CPT/Inf (2013) 30 [Part 1]

Report

to the Italian Government on the visit to Italy carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

from 14 to 18 June 2010

The Italian Government has requested the publication of this report and of their response. The Government's response is set out in document CPT/Inf (2013) 31.

Strasbourg, 19 November 2013

Note:
In accordance with Article 11, paragraph 3, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, certain names have been deleted.

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Copy of the letter transmitting the CPT's report

Mr Diego Brasioli
Minister Plenipotentiary
President of the Inter-Ministerial Committee on
Human Rights
Ministry of Foreign Affairs
Piazzale della Farnesina 1
I – 00194 Rome

Strasbourg, 3 December 2010

Dear Mr Brasioli,

In pursuance of Article 10, paragraph 1, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, I enclose herewith the report to the Government of Italy drawn up by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) concerning two aspects of its visit to Italy from 14 to 18 June 2010, namely the prevention of suicide in the prison context, and the transfer of responsibility for prison health care from the Ministry of Justice to the regional health-care authorities. This report was adopted by the CPT at its 73rd meeting, held from 8 to 12 November 2010. A further report concerning the third aspect of the visit, namely accountability for ill-treatment allegedly inflicted on detained persons, will be forwarded to the Italian authorities separately, at a later date.

The various recommendations, comments and requests for information formulated by the CPT are listed in the Appendix of the report. As regards more particularly the CPT's recommendations, having regard to Article 10 of the Convention, the Committee requests the Italian authorities to provide within **four months** a response giving a full account of action taken to implement them. The CPT trusts that it will also be possible for the Italian authorities to provide, in the above-mentioned response, reactions and replies to the comments and requests for information.

It would be most helpful if a copy of the response could be provided in a computer-readable form.

I am at your entire disposal if you have any questions concerning either the CPT's report or the future procedure.

Yours sincerely,

Mauro Palma
President of the European Committee for the
Prevention of Torture and Inhuman
or Degrading Treatment or Punishment

I. INTRODUCTION

A. Dates of the visit and composition of the delegation

1. In pursuance of Article 7 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as "the Convention"), a delegation of the CPT carried out a visit to Italy from 14 to 18 June 2010. The visit was one which appeared to the Committee "to be required in the circumstances" (see Article 7, paragraph 1, of the Convention).

2. The visit was carried out by the following members of the CPT:

- Marc NÈVE, Head of delegation
- Dan DERMENGIU
- Pétur HAUKSSON
- Xavier RONSIN.

They were supported by Caterina BOLOGNESE and Francesca MONTAGNA, of the CPT's Secretariat, and were assisted by:

- Alan MITCHELL, medical doctor, former Head of Health-care, Scottish Prison Service, United Kingdom (expert)
- Paula BRUNO (interpreter)
- Maria FITZGIBBON (interpreter)
- Salim GHOSTINE (interpreter)
- Antonella LUCCARINI (interpreter).

B. Context of the visit and establishments visited

3. The visit focused on three issues. Following its previous periodic visit to Italy in 2008, the CPT had recommended a number of measures in relation to suicide prevention in prisons[1]. In the light of the high number of suicides in Italian prisons, the Committee decided to take a closer look at this issue.

Further, the CPT decided to take stock of the ongoing transfer of responsibility for prison health care from the central penitentiary administration to the regional health-care authorities.

The opportunity was also taken during the visit to examine accountability for ill-treatment by law enforcement officials and prison officers, including the effectiveness of investigations. In this connection a number of recent cases of alleged ill-treatment were considered. On 13 September 2010, the Italian authorities provided the CPT with extensive documentation concerning, inter alia, this issue; on 9 November 2010, they provided the Committee with the full record of the investigative acts taken in respect of one of the specific cases considered during the visit. In light of this information, the Committee decided to consider the issue of accountability in a separate report, to be delivered at a later date.

4. The delegation paid targeted visits to a number of establishments, none of which had previously been visited by the CPT.

Castrogno Prison[2], located in the outskirts of Teramo (Abruzzo region), opened in 1986. With an official capacity for 231 inmates, the establishment comprises a small section for up to 21 women and four detention blocks for men. At the time of the visit, it was overcrowded, accommodating 29 women and 360 men.

Mammagialla Prison[3], in Viterbo, north of Rome (Lazio region), was originally built in 1993 as a high security prison for men and consists of several three-storey blocks. At the time of the visit it was overcrowded, holding 683 inmates, for an official capacity of 443. According to the prison authorities, a high proportion of the inmate population had been transferred to the establishment because they were considered to be particularly challenging, either from a security perspective or due to their suffering from a psychiatric condition.

The vast majority of inmates, 570, were held in six sections with medium-security (standard) accommodation; the high security unit, consisting of three sections (including so-called "41 bis" prisoners, suspected or convicted of very serious organised crime) held 52 prisoners; and the protection unit for vulnerable persons accommodated 43 inmates. A further 18 inmates were held in the section for newly arrived prisoners.

The **Prison Health-Care Unit at Sandro Pertini Hospital** in Rome is a 22-bed facility which opened in 2005. It is one of three such facilities in Italy, providing inpatient and outpatient care to inmates primarily from prisons in Lazio. Nine patients were hospitalised at the time of the visit.

