Articles

Preventing Human Rights Violations in Places of Detention:
A European Initiative

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International human rights law defines certain fundamental freedoms which individuals should enjoy and proscribes a number of actions by the State or its agents, such as torture and cruel, inhuman, or degrading treatment. Its major defect is a lack of effective procedures by which individuals can file complaints and through which states can be condemned for violations. The [European] Convention for the Protection of Human Rights and Fundamental Freedoms has been ratified by over 30 European states and is commonly known as the European Convention of Human Rights (ECHR).[1] It is remarkable not for the originality of the rights defined and protected but for its provisions, which are to a significant extent, enforceable by supranational legal procedures accessible to individuals as well as to states. Thus, the European Court of Human Rights (ECtHR) regularly finds that states have been parties to human rights violations, and obligates them to pay damages to individuals concerned. The ECtHR's decisions also oblige states to modify national legislation and to change procedures which they determine constitute human rights violations.

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The ECtHR has made a number of judgements directly related to the field of health. For example, these may concern involuntary hospitalization of transsexuals, those infected with HIV through blood transfusions, and the mentally ill. More specifically, the proscription of torture and inhuman or degrading treatment under Article III of the ECHR has led to important decisions concerning detained persons. In the case of *Ireland v. the United Kingdom*, the UK was condemned for the using of interrogation methods in Northern Ireland considered by the Court to be inhuman or degrading.[2] In the *Soering v. United Kingdom* case, the ECtHR held that extradition of a US citizen from the United Kingdom to the USA, where he faced charges carrying the death penalty, would constitute inhuman and degrading treatment in view of likely prolonged detention preceding execution.[3] Felix Tomasi in *Tomasi v. France,* claimed to have been kicked, punched, and threatened during interrogation for suspected terrorist acts at a Corsican police station in 1983. The ECtHR upheld his complaint, supported principally by two independent medical examinations.[4]

From Supranational Judicial Proceedings to Legally Enforced, On-Site Inspection

Clearly, even the remarkable procedures established under the ECHR and the growing body of ECtHR case law are not sufficient to prevent human rights violations in high risk settings like police stations, prisons, and psychiatric hospitals. Complaint procedures are slow and only in exceptional cases can violations be prevented or corrected in a timely fashion. Decisions can influence national legislation, but lack of any inspection mechanism allows for little impact on what actually happens in detention facilities. For these reasons, a new regional instrument, designed to enhance protection of those deprived of their liberty, was developed within the framework of the Council of Europe, following a sustained campaign by the Swiss Committee Against Torture. Swiss Committee president Jean-Jacques Gautier's attempts to introduce the new instrument on a global level under the UN had been unsuccessful. The Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment was adopted unanimously by the Council of Europe's Committee of Ministers in 1987.[5] Rarely has a convention been so

well received: it was ratified by seven states within one year and entered into force on February 1, 1989. As of mid-1995, 29 states have ratified the Convention, including several countries from the former socialist bloc (Bulgaria, Czech Republic, Hungary, Romania, Slovakia, Slovenia). The Convention created a committee having nearly unlimited access to all places of detention, including the right to interview detainees without witnesses. The aim is to create a dynamic, extra-judicial mechanism to prevent torture and ill-treatment through detection of high risk situations, and via recommendations to national authorities of measures to reinforce human rights protections. The committee is widely known as the Committee for the Prevention of Torture (CPT); unfortunately, this name over-emphasizes torture, whereas the Committee is concerned primarily with other forms of abuse. The CPT consists of members from each state party who act independently and impartially.

As the first body in international human rights law to monitor detention conditions as "an important part of its functioning," the CPT has been described by legal scholars as a "crucial evolutionary step within the panoply of international human rights interventions, a step that other bodies already wish to emulate," and as developing "a corpus of standards for the treatment of persons deprived of their liberty."[6,7]

In some ways the CPT mechanism resembles the International Committee of the Red Cross (ICRC) mandate to visit prisoners of war and civilian detainees in situations of conflict. Indeed, original proponents of the new Convention were strongly influenced by the work of the Geneva-based ICRC. The ICRC role in visiting detainees is "to prevent torture, to prevent 'disappearances' and to work for overall improvements in the material and psychological conditions of detention."[8] The ICRC maintains strict neutrality and all of its observations and reports remain confidential. These conditions are necessary in order for it to access prisoners and conduct interviews without witnesses. Observers have regarded the CPT as a "peacetime ICRC," but important differences exist between the two institutions. In particular, the ICRC's detention work is almost always part of a wider humanitarian action under conditions of war or armed disturbances, whereas the CPT mandate is limited to prevention and investigation of human rights violations in places of detention.

