should contain a statement of allegations, a clinical description and the corresponding conclusions). Further, appropriate steps should be taken to guarantee the independence of both Forensic Institute doctors and other doctors who perform forensic tasks, as well as to provide such doctors with specialised training.

Proper managerial control and supervision of law enforcement officials must also be ensured, including through the institution of effective independent monitoring mechanisms possessing appropriate powers. Neither should the issue of the conditions of service of such officials be overlooked, as satisfactory conditions of service are indispensable to the development of a high-calibre police force.

Application of the recently drawn up Custody Regulations, which relate inter alia to material conditions of detention, must also be vigorously pursued throughout the whole of Turkey. Considerable progress in this area has been made in Ankara and Diyarbakır, in pursuance of the CPT's recommendations. However, the situation found recently at Adana Police Headquarters (in particular in the Anti-Terror Department) suggests that in other parts of the country, persons detained by the police or gendarmerie may still be held under totally unacceptable conditions.

27. Particular reference must be made to the recently adopted Law amending some provisions of the Code of Criminal Procedure and of the Law relating to the organisation and procedure of State Security Courts, which entered into force on 1 December 1992. This is a revised version of the text returned to the Grand National Assembly earlier in the year by the President of the Republic. The new Law inter alia clarifies the existence of certain fundamental safeguards against ill-treatment, such as the right to have a relative notified of one's custody and the right of access to a lawyer (safeguards which had been provided for previously but which had been largely inoperative in practice), regulates in detail the mechanics of the interrogation process, introduces a right to apply to a judge for the immediate release of an apprehended person and shortens the maximum periods of police/gendarmerie custody. The introduction of these provisions is a most welcome step forward. However, it is a matter of great regret to the CPT that their application to offences within the jurisdiction of State Security Courts has been specifically excluded. Admittedly, the number of offences under the jurisdiction of such courts has also been reduced by the new Law, but it remains considerable: crimes against the State; terrorist offences; drugs and arms-related offences, etc..

28. The CPT wishes to take this opportunity to underscore that it abhors terrorism, a crime which is all the more despicable in a democratic country such as Turkey. The Committee also deplores illicit drug and arms dealing. Further, it is fully conscious of the great difficulties facing security forces in their struggle against these destructive phenomena. Criminal activities of this kind rightly meet with a strong response from state institutions. However, under no circumstances must that response be allowed to degenerate into acts of torture or other forms of ill-treatment by law enforcement officials. Such acts are both outrageous violations of human rights and fundamentally flawed methods of obtaining reliable evidence for combatting crime. They are also degrading to the officials who inflict or authorise them. Worse still, they can ultimately undermine the very structure of a democratic State.

29. Unfortunately, Turkish law as it stands today does not offer adequate protection against the application of those methods to persons apprehended on suspicion of offences falling under the jurisdiction of State Security Courts; on the contrary, it facilitates the use of such methods. Suspects in relation to collectively committed crimes may be held for up to 15 days by the police or gendarmerie (rising to 30 days in regions where a state of emergency has been declared), during which time they are routinely denied any contact with the outside world.

It is true that the provisions of section 13 of the new Law, concerning prohibited interrogation procedures, apply also to persons suspected of offences under the jurisdiction of State Security Courts. However, it would be unwise to believe that these provisions alone will be able to stem torture and ill-treatment. The methods described in section 13 have been illegal for many years under Turkish Law by virtue of the general prohibition of torture and ill-treatment in Article 17 (3) of the Constitution. Further, the stipulation that statements made as a consequence of such methods shall not have the value of evidence is merely a welcome reaffirmation of a principle already recognised by the Turkish legal system.

In reality, the long periods of incommunicado custody allow time for physical marks caused by torture and ill-treatment to heal and fade; countless prisoners have described to CPT delegations the treatment techniques applied by police officers. It should also be noted that certain methods of torture commonly used do not leave physical marks, or will not if carried out expertly. Consequently, it shall often be difficult to demonstrate that a statement has been made as a consequence of ill-treatment. The same point applies to the admissibility of other evidence obtained as a result of ill-treatment (cf. section 24 of the new Law).