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1 See CPT/Inf (2010) 12, at paragraphs 106, 108, 109, 112 and 113.
2 Hereinafter "Teramo Prison".
3 Hereinafter "Viterbo Prison".

The **holding cells at the Rome Courthouse** are located at lower ground floor level in two separate buildings. They are intended for stays of up to a few hours prior to or after a court hearing.

The delegation also visited three ***Carabinieri*** establishments, all in Rome: **Trionfale area Headquarters** and the **stations of Monte Mario** and **Ponte Milvio**. Whereas the cells at Trionfale had been out of service for a few months prior to the visit, Monte Mario and Ponte Milvio stations each possessed two cells in which most persons deprived of their liberty by the *Carabinieri* usually did not spend more than a few hours (and in no case more than 24 hours).

Some of the above-mentioned establishments were visited with reference to the third aspect of the visit (see paragraph 3 above).

C. Consultations held by the delegation and cooperation received

5. In the course of the visit, the CPT's delegation held consultations with officials from the Ministries of Foreign Affairs, Health, Interior (in particular, representatives of the national police) and Justice, as well as with representatives of the *Carabinieri* and the *Guardia di Finanza*. It also met with health-care service providers in the regions of Abruzzo and Lazio.

The delegation had discussions with Mr Vitaliano ESPOSITO, the Prosecutor-General, Mr Giovanni FERRARA, Chief Prosecutor of Rome, Mr Gabriele FERRETTI, Chief Prosecutor of Teramo, and a number of prosecutors at the Supreme Court and the Rome District Court.

The CPT's delegation also met two parliamentarians: Senator Albertina SOLIANI and Deputy Leoluca ORLANDO, President of the parliamentary *inquiry on deficiencies in the health-care sector and on regional health-care deficits*.

Further, the delegation met Mr Angiolo MARRONI, the *Garante dei detenuti* (detained persons' Ombudsman) for the Lazio region, as well as representatives of non-governmental organisations active in the areas of interest to the Committee.

Some of the above-mentioned persons were met by the delegation in relation to the third aspect of the visit (see paragraph 3 above).

6. With one exception, the CPT's delegation had unlimited access to places it wished to visit. The delegation was also able to meet in private with all detained persons with whom it wanted to speak.

The exception referred to above concerned the initial refusal of access – expressed in an improper and, in particular, arrogant manner by officers on duty – to one of the two detention blocks situated at the Rome Courthouse. The incident was resolved after three quarters of an hour, following clarification of the situation by the central authorities. **The Committee trusts that, in future, the credentials supplied by the Italian authorities to CPT visiting delegations will cover all places where persons may be deprived of their liberty by a public authority, including courthouse detention cells, and that delegations will be received with a level of courtesy which is in keeping with good cooperation.**

As regards access during the visit to information requested, the CPT's delegation did not receive complete copies of the reports on investigations into deaths at Teramo and Viterbo Prisons in 2008 and 2009. In particular, no copies of autopsy results or conclusions of the prosecutor into the circumstances surrounding the deaths were provided. Statistics requested on criminal and/or disciplinary proceedings concerning alleged ill-treatment by law enforcement officials and prison staff were also not provided in the course of the visit.

7. At the end of the visit, the delegation provided the Italian authorities with its preliminary observations and reiterated a number of requests for information and documentation.

By letter of 13 September 2010, the Italian authorities informed the CPT of measures taken in response to some of the delegation's preliminary observations, and provided the Committee with much of the specific information and documentation requested by the delegation. This information and documentation has been taken into account in the relevant sections of the present report.

Further, as mentioned at paragraph 3, extensive documentation pertaining in particular to investigations into alleged ill-treatment was provided on 9 November 2010. This information will be taken into account in the separate report addressing this issue.

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Prevention of suicide (and self-harm) in the prison context

1. Preliminary remarks

8. By virtue of its preventive mandate, the CPT is concerned with every aspect of prison life related to the safety and well-being of prisoners, including measures taken by the authorities, in the discharge of their duty of care towards prisoners, to prevent instances of suicide and self-harm.

9. In 2009, 52 suicides[4] were officially recorded throughout the Italian prison system, for an average daily inmate population of 63,087. In the first seven months of 2010, there had already been 38 suicides for an average daily prison population of 67,596 inmates[5]. This represents a worrying suicide rate.

At Viterbo Prison, two suicides were registered in 2008 and one in 2009. Six suicides were recorded at Teramo Prison since 2005, i.e. around one per year, whereas in the past they had occurred far less frequently.

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4 This figure does not include six cases of gas inhalation, where it was not possible to ascertain a suicidal intent.

5 It should also be noted that the (non-governmental) "Permanent Observatory on Deaths in Prison" registered 72 suicides in Italian prisons in 2009. Both the Observatory and OSAPP, a national prison staff trade union, had registered 58 suicides in 2010 by 31 October 2010, when the official prison population stood at 68,795 inmates.

The suicide rate among the general population in Italy was less than five per 100,000 inhabitants in 2008[6]. While it is not unusual for the suicide rate to be higher in prison[7], the number of suicides in the prisons visited, as well as in Italian prisons in general, appears to be disproportionately high.