The CPT at Work

The CPT's work is based on the principle of cooperation *with states*. Its proceedings are always held in private. The CPT's principle method of work involves on-site visitations by a member delegation of 2 to 5 members per visit, as well as experts and often, interpreters. Following its visits, the CPT sends confidential reports to the government concerned. These include observations, recommendations, and requests for further information, while not normally citing names of prisoners involved. The government then sends a formal reply to the CPT, which may in turn request further information from the government.

Two types of visits—periodic and *ad hoc*—are undertaken by the CPT. Periodic visits are made to each country that ratified the Convention. These last from one to two weeks and cover a wide variety of places of detention selected by the CPT, based on advice received from nongovernmental organizations and other sources. *Ad hoc* visits are made to specific institutions or regions from which information indicates a particularly high risk of torture or ill treatment.[9]

The CPT has developed a method of work that imposes an extraordinarily heavy workload and level of commitment on members and experts. Most police station visits take place in the middle of the night; prisons and hospitals are sometimes visited in the early hours of the morning. Visiting a large prison can involve up to five days of continuous work, often stretching into the evenings. The CPT delegation also normally works through weekends. There is a heavy travel schedule, as the delegation tries to cover as much ground as possible, often splitting into small groups and changing its program as the visit progresses.

Confidentiality and Disclosure

When members founded the CPT, they felt that public information on their work would be limited to dates and places visited and to general observations in an annual "General Report." The only exception would be the case of a contracting party refusing to cooperate or take active steps to implement recommendations. Such a situation has arisen only once, involving Turkey. Following two *ad hoc* visits in 1990 and 1991 and a periodic visit in 1991, CPT released a public statement in September 1992, expressing regret at Turkey's failure to deal with

the widespread and routine use of torture in police stations.[10] These allegations had been strongly supported by observations of medically qualified members and experts.

The dramatic case of Turkey aside, the CPT's relations with countries are characterized by satisfactory dialogue and cooperation. This was illustrated by many countries' decision to authorize publication of their CPT report, often together with their government's reply. Thus, approximately two-thirds of the country reports have been published to date, providing the public with insight into the CPT's work method and observations, as well as the human rights issues raised and governmental responsiveness.

The CPT and Health

When the Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment came into force, it was thought that it would have "important implications for the medical profession: firstly, visits to psychiatric hospitals will be included and, secondly, the adequacy and ethics of medical care in prisons will be a key issue ...."[11] Health-related issues have, in fact, been of major importance in CPT work; many of its most trenchant conclusions have been based on medical observations, and the Committee has paid constant attention to health care in prisons. Several members of the CPT are medically qualified, including both of its first Vice-Presidents: Professor Bent Sørensen, well known for his work at the Copenhagen Centre for Rehabilitation of Torture Victims, and Professor Jacques Bernheim, a forensic specialist with psychiatric training. A medical expert, usually a doctor or occasionally a nurse, almost always accompanies the CPT on its visits.[12]

Early CPT country visits resulted in several conclusions relevant to health and to medical practice. For example, in Denmark, an unusually harsh form of solitary confinement was being applied to remand prisoners for up to 21 months, resulting in serious psychiatric disturbances. Prisoners in solitary confinement asking to see a doctor were not seen promptly and judicial authorities consistently ignored medical recommendations to terminate isolation.[13] In Austria, medical care of persons in police custody was said to be inadequate and allegations of serious ill-treatment of detainees in police custody during interrogation were supported by medical reports of contusions, bruising and eardrum damage.[14] The United Kingdom report included devastat-

ing criticism of gross over-crowding and squalid conditions in remand prisons. The CPT declared that the combination of overcrowding, lack of sanitation, and inactivity constituted "inhuman and degrading treatment." The medical care given systematically violated basic ethical standards, and mental health care in Brixton prison's notorious F Wing was said to more likely exacerbate than alleviate psychiatric disorders. Furthermore, the segregation of HIV-infected prisoners was deemed unjustified and degrading.[15] The *Lancet*, commenting on the CPT's first two years of activity, expressed hope that the CPT would help to overcome barriers that separate prison from society, and prison health from community health.[16]