30. The CPT does not contest that exceptionally, specific legal procedures might be required in order to combat certain types of crime, in particular those of a terrorist nature. However, even taking into account the very difficult security conditions prevailing in several areas of Turkey, an incommunicado custody period of up to 15 days, let alone 30, is patently excessive; it is clear that a proper balance has not been struck between security considerations and the basic rights of detainees.

The CPT calls upon the Turkish Government to take appropriate measures to reduce the maximum periods for which persons suspected of offences falling under the jurisdiction of State Security Courts can be held in police or gendarmerie custody, to clearly define the circumstances under which the right of such persons to notify their next of kin of their detention can be delayed and strictly limit in time the application of such a measure, and to guarantee to such persons, as from the outset of their custody, a right of access to an independent lawyer (though not necessarily their own lawyer) as well as to a doctor other than one selected by the police.

31. As regards ordinary criminal suspects, the amendments introduced by the above-mentioned Law could deal a severe blow to the practice of torture and ill-treatment. However, much will depend on how the new provisions are applied in practice. This is a matter that the CPT intends to follow carefully in the coming months, in close co-operation with the Turkish authorities. Nevertheless, a number of points should be raised now.

32. The maximum period of police custody for collective crimes (three or more persons), although reduced, remains quite high - up to eight days at the request of a public prosecutor and by decision of a judge. In this regard, the CPT wishes to emphasise that in the interests of the prevention of ill-treatment, it is essential that the person in custody be physically brought before the judge to whom the request for an extension of the custody period is submitted. The new Law is not clear on this point.

33. Although the precise content of the right of access to a lawyer is impressive (cf. in particular sections 14, 15 and 20 of the Law), a potential flaw lies in the fact that, with the exception of persons who are under the age of 18 or disabled, a lawyer will only be appointed if the person in custody so requests. A failsafe procedure will have to be found that ensures detainees are (as the Law requires) informed of their right to appoint a lawyer and not subjected to pressure when considering the exercise of that right. The same point applies as regards the right of persons in custody to make known to a relative of their choice that they have been apprehended. Care will also have to be taken that the possibility offered to take a statement, in certain cases, in the absence of the lawyer appointed by the person detained is not abused.

34. Under the new provisions, public prosecutors are in an even better position to exercise considerable influence over the manner in which police officers perform their duties and, more specifically, treat persons in their custody. The CPT very much hopes that they will make effective use of the possibilities open to them, with a view to the prevention of ill-treatment.

35. The new Law is silent on the question of the right of persons in police or gendarmerie custody to have access to a doctor. However, by a circular issued by the Ministry of the Interior on 21 September 1992, a right of access to a doctor in the form previously recommended by the CPT (i.e. a right for the detainee to be examined by a doctor chosen by him - if appropriate from among a list of doctors agreed with the relevant professional body - in addition to any examination carried out by a state-employed doctor) was recognised. The CPT welcomes this development, though the inclusion of this right in a law would be preferable. Previous circulars relating to important safeguards for detained persons have remained a dead letter.

36. Finally, it should be re-emphasised that the phenomenon of torture and other forms of ill-treatment by the police will not be eradicated by legislative fiat alone. It shall always be possible for the impact of legal provisions to be diminished by ever more expertly applied techniques of ill-treatment. Indeed, it can legitimately be advanced that attacking the root of the problem of torture and ill-treatment involves not so much changing laws as transforming mentalities. This process is required not simply amongst police officers but throughout the criminal justice system.

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37. The CPT is convinced that it would have been counterproductive from the standpoint of the protection of human rights for it to have refrained - as it was requested to do by the Turkish authorities - from making this public statement. **The statement is issued in a constructive spirit. Far from creating an obstacle, it should facilitate the efforts of both parties - acting in cooperation - to strengthen the protection of persons deprived of their liberty from torture and inhuman or degrading treatment or punishment.**

APPENDIX 5

**Letter from the President of the CPT to the United Nations
Deputy Secretary General for Human Rights**

Strasbourg, 20 October 1992

Dear Deputy Secretary General,

1. I refer to your letter of 27 August 1992, by which you drew the attention of the European Committee for the prevention of torture and inhuman or degrading treatment or punishment (CPT) to the draft Optional Protocol to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, proposed by the Costa-Rican Government on 22 January 1991.