10. The CPT notes that the causes of prisoner deaths were often not recorded in a medically satisfactory or consistent manner. For example, for certain inmates who had died in their thirties, who apparently suffered from no relevant pre-existing pathological condition, the cause of death noted was "cardio-respiratory arrest"; this is not a cause of death *per se* but merely confirmation that a person is dead.

Further, the criteria for classifying apparently self-inflicted death as suicide varied. Nearly all suicides officially recorded by the Italian authorities concern deaths by hanging. The delegation was told by the authorities that a considerable number of prisoner deaths were classified as "accidental overdose" or as other types of accident, such as gas inhalation, even when they might have been suicides. As a result, the statistics on suicides are not necessarily reliable and it is very difficult to assess the impact of suicide prevention interventions.

11. The various circulars issued by the Department of Penitentiary Administration[8] provide for a comprehensive, multidisciplinary approach to the question of prevention of suicide in prisons. However, the CPT delegation's observations indicated that the practical implementation of the above suicide prevention policy was facing a number of challenges which undermined its effectiveness. For example, in one of the establishments visited there was no new arrivals section, and the delegation saw little evidence in either establishment of so-called "listener" staff.

12. The delegation also observed that suicide prevention programmes varied significantly between the two prisons visited. At Viterbo Prison, a "multi-disciplinary suicide prevention team" had been established and met every fortnight. It was composed of an educator, a psychologist, a nurse, prison officers and the prison director, and assisted by a trainee psychiatrist. In Teramo Prison, on the other hand, the delegation was informed that a similarly composed team existed but it only met on an ad hoc basis. The management of both prisons pointed to the lack of a sufficient number of educators to ensure the effectiveness of coordination among the individual team members.

Given the average of one suicide per year and the significant number of inmates (around 120) identified to be at risk of suicide (or self-harm), regular and frequent coordination of suicide prevention efforts would appear to be essential at Teramo Prison.

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6 In 2008, 2828 suicides were registered in the general population in Italy, which corresponds to 4.7 suicides per 100,000 inhabitants. In the Lazio region 182 suicides were recorded, corresponding to a rate of 3.3. Sixty-two suicides were recorded in Abruzzo, corresponding to a rate of 4.7. It is acknowledged that the rate of notified suicides in the general population might be lower than the rate of actual suicides.

7 See Seena Fazel *et al* "Prison suicide in 12 countries: an ecological study of 861 suicides during 2003-2007", *Soc Psychiat Epidemiol*, 7 February 2010.

8 See DAP circular no. 0177644 of 26 April 2010, *aimed at reducing uneasiness resulting from detention and preventing self-harm*, as well as circulars no. 3233/5683 (1987) on *protection of the life and physical and psychological integrity of prisoners*, no. 3524 (2000) on *guidelines on self-harm and suicide*, no. 0181045 (2007) on *guidelines on reception of inmates first arriving in prison*, and no. 0032296 (2010) on *the suicide emergency and the establishment of listener units among prison staff*.

2. Identification of prisoners who may be at risk of suicide or self-harm

13. Medical screening on arrival, and the reception process as a whole, has an important role to play in suicide prevention; performed properly, it should assist in identifying those at risk and relieve some of the anxiety experienced by all newly-arrived prisoners.

14. At Teramo and Viterbo Prisons, inmates were medically screened by a doctor usually within a few hours of their arrival, irrespective of whether it was their first point of entry into the prison system or they had been transferred from another prison. The screening included, in theory, a suicide risk assessment carried out by the doctor and subsequently by a psychologist; the doctor could also refer an inmate for a psychiatric assessment.

However, no identified screening tool[9] was in place at either of the prisons visited to assist in assessing the risk of suicide or self-harm. Further, it appeared from the delegation's interviews and from the medical files examined, that the increased risk of suicide among drug and alcohol dependent inmates was not sufficiently taken into account in the course of the screening process[10].

Finally, when prisoners were transferred from other establishments, information about self-harm, suicide risk or other indicators of vulnerability was not immediately and systematically transmitted to the new prison establishment[11].

The CPT recommends that the Italian authorities introduce a standard screening algorithm to assess the risk of suicide (and self-harm) in prisons; such a tool should, in particular, ensure that drug and/or alcohol dependence are adequately taken into account in the screening process as factors potentially heightening the risk of suicide. Further, steps should be taken to ensure that information on an inmate at risk of suicide or self-harm is transmitted in full and promptly to all those who have a role in caring for the prisoner, including when he or she is transferred to another establishment.

15. The prevention of suicide, including the identification of those at risk, should not rest with the health-care service alone. All prison staff coming into contact with inmates – and as a priority staff who work in the reception and admissions units – should be 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, are associated with an increased risk of suicide.

Although the delegation was informed by the authorities that staff members had succeeded in averting deaths by suicide, it was also noted that staff at the prisons visited received no specific training in suicide prevention. **The CPT recommends that all prison staff in contact with inmates be provided with practical training on the recognition of behaviour indicative of a risk of suicide. Training should also be provided on basic resuscitation skills.**

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9 Including a checklist of standard questions, e.g. the Viennese Instrument for Suicidality in Correctional Institutions, or "VISCI".

10 For example, one inmate who committed suicide by hanging was initially evaluated at both Regina Coeli and Viterbo Prisons as presenting a "minimal risk of self-harm and/or violence", despite suffering from drug addiction.

