Conditions in prisons

Prison visits
Medical legality

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Guidelines for visits to prisons

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PREFACE

Guidelines for visits to prisons is a contribution to the work which has emerged from the mandate of the European Committee for the Prevention of Torture (CPT). However, the Guidelines reach beyond the target group of this organisation and are normative, not just for a single continent, but as a global recommendation on general precautions for prisons of all kinds, not least with respect to the treatment of political prisoners. This is the reason why the CPT is an important tool in the fight against torture, as a significant part of government sanctioned torture is carried out during imprisonment, in fact, during the very first days of imprisonment.

It is an obvious necessity that recognized guidelines exist, and that they can be used against Council of Europe member countries, in order that criticism can be directed at countries which break the rules and that conditions in prisons in this way can be improved. In addition, it is important to be able to use such guidelines as references for other governmental institutions which deal with prisoners, as for example the police and the military, in the European member states as well as on the other continents, in order that nations which have signed the UN Convention against Torture have specific aims for their treatment of prisoners of all kinds and in all types of detention carried out by state agents. This further function may be a vain hope, but will in any case be a challenge and will encourage continued considerations to prevent serious violations of human rights, including torture, in line with the provisions of the UN Convention against Torture. For this reason alone, it is important that the first step has been taken. IRCT is pleased to be able to contribute to this work for torture prevention, which corresponds very well with the IRCT objectives.

The main author of Guidelines for visits to prisons, Professor Bent Sørensen has now left the CPT after the two terms which is the maximum period possible, and has, as a medical doctor and organizer of a new surgical discipline (treatment of burns), and as highly estimated former Chairman of the Board of RCT, been a very important resource person in CPT's work, documenting the conditions in prisons, etc.

The editorial board of TORTURE has seen it as a fine gesture on behalf of the authors and as a big step forward for our publication activities to be able to publish this material together with other articles dealing with associated issues.

In this connection, the editorial board has found it relevant to bring an analysis dealing with specific conditions concerning medical involvement, although the issue of torture is not touched upon in the article. The article Ethical and legal aspects of working as a doctor in the Danish prison system has a practical, legal origin. The background is an analysis based on a democratic system, and therefore the work cannot be compared directly with the wider target group for the Visits to Prisons part of this supplement. However, the article presents new ideas and inspiring points of view, and the editorial board wishes to thank the authors for letting us publish their article.

H.M.
Guidelines for visits to prisons

Bent Sørensen

With contributions from:

Derrick Pounder
Hernan Reyes
Gerard Rooney

"No one shall be submitted to torture or to cruel, inhuman or degrading treatment or punishment"

United Nations Universal Declaration of Human Rights, Article 5, 1948
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TORTURE Supplementum No. 1, 1997
I. PREFACE

The following is an attempt to give advice to persons inspecting prisons.

The author was Chairman of the Board of the Rehabilitation and Research Centre for Torture Victims in Copenhagen (RCT) 1984-90. Torture is one of the severest (the severest!) violations of human rights. Torture is practised in more than one third of the countries of the world. Torture is destructive to individual persons, it constitutes a general health problem, and it is devastating for democracy.

Government-sanctioned torture usually takes place at police stations, and the victims are often found in prisons, where they may also have been subjected to "inhuman or degrading treatment or punishment".

Based on knowledge from the RCT, I was elected a member of the United Nations Committee Against Torture (CAT) from its very beginning in 1988, and of the Council of Europe's Committee for the Prevention of Torture (CPT) from its start in 1989; for the first six years as First Vice-President.

It is first and foremost my experience from the CPT, founded on my knowledge from the RCT, which constitutes the basis of this supplement. Part one of the supplement is a quotation of the CPT's "constitution", the 2nd and 3rd General Report on the CPT's Activities. Both reports are public papers. The relevant paragraphs, quoted in these guidelines on p. 10 to p. 18, were drawn up by the first Bureau - with regard to Health Care Service in Prisons especially by Professor Jacques Bernheim - in cooperation with the Secretariat and approved by the plenum of the CPT.

In this connection, I wish to thank the two other members of the first Bureau, the former President, Professor Antonio Cassese, Italy, the former Second Vice-President, Professor Jacques Bernheim, Switzerland, and the Secretary of the CPT, Mr. Trevor Stevens, for excellent and fruitful cooperation. Finally, the 7th General Report (1996) contains a substantial part describing the CPT policies concerning foreign nationals detained under aliens legislation.

Professor Derrick J. Pounder, Dundee, Scotland, has been kind enough to give his permission to publish the paper "Wounds and the paper Ethical and practical aspects of medical opinions", both of which were used in part at the Training Seminar on Prison Visits, held in Copenhagen in October 1996.

Dr. Hernan Reyes, Delegate to the International Committee of the Red Cross (ICRC), has kindly given permission to publish his contribution on the ICRC's work, and especially the importance of the firm mandate - also used in part at the Training Seminar on Prison Visits, October 1996.