By 1992, national authorities were generally reacting positively to the CPT's criticisms and recommendations concerning health-related matters. The weight and authority of a supranational, impartial body often facilitated efforts to improve material conditions and to increase staffing levels, especially of nurses and doctors. In its Third General Report, the CPT devoted a chapter to health care in prisons, in which seven basic principles were defined: access to a doctor, equivalence of care, consent and confidentiality, preventive measures, humanitarian interventions, professional independence, and competence. The need for access to hospital care, including psychiatric care, was emphasized and regular use of physical restraint for psychiatrically disturbed prisoners was condemned. In the report, the CPT also advocated systematic recording of all cases of trauma by prison medical services as a contribution to violence prevention. In addition, CPT endorsed a non-discriminatory and non-coercive approach to prevention and management of HIV infection and AIDS, thereby aligning itself with World Health Organization (WHO) guidelines in this field.[17]

In its most recent visits, the CPT appears to give increasing attention to conditions in psychiatric hospitals, especially to special security hospitals for patients considered dangerous. For example, during the CPT visit to Greece, psychiatric institutions on the island of Leros were studied intensively, leading to substantial critical observations.

France provides an interesting case study of CPT's health-related interventions. The first periodic visit was carried out in October/November 1991 and the CPT's report, together with the government's reply, were published in January 1993.[18] One year

later, the government published a follow-up report, and in 1994, a second periodic visit was conducted. Several weeks later the CPT made a brief and unannounced visit to Paris police headquarters. The reports of these last two visits have not yet been published. In its first visit, the CPT discovered that prisoners transferred to civil hospitals were frequently handcuffed to their beds and that this form of restraint was used even for women during childbirth. The practice was stigmatized as a "flagrant example of inhuman and degrading treatment." The French government set up a commission of enquiry, which corroborated CPT allegations and declared this practice "inadmissible and shocking." Urgent preventive measures were ordered. CPT findings in France also led to a new regulation requiring all persons detained by police to be examined rapidly by a doctor under conditions of confidentiality. The CPT strongly supported initiatives to transfer responsibility for health care from the prison administration to the Ministry of Health, in order to ensure professional independence and community standards of competence. In addition, the CPT made a series of critical comments on a large psychiatric hospital for "difficult patients;" these noted its understaffing, inappropriate use of solitary confinement and physical restraint, and absence of a complaint procedure. In response, the French government increased staffing levels and provided more detailed information and response to patients.

The CPT's First Five Years

By 1993, the CPT had completed its first round of periodic visits. In 1994, it conducted second periodic visits to France, the United Kingdom, Austria, Spain, and Sweden, as well as the first visit to a former socialist bloc country (Hungary) and to territories outside of Europe (Martinique and the Dutch Antilles).

Independent observers have concluded that the CPT has shown considerable courage, has succeeded in establishing "cooperative dialogue" with most governments, and has demonstrated extraodinary dedication, imagination, and skill. The first five years of the CPT's work have been remarkable and its practical impact on prison conditions and police custody have been positive. With emergence of health as a major dimension in the prevention of inhuman and degrading treatment, the role of medically qualified persons in the CPT's work is growing. However, a few notes of caution must be expressed.

The CPT's effectiveness depends largely on the positive attitude of national authorities and of the medical and legal professions. The CPT has rarely engaged public opinion. CPT criticisms are often detailed and specialized; victims of ill-treatment, such as mentally ill prisoners or dangerous offenders, do not readily appeal to the mass media. The CPT has taken ambiguous or unsatisfactory positions about certain health-related issues. One example concerns medical interventions during hunger strikes. It is disappointing that the CPT did not criticize the involuntary detention of HIV-infected persons whose behavior was thought to be irresponsible, as practiced in Sweden, although it visited a unit where such detention is carried out.[19]

The CPT must strike a balance between realism (risking acceptance of certain unacceptable situations and practices) and activism (risking provocation of the authorities). The Swiss Federal Government reacted in a defensive manner to the CPT report on Switzerland, and suggested that the standards demanded are too high. This was ironic, in view of the Convention's origins, but may indicate a need for more explicitness in setting acceptable standards. There are also legitimate fears of "burn out" of CPT members (especially the President and Vice-Presidents) and the Secretariat's attempt to maintain the current intensive rhythm of periodic visits. Certainly, more resources are required to cover the burgeoning workload created by the growing number of states ratifying the Convention.

Conclusion

In the past, too many international human rights initiatives have been sterile exercises: unenforceable declarations by UN bodies, inconclusive debates in the UN Commission of Human Rights, and hypocritical double standards in which real-life human rights violations are rarely identified and condemned. The ECHR represents an attempt to provide an effective supranational judicial procedure to enforce human rights in Europe. Within this context, the creation of the CPT has demonstrated that an international legal framework can provide for a targeted, on-site inspection process and standard setting to promote human rights in the high risk situation of detention. Health has emerged as one of the major preoccupations within this process.[20]

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