11 Notwithstanding this being required by Penitentiary Administration Circular Letter no. 3233/5683 of 30 December 1987 and, at Viterbo Prison, by Service Order No. 282/2008 of 27 October 2008.

3. Management of prisoners at risk

16. Prison management, including the head of the prison health service, should ensure that there is an adequate awareness of the subject of suicide prevention throughout the establishment, and that appropriate procedures are in place. Steps should also be taken to ensure a proper flow of information within a given establishment about persons who have been identified as potentially at risk[12].

All persons identified as presenting a suicide risk should benefit from counselling, support and appropriate association. Further, such persons should be subject to special precautions (see paragraph 19).

17. At Viterbo and Teramo Prisons, inmates manifesting inclinations of suicide or self-harm at the first medical screening or later during their sentence were classified as requiring "high" or "very high" surveillance. A very small number of inmates were identified as having to be under "constant" supervision of staff, usually at the request of a psychiatrist. These classifications essentially determined the frequency of visual checks to be made by prison staff on the prisoners concerned[13].

The supervision of prisoners at risk was carried out by prison officers only, who evidently understood this duty as a security measure and not as being a welfare-related task. Medical staff appeared to have little if any role in following up their assessment of the potentially life-threatening situation of prisoners classified as requiring high or very high surveillance. As regards, more specifically, prisoners identified as requiring very high surveillance, they remained in their cells alone.

In the CPT's view, the treatment and care of patients identified as being at risk of suicide should be overseen by medical staff. Once such a person has been identified, he or she should be the subject of regular medical visits and follow-up. Risk factors should be identified and removed, as far as possible.

Both medical and custodial staff should have an important role to play in the management of the risk of suicide or self-harm. **The CPT recommends that their respective roles be better defined and strengthened in this regard.**

18. At both Teramo and Viterbo Prisons, many prisoners classified as needing high or very high surveillance claimed that prison staff only looked into their cells on an infrequent basis and only via the spy-hole, rather than entering the cell and engaging the inmate in conversation, and that staff often did not respond to their calls for assistance.

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12 As regards transfers of inmates and the exchange of information between establishments, see paragraph 14 above.

13 "High" being 4 to 5 times daily; "very high" being 2 to 3 times per hour; "constant" being four times per hour.

In the CPT's view, a key element of suicide prevention is the establishment of constructive relations between staff and inmates, as well as between inmates themselves. The death of an inmate is likely to cause suffering and warrants the provision of appropriate psychological support to inmates and prison staff. But each life saved by a staff member also gives greater meaning to custodial tasks, and should be valued as such by the prison staff and management alike.

As far as the CPT's delegation could observe, contacts between prison staff and inmates in the prisons visited were distant. Moreover, several allegations of verbal abuse were heard at Viterbo Prison, including claims that when inmates asked to see a doctor for already diagnosed depression, certain prison staff responded in an unacceptable manner, for example by telling them to "go hang" themselves. This observation reinforces the necessity to ensure that staff working with vulnerable prisoners possess the requisite skills. **The CPT recommends that staff entrusted with the supervision of prisoners presenting a suicide risk receive specific training on interpersonal communication skills.**

19. Several inmates classified as requiring high surveillance at Teramo and Viterbo Prisons had died from asphyxiation using makeshift nooses (bed sheets, underwear or fabricated items) to hang themselves from a window or a hook affixed by the inmate in the cell bathroom. Suicide-proof clothing and bedding was apparently not in use at the establishments visited.

The CPT recommends that persons who present a major suicide risk are placed in a cell which does not contain any ligature points or other means which might facilitate an attempt to commit suicide (e.g. cell window bars, broken glass, belts or ties, etc), and kept under constant supervision by prison staff. Further, the Committee calls upon the Italian authorities to ensure that, when necessary, appropriate suicide-proof clothing is provided to inmates.

20. The CPT's delegation learned that a considerable number of deaths, including of inmates under surveillance, have occurred as a result of intentional inhalation of gas from small canisters available to prisoners for cooking purposes. Although it is difficult to ascertain precisely how many of these deaths are attributable to suicide as opposed to accidental overdose, the provision of such gas canisters to prisoners, especially those inmates already identified as being at risk of suicide, is not compatible with ensuring a safe prison environment. **The CPT recommends that such devices never be available in prison cells occupied by prisoners who present a risk of suicide (or self-harm); alternative cooking arrangements should be made in such cases.**

21. Further, the delegation was informed of cases in which prisons, due to delays in access to acute mental health care services, were obliged to cope with prisoners showing signs of severe suicidal or auto-aggressive behaviour. In a number of such cases, the prisoner in question committed suicide while in prison[14].

The CPT recommends that the necessary steps be taken to ensure that persons presenting an acute risk of suicide are immediately transferred, for appropriate care, to an acute mental health unit.

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[14] For example, an inmate who committed suicide at Viterbo Prison on 19 January 2008 had been recommended by two separate doctors in September and December 2007 for transfer to a Judicial Psychiatric Hospital due to a very high risk of suicide.