Gerard Rooney, Chief Psychologist, Scotland, has permitted the publication of the section on hostage taking, based on a contribution which was given as training for the members of the CPT in December 1996.

Finally, the Editor in Chief of the journal TORTURE - Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture, has agreed to have this book printed as Supplementum no 1, 1997 to the journal.

The author wishes to express his deep gratitude to the persons mentioned.

Boe Værensen, September 1997

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

The CPT consists of one member from each of the Member States. At present (July 1997), 34 States out of 40 possible ones have ratified the Convention.

The mandate of the CPT

The target group is "persons deprived of their liberty by the State authorities". The Convention gives a delegation, consisting of CPT members (generally 4-5), assisted by experts (generally 2-3), secretaries (generally 1-3) and the number of interpreters needed, the right to visit the country and visit these groups of persons, whether they are in police stations, prisons, mental hospitals, refugee camps or the like. The mandate is very extensive indeed: the delegation has the right to:

1. talk to "everybody" (detainees and employees) in private
2. see all premises (not only cells)
3. see all papers
4. make unannounced visits
5. repeat the visit unannounced.

After such an inspection visit, which generally takes 10-14 days, the delegation, based on the facts found, prepares a report, which contains comments, questions and recommendations, and is then forwarded to the State concerned via the CPT. As a consequence, the CPT has over the years acquired a fairly extensive knowledge about the conditions in police stations and prisons in Europe. There is of course a difference in function between prisons in Europe and in other continents based on cultural and resource differences, but on the other hand, ill-treatment should not occur in any location. The experience of the CPT, especially about ill-treatment, might therefore be useful.

The work of the CPT is based on the two C's: Confidentiality and Cooperation. However, in September 1991 Denmark made public the CPT's report on its visit in 1990, and since then more and more states - in cooperation with the CPT - have published their reports, often accompanied by the reply of the States. It is now rather the rule than the exception for a country to publish the respective report.

It is my opinion that the published reports are goldmines as regards prison visits - what can be criticized, which conditions can be improved?

The principle of confidentiality is however still of very great importance: the States receive recommendations/ instructions from the CPT, and they have an opportunity to discuss these with the CPT before deciding whether to publish the report.
II. VISIT TO PRISONS – THE GOALS OF THE CPT

The CPT has compiled its experience so far in the Second, the Third, and the Seventh General Report on the CPT's Activities. The author has chosen to begin the guidelines with the above official considerations on prison inspection visits. The three reports may be considered as the CPT's "policy paper" in its work for prevention: How should the prison conditions be in order to avoid ill-treatment? They may therefore function as a guiding light for inspection activities in prisons.

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

2nd General Report on the CPT's activities, covering the period 1 January to 31 December 1991 (CPT/Inf (92) 3), (page 11-17)

"III. SOME SUBSTANTIVE ISSUES PURSUED BY THE CPT DURING VISITS"

35. The CPT's role is essentially preventive in nature; its main purpose is to forestall torture or inhuman or degrading treatment or punishment rather than to establish that it has actually occurred (see further the 1st General Report, op. cit. Part IV). To fulfil that role, the Committee must explore a wide range of issues – rights possessed by persons deprived of their liberty; custody and interrogation procedures; disciplinary procedures; avenues of complaint; physical conditions of detention; regime activities; health care and standards of hygiene; etc. – in order to assess not only whether there is an imminent risk of ill-treatment but also whether conditions or circumstances exist which could degenerate into ill-treatment. Further, these issues must be viewed both individually and cumulatively.

a. Police custody

36. The CPT attaches particular importance to three rights for persons detained by the police: the right of the person concerned to have the fact of his detention notified to a third party of his choice (family member, friend, consulate), the right of access to a lawyer, and the right to request a medical examination by a doctor of his choice (in addition to any medical examination carried out by a doctor called by the police authorities). They are, in the CPT's opinion, three fundamental safeguards against the ill-treatment of detained persons which should apply as from the very outset of deprivation of liberty, regardless of how it may be described under the legal system concerned (apprehension, arrest, etc.).

37. Persons taken into police custody should be expressly informed without delay of all their rights, including those referred to in paragraph 36. Further, any possibilities offered to the authorities to delay the exercise of one or other of the latter rights in order to protect the interests of justice should be clearly defined and their application strictly limited in time. As regards more particularly the rights of access to a lawyer and to request a medical examination by a doctor other than one called by the police, systems whereby, exceptionally, lawyers and doctors can be chosen from pre-established lists drawn up in agreement with the relevant professional organisations should remove any need to delay the exercise of these rights.

38. Access to a lawyer for persons in police custody should include the right to contact and to be visited by the lawyer (in both cases under conditions guaranteeing the confidentiality of their discussions) as well as, in principle, the right for the person concerned to have the lawyer present during interrogation.