Pursuant to paragraph 5 of Resolution 1992/43, adopted by the United Nations Commission on Human Rights on 3 March 1992, the CPT would like to submit the following observations to the working group of the Commission on Human Rights entrusted with the task of elaborating the draft Optional Protocol.

2. The CPT considers that it should refrain from expressing any view as regards the advisability of establishing at universal level a system of visits by a committee of experts to places of detention. This is a policy issue which others must address. However, if and when such a system is established, it shall obviously be essential for the activities of the new body to be effectively coordinated with those of regional bodies performing a comparable task.

3. In this connection, the CPT has taken note with interest of Article 9, paragraph 1, of the draft Optional Protocol. The Committee fully approves of the basic spirit of this provision, which is, through consultation, to avoid a wasteful duplication of efforts by parallel systems of control. To this end the CPT would certainly be eager to have the closest possible relations with the Sub-Committee envisaged by the draft Optional Protocol.

4. However, the CPT has misgivings as regards the specific means of coordinating the respective activities of the Sub-Committee set up under the draft Optional Protocol and regional bodies, highlighted in Article 9, paragraph 1. The participation of a member of the Sub-Committee, as an "observer", in missions carried out by regional bodies is foreseen; this member would subsequently make a "strictly confidential" report to the Sub-Committee.

5. The implementation of such a measure could give rise to significant legal and practical problems insofar as the CPT is concerned. Almost certainly it would involve amending the provisions of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment concerning the composition of visiting delegations and the rule of confidentiality. Further, the presence of an observer from the Sub-Committee in the midst of a visiting delegation could well cause operational complications in the field, no matter how closely defined his position might be in advance. The effectiveness of a visiting delegation depends in large measure on its unity; the latter would not be facilitated by the proposal presently under consideration.

6. Moreover, it is far from certain that such a system would be the best method of ensuring a good coordination of activities, since the observer would obtain only an imperfect picture of the outcome of a visit. His detailed knowledge would be limited to those parts of the visit in which he participated personally (in this connection it should be recalled that CPT visiting delegations operate for much of the time in sub-groups, often located in quite different parts of the country concerned). Further, he would possess neither the report subsequently sent to the State visited nor the latter's response. It follows that his report to the Sub-Committee would be incomplete and hence potentially misleading.

7. As regards the remark made in the middle of paragraph 13 of the Introductory Memorandum to the draft Optional Protocol, ("It might be problematic if some State Parties could have their own nationals among the members of the Sub-Committee visiting places of detention on the territory of other State Parties, but could escape, at the same time, any control of their places of detention by the Sub-Committee simply because they also have ratified a regional Convention establishing some kind of system of preventive visits"), it is essentially political in nature. Such an argument is not directly related to ensuring a good coordination of the activities of regional bodies with those of a universal body.

8. A possible alternative - and more efficacious - means of facilitating the desired coordination of activities could be for a State which has ratified both a regional system and the Optional Protocol to agree that visit reports drawn up by the regional body in respect of that country and the State's response are to be systematically forwarded to the Sub-Committee on a confidential basis. In this way the Sub-Committee would have a full picture of the situation in the regional context, and the consultations between the regional body and the Sub-Committee foreseen in Article 9(1) of the draft Optional Protocol could be held in the light of all the relevant facts.

The implementation of this measure vis-à-vis the CPT's activities might not require an amendment of the European Convention.

9. The CPT wishes to limit itself for the time being to these few remarks concerning the relationship of regional bodies with the Sub-Committee envisaged in the draft Optional Protocol. However, it would be ready upon request to submit further observations on specific topics.

Yours faithfully,

Antonio CASSESE