22. More generally, the limited availability of psychiatric, psychological and educator staff – coupled with the absence of meaningful activities – undermined overall efforts at a systematic, multi-disciplinary approach towards the prevention of self-harm and the associated risk of suicide. **The Committee reiterates its recommendation[15] that effective access to psychological or psychiatric care for all prisoners who require it be ensured.**

23. In some cases, prisoners considered to be at risk of suicide or self-harm were isolated from other prisoners. *De facto* isolation, resulting from a combination of confinement to a cell for most of the day, little or no contact with staff, and a poor regime, is the exact opposite of the care required; prisoners presenting a risk of suicide or self-harm should be afforded increased contacts with other persons. Indeed, isolation may well increase the risk of suicide rather than decrease it. The CPT's delegation met a number of inmates who had been in de facto isolation for several weeks and who declared that they would go insane if their isolation were to continue.

24. Provision of contact with the outside world should also be reviewed. The delegation noted that infrequent contact with family members was considered by medical staff in the prisons visited as the most pronounced damaging factor for a prisoner's mental health. In certain instances, increased family contact (i.e. visits and telephone calls) had been helpful in improving the mental health of persons met by the delegation. However, the need for enhanced contacts did not appear to be individually assessed.

25. To sum up, the central plank of a suicide prevention programme in the Italian prison context must be to address the problems of inadequate regimes and understaffing and to ensure that appropriate staff training needs are met. It should also be noted that the multiple adverse consequences of overcrowding may increase the risk of suicide.

The CPT calls upon the Italian authorities to analyse the high suicide rate and its causes and to introduce alternative suicide prevention measures – instead of isolation – such as increased and varied activities, opportunities for association, contact with the outside world and effective, multidisciplinary addiction treatment. Active suicide prevention efforts are needed, through the provision of supportive monitoring and the development of trusting relationships between inmates and staff. Further, **measures should be taken to ensure that prevention efforts are adequately coordinated, in particular by regular and frequent meetings of the multidisciplinary team and through an adequate level of input from specialist staff such as psychiatrists and educators.**

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15 See the report on the CPT's previous periodic visit to Italy in 2008 (CPT/Inf (2010) 12), at paragraphs 106, 108, 109, 112 and 113.

4. Measures taken in the event of death or self-harm in custody

26. All prison deaths were investigated internally by the Department of Penitentiary Administration Inspectorate in order to establish whether the death could be linked to any negligence or wrongdoing on the part of prison administration staff. From the files provided to the CPT's delegation, it would appear that such investigations were conducted in a thorough, apparently critical manner, leading to recommendations, where appropriate, aimed at preventing deaths in future.

Nevertheless, it is not clear from the information provided to the delegation which cases are investigated by the judicial authorities, or what are the criteria for carrying out an autopsy.

Further, the conclusions of investigations, including autopsy reports, were not routinely communicated to the prison management which, in the CPT's view, limits their ability to see what lessons could be learned from the deaths and to respond accordingly. Completeness of information about the actual cause and modality of death is needed in order to identify the magnitude of the problem, the profiles of the prisoners who commit suicide, and to develop a strategy aimed at preventing this phenomenon.

27. It should also be noted that acts of self-harm frequently reflect problems and conditions of a psychological or psychiatric nature, and should be approached from a therapeutic and not from a punitive standpoint. As already noted above, the isolation of the prisoners concerned (even if it is not considered a disciplinary sanction) is likely to exacerbate their psychological or psychiatric problems. It should also be added that all cases of self-harm ought to be assessed medically immediately after the incident to evaluate the extent of any injuries and to assess the psychological state of the prisoner. **In the CPT's view, these requirements were not being met to a satisfactory extent at the prisons visited.**

28. **The CPT recommends that the Italian authorities introduce a clear policy and comprehensive procedure on the identification of the causes of death of detained persons – including when the death occurs in (or on the way to) hospital – and clear criteria on the classification of deaths as suicides.**

In particular, every death of a prisoner should be the subject of a thorough investigation (separate from the *internal* investigation referred to at paragraph 26, subparagraph 1) **to ascertain, *inter alia*, the cause of death, the facts leading up to the death, including any contributing factors, and whether the death might have been prevented.** Further, **whenever a person dies in prison (or soon after transfer from prison), an autopsy should be carried out[16] and the prison's management and medical services should be informed of the outcome.**

Finally, **an analysis should be undertaken of each death in prison to consider what general lessons may be learned for the prison in which the death occurred and whether in the case of self-inflicted death there are any systemic, nationwide measures that need to be taken.**

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16 The Committee acknowledges that there may be highly exceptional cases in which, as prescribed by law, an independent authority may decide that an autopsy is not required.

B. Transfer of responsibility for prison health care from the Ministry of Justice to the regional health-care authorities

29. Extensive prison healthcare reform has been under consideration in Italy for the past few decades, with the main aim of integrating those services into the national health-care system, i.e. to transfer responsibility for the health care of inmates away from the central prison administration and towards the *Aziende Sanitarie Locali* ("ASLs"), which are the regional entities responsible for providing health-care services to the general population. A major part of the reform has been concluded in respect of most regions since the CPT's periodic visit in 2008. Having raised a number of concerns in the report on that visit in view of the imminent transfer of responsibility[17], the Committee decided to take stock of progress made since 2008.

30. The recent policy trend in Europe has favoured prison health-care services being placed either to a great extent, or entirely, under Ministry of Health responsibility[18]. In principle, the CPT supports this trend. In particular, it is convinced that a greater participation of Health Ministries in this area will help to ensure optimum health care for prisoners, as well as implementation of the general principle of the equivalence of health care in prison with that in the wider community.

31. One of the stated aims of the transfer of responsibility in Italy was to ensure that persons held in prison benefit from the same level of medical care as persons in the wider community. In this respect, the CPT would emphasise that equality of care must mean effective equality. The fact that ASLs would treat prisoners just as they would other patients should be positive. In practice, however, effective equality of care requires the special circumstances of detained patients to be adequately taken into consideration.

There would appear to be a variation in the level of health-care benefits provided to persons residing in different Italian regions. This means that prisoners, too, will receive a varying degree of health care depending on the region in which they are incarcerated. Given also that prisoners are often transferred between prisons in different regions, such regional differences may signify a variation in the level of care and may also have an impact on the continuity of care.

The CPT would welcome the comments of the Italian authorities as regards the above-mentioned issues.

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17 See the 2008 visit report (CPT/Inf (2010) 12, at paragraph 87. The transfer in respect of Italy's autonomous regions (Friuli Venezia Giulia, Sardinia, Sicily and Val d'Aosta) and provinces (Trento and Bolzano) was still pending at the time of the 2010 visit.

18 See, for example, Recommendation No R (87) 7 of the Committee of Ministers of the Council of Europe to member States concerning the ethical and organisational aspects of health care in prison.

32. Funding in general appeared to present a problem, in that the ASLs had, at least until the visit in June 2010, been advancing payment for health care staff salaries and services from the regional budgets, to which the relevant financial resources had still not been transferred from the Justice Ministry. Fortunately, the situation had not led to an interruption of services. However, it was clear that such a situation could not be sustained financially in the long term, especially in the less affluent regions.

The CPT trusts that the above-mentioned budgetary difficulties have now been resolved **and would like to receive confirmation that this is the case.**

33. In terms of access to health-care services, it would appear from the delegation's observations that, on the whole, since the transfer of responsibility, a level of health-care service similar to that in the outside community has been provided to inmates in the establishments visited. In particular, at both prisons visited, it had become easier for an inmate to be referred to a local hospital for a specialist opinion and, if necessary, specialist treatment. The CPT welcomes this development.

A wide variety of specialists visited the prisons in order to see patients. Nevertheless, it was also noted that specialists were generally more reluctant than in the past to provide services in prison, or at any rate did so to a lesser extent. This difference was partly attributable to the fact that some specialist medical equipment within prisons was found not to be in compliance with national health service standards and had been taken out of service since the transfer. In this context, it should be noted that some of this equipment is relatively inexpensive machinery for routine tests (e.g. ECG), and ought to be replaced rapidly.

As a result of the increase in medical transfers for specialist care outside prisons, more prison officer time was spent escorting inmates to hospital. This has clearly had a negative impact on staffing levels within prisons, which are already understaffed (particularly compared to current prison occupancy levels[19]).

Specialist health-care services should be provided in an appropriate setting, whether within a prison establishment or outside. Whatever arrangements are made to ensure that this requirement is met, **the CPT recommends that the relevant authorities take the necessary steps to ensure that these arrangements do not undermine other important aspects of prison life, such as the provision of an appropriate regime and sufficient numbers of staff present on the wings.**

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[19] On 31 October 2010, prisons in Italy accommodated 68 795 inmates for an official capacity of 44 962. See also paragraph 4.

34. It was not clear to the delegation what criteria were applied for selecting prisoners to receive consultations or care from specialists attending the prisons visited. For instance, certain prisoners appeared to be given priority and moved up the waiting list even though their health condition was clearly not urgent compared to that of other inmates. Particular mention should be made to dental care provided at Teramo Prison: a consultation of the registers showed that inmates of certain nationalities appeared to have no effective access to such care.

In the interest of dispelling any possible perception of favouritism or discrimination, **the CPT recommends that the Italian authorities ensure that access to health care and, in particular, to consultations and care provided by specialists visiting prisons, is managed in a transparent, non-discriminatory manner.**

35. A positive aspect of the service provided to persons on their arrival in the two prisons visited was the promptness with which medical screening was generally carried out.

Although no central trauma register was kept in the establishments visited, the medical files examined showed that injuries were recorded thoroughly. However, the record did not always indicate statements of the inmates as to the origin of injuries observed. Further, in none of the medical files examined in the course of the visit was the doctor's opinion noted regarding the consistency between the injuries observed and the inmate's explanation for them. Finally, and perhaps most importantly, the delegation's observations during the visit indicate that no automatic reporting of any injuries to the appropriate authority is required of prison doctors.

The CPT calls for steps to be taken to ensure, throughout the Italian prison system, that the record drawn up after a medical examination of a prisoner, whether newly-arrived or not, contains:

(i) a full account of statements made by the prisoner concerned which are relevant to the medical examination, including any allegations of ill-treatment made by him/her;

(ii) a full account of objective medical findings based on a thorough examination;

(iii) the doctor's conclusions in the light of (i) and (ii). In his/her conclusions, the doctor should indicate the degree of consistency between any allegations made and the objective medical findings; a copy of the conclusions should be made available to the prisoner concerned and to his/her lawyer, on request.

Further, **if the prisoner refuses to reveal the cause of any signs of violence or gives reasons other than ill-treatment, his or her statement should also be accurately reported by the doctor.** Finally, **when detained persons are found to show signs of ill treatment, doctors should be required immediately to bring the record of such injuries to the attention of the relevant prosecutor.**

36. As regards forensic psychiatric patients in Judicial Psychiatric Hospitals (OPGs), the Italian authorities informed the delegation during the visit that the implications for OPGs of the transfer of prison health-care responsibility were not yet determined. It was not clear, for example, whether penitentiary regions in which no OPG was located would each have to establish their own forensic psychiatric hospital unit in order to cater for patients requiring forensic psychiatric observation or placement. The delegation was told that around 70 forensic patients from Abruzzo would soon have to leave the OPG in Campania where they were placed, but the Abruzzo regional penitentiary authorities had not yet made provision for how or where they would be managed or accommodated.

The CPT would like to receive confirmation that persons requiring forensic psychiatric care will continue to receive such specialist care in an appropriate setting.

Further, **the Committee would like to receive comprehensive information as regards the Italian authorities' medium and long-term plans in relation to forensic psychiatric placements.**

37. The delegation observed that medical confidentiality was not ensured in the prisons visited. Consultations between doctor and patient were often carried out in the presence of prison officers. Moreover, the prison health-care service is required to provide a prisoner's full medical history to the prison management and the relevant judicial authority before any transfer to hospital for examination or treatment may be authorised. This is not acceptable.

Medical confidentiality is a fundamental principle, which is enshrined in Italy's national health-care system and which needs to be equally respected within the prison environment. And yet, despite the transfer of responsibility for health-care services away from the prison administration, this requirement was still not being met.

The CPT recommends that the necessary steps be taken by the relevant authorities to ensure full respect for prisoners' medical confidentiality. In particular, medical examinations of prisoners should be conducted out of the hearing and – unless the doctor concerned expressly requests otherwise in a given case – out of the sight of non-medical staff. Further, **whenever a prisoner needs to be hospitalised or examined by a specialist outside the prison, the medical information passed on by the doctor to the prison management or judicial authorities should be limited to that which is strictly necessary to facilitate the prisoner's transfer and supervision.**

38. In the CPT's view, doctor-patient confidence in the wider sense is also undermined by the presence of the prison doctor on the panels of prisoner disciplinary proceedings. This practice was criticised by the Committee in past visit reports[20] and was noted once again in the prisons visited.

The CPT recommends that, in the interest of fostering doctor-patient trust, prison doctors do not sit on prisoner disciplinary panels.

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20 See, e.g. CPT/Inf (2010) 12, paragraph 117.

39. As with other aspects of deprivation of liberty, prison health-care services should be subject to adequate supervision. One practical difference since the transfer of responsibility has been that Ministry of Justice inspections no longer cover health-care services in prisons, as these services now fall within the remit of the Ministry of Health.

From the information gathered during the visit, it appeared that inspections carried out by the Ministry of Health focus largely on the clinical and hygiene aspects of health-care service performance, and are less concerned with other aspects of those services' tasks for which there might be greater awareness within an inspection carried out by the Ministry of Justice. One such aspect is the adequate recording of injuries, whether during medical screening on arrival or after a violent incident in prison.

In the light of the above remarks, **the CPT recommends that the Italian authorities take appropriate measures to ensure that all aspects of the work of health-care services are supervised; if necessary, prison health-care services should be the subject of joint inspections by the Ministries of Health and Justice.**

40. To sum up, the CPT welcomes the integration of prison health care within the national health-care system. Nevertheless, the transfer process is experiencing teething problems and a number of issues raised by the Committee – some of which it has already raised in previous visit reports concerning prison health care – need to be addressed. The CPT trusts that the Italian authorities will review the provision of health care to detained persons in the light of the remarks in this and previous reports.

The Committee recommends that the relevant health-care authorities be apprised of the contents of both chapters of this report, as each addresses prison health care.

APPENDIX

LIST OF THE CPT'S RECOMMENDATIONS, COMMENTS AND REQUESTS FOR INFORMATION

Cooperation received

comments

- the Committee trusts that, in future, the credentials supplied by the Italian authorities to CPT visiting delegations will cover all places where persons may be deprived of their liberty by a public authority, including courthouse detention cells, and that delegations will be received with a level of courtesy which is in keeping with good cooperation (paragraph 6).

Prevention of suicide (and self-harm) in the prison context

Identification of prisoners who may be at risk of self-harm or suicide

recommendations

- the Italian authorities to introduce a standard screening algorithm to assess the risk of suicide (and self-harm) in prisons; such a tool should, in particular, ensure that drug and/or alcohol dependence are adequately taken into account in the screening process as factors potentially heightening the risk of suicide (paragraph 14);

- steps to be taken to ensure that information on an inmate at risk of suicide or self-harm is transmitted in full and promptly to all those who may have a role in caring for the prisoner, including when he or she is transferred to another establishment (paragraph 14);

- all prison staff in contact with inmates to be provided with practical training on the recognition of behaviour indicative of a risk of suicide; training should also be provided on basic resuscitation skills (paragraph 15).

Management of prisoners at risk

recommendations

- the respective roles of medical and custodial staff in the management of the risk of suicide or self-harm to be better defined and strengthened (paragraph 17);

- staff entrusted with the supervision of prisoners presenting a suicide risk to receive specific training on interpersonal communication skills (paragraph 18);

- persons who present a major suicide risk to be placed in a cell which does not contain any ligature points or other means which might facilitate an attempt to commit suicide (e.g. cell window bars, broken glass, belts or ties, etc), and kept under constant supervision by prison staff (paragraph 19);

- the Italian authorities to ensure that, when necessary, appropriate suicide-proof clothing is provided to inmates (paragraph 19);

- devices such as gas canisters never to be available in prison cells occupied by prisoners who present a risk of suicide (or self-harm); alternative cooking arrangements should be made in such cases (paragraph 20);

- the necessary steps to be taken to ensure that persons presenting an acute risk of suicide are immediately transferred, for appropriate care, to an acute mental health unit (paragraph 21);

- effective access to psychological or psychiatric care, for all prisoners who require it, to be ensured (paragraph 22);

- the Italian authorities to analyse the high suicide rate and its causes and to introduce alternative suicide prevention measures – instead of isolation – such as increased and varied activities, opportunities for association, contact with the outside world and effective, multidisciplinary addiction treatment. Active suicide prevention efforts are needed, through the provision of supportive monitoring and the development of trusting relationships between inmates and staff (paragraph 25);

- measures to be taken to ensure that prevention efforts are adequately coordinated, in particular by regular and frequent meetings of the multidisciplinary team and through an adequate level of input from specialist staff such as psychiatrists and educators (paragraph 25).

Measures taken in the event of death or self-harm in custody

recommendations

- the Italian authorities to introduce a clear policy and comprehensive procedure on the identification of the causes of death of detained persons – including when the death occurs in (or on the way to) hospital – and clear criteria on the classification of deaths as suicides. In particular, every death of a prisoner should be the subject of a thorough investigation to ascertain, inter alia, the cause of death, the facts leading up to the death, including any contributing factors, and whether the death might have been prevented (paragraph 28);

- an autopsy to be carried out whenever a person dies in prison (or soon after transfer from prison) and the prison's management and medical services to be informed of the outcome (paragraph 28);

- an analysis to be undertaken of each death in prison to consider what general lessons may be learned for the prison in which the death occurred and whether in the case of self-inflicted death there are any systemic, nationwide measures that need to be taken (paragraph 28).

comments

- the requirements described in paragraph 27 in relation to acts of self-harm were not being met to a satisfactory extent at the prisons visited (paragraph 27).

Transfer of responsibility for prison health care from the Ministry of Justice to the regional health-care authorities

recommendations

- the relevant authorities to take the necessary steps to ensure that the arrangements for providing specialist health-care services do not undermine other important aspects of prison life, such as the provision of an appropriate regime and sufficient numbers of staff present on the wings (paragraph 33);

- the Italian authorities to ensure that access to health care and, in particular, to consultations and care provided by specialists visiting prisons, is managed in a transparent, non-discriminatory manner (paragraph 34);

- steps to be taken to ensure, throughout the Italian prison system, that the record drawn up after a medical examination of a prisoner, whether newly-arrived or not, contains:

  (i) a full account of statements made by the prisoner concerned which are relevant to the medical examination, including any allegations of ill-treatment made by him/her;

  (ii) a full account of objective medical findings based on a thorough examination;

  (iii) the doctor's conclusions in the light of (i) and (ii). In his/her conclusions, the doctor should indicate the degree of consistency between any allegations made and the objective medical findings; a copy of the conclusions should be made available to the prisoner concerned and to his/her lawyer, on request.

  (paragraph 35);

- if the prisoner refuses to reveal the cause of any signs of violence or gives reasons for the injuries other than ill-treatment, his or her statement also to be accurately reported by the doctor (paragraph 35);

- doctors to be required immediately to bring the record of injuries to the attention of the relevant prosecutor when detained persons are found to show signs of ill-treatment (paragraph 35);

- the necessary steps to be taken by the relevant authorities to ensure full respect for prisoners' medical confidentiality. In particular, medical examinations of prisoners should be conducted out of the hearing and – unless the doctor concerned expressly requests otherwise in a given case – out of the sight of non-medical staff (paragraph 37);

- the medical information passed on by the doctor to the prison management or judicial authorities to be limited to that which is strictly necessary to facilitate the prisoner's transfer and supervision, whenever a prisoner needs to be hospitalised or examined by a specialist outside the prison (paragraph 37);

- prison doctors not to sit on prisoner disciplinary panels (paragraph 38);

- the Italian authorities to take appropriate measures to ensure that all aspects of the work of health-care services are supervised; if necessary, prison health-care services should be the subject of joint inspections by the Ministries of Health and Justice (paragraph 39);

- the relevant health-care authorities to be apprised of the contents of both chapters of the visit report, as each addresses prison health care (paragraph 40).

requests for information

- the comments of the Italian authorities as regards the issues of effective equality and continuity of care mentioned in paragraph 31 (paragraph 31);

- regarding the budgetary difficulties described in paragraph 32, confirmation that they have now been resolved (paragraph 32);

- confirmation that persons requiring forensic psychiatric care will continue to receive such specialist care in an appropriate setting (paragraph 36);

- comprehensive information as regards the Italian authorities' medium and long-term plans in relation to forensic psychiatric placements (paragraph 36).