As regards the medical examination of persons in police custody, all such examinations should be conducted out of the hearing, and preferably out of the sight, of police officers. Further, the results of every examination as well as relevant statements by the detainee and the doctor's conclusions should be formally recorded by the doctor and made available to the detainee and his lawyer.

39. Turning to the interrogation process, the CPT considers that clear rules or guidelines should exist on the way in which police interviews are to be conducted. They should address inter alia the following matters: the informing of the detainee of the identity (name and/or number) of those present at the interview; the permissible length of an interview; rest periods between interviews and breaks during an interview; places in which interviews may take place; whether the detainee may be required to stand while being questioned; the interviewing of persons who are under the influence of drugs, alcohol, etc. It should also be required that a record be systematically kept of the time at which interviews start and end, of any request made by a detainee during an interview, and of the persons present during each interview.

The CPT would add that the electronic recording of police interviews is another useful safeguard against the ill-treatment of detainees (as well as having significant advantages for the police).

40. The CPT considers that the fundamental safeguards granted to persons in police custody would be reinforced (and the work of police officers quite possibly facilitated) if a single and comprehensive custody record were to exist for each person detained, on which would be recorded all aspects of his custody and action taken regarding them (when deprived of liberty and reasons for that measure; when told of rights; signs of injury, mental illness, etc; when next of kin/consulate and lawyer contacted and when visited by them; when offered food; when interrogated; when transferred or released, etc.). For various matters (for example, items in the person's possession, the fact of being told of one's rights and of invoking or waiving them), the signature of the detainee should be obtained and, if necessary, the absence of a signature explained. Further, the detainee's lawyer should have access to such a custody record.

41. Further, the existence of an independent mechanism for examining complaints about treatment whilst in police custody is an essential safeguard.

42. Custody by the police is in principle of relatively short duration. Consequently, physical conditions of detention cannot be expected to be as good in police establishments as in other places of detention where persons may be held for
lengthy periods. However, certain elementary material requirements should be met.

All police cells should be of a reasonable size for the number of persons they are used to accommodate, and have adequate lighting (i.e. sufficient to read by, sleeping periods excluded) and ventilation; preferably, cells should enjoy natural light. Further, cells should be equipped with a means of rest (e.g. a fixed chair or bench), and persons obliged to stay overnight in custody should be provided with a clean mattress and blankets.

Persons in custody should be allowed to comply with the needs of nature when necessary in clean and decent conditions, and be offered adequate washing facilities. They should be given food at appropriate times, including at least one full meal (i.e. something more substantial than a sandwich) every day.

43. The issue of what is a reasonable size for a police cell (or any other type of detainee/prisoner accommodation) is a difficult question. Many factors have to be taken into account when making such an assessment. However, CPT delegations felt the need for a rough guideline in this area. The following criterion (seen as a desirable level rather than a minimum standard) is currently being used when assessing police cells intended for single occupancy for stays in excess of a few hours: in the order of 7 square metres, 2 metres or more between walls, 2.5 metres between floor and ceiling.

b. Imprisonment

44. In introduction, it should be emphasised that the CPT must examine many questions when visiting a prison. Of course, it pays special attention to any allegations of ill-treatment of prisoners by staff. However, all aspects of the conditions of detention in a prison are of relevance to the CPT’s mandate. Ill-treatment can take numerous forms, many of which may not be deliberate but rather the result of organisational failings or inadequate resources. The overall quality of life in an establishment is therefore of considerable importance to the CPT. That quality of life will depend very largely on the activities offered to prisoners and the general state of relations between prisoners and staff.

45. The CPT observes carefully the prevailing climate within an establishment. The promotion of constructive as opposed to confrontational relations between prisoners and staff will serve to lower the tension inherent in any prison environment and by the same token significantly reduce the likelihood of violent incidents and associated ill-treatment. In short, the CPT wishes to see a spirit of communication and care accompany measures of control and containment. Such an approach, far from undermining security in the establishment, might well enhance it.

46. Overcrowding is an issue of direct relevance to the CPT's mandate. All the services and activities within a prison will be adversely affected if it is required to cater for more prisoners than it was designed to accommodate; the overall quality of life in the establishment will be lowered, perhaps significantly. Moreover, the level of overcrowding in a prison, or in a particular part of it, might be such as to be in itself inhumane or degrading from a physical standpoint.

47. A satisfactory programme of activities (work, education, sport, etc.) is of crucial importance for the well-being of prisoners. This holds true for all establishments, whether for sentenced prisoners or those awaiting trial. The CPT has observed that activities in many remand prisons are extremely limited. The organisation of regime activities in such establishments - which have a fairly rapid turnover of inmates - is not a straightforward matter. Clearly, there can be no question of individualised treatment programmes of the sort which might be aspired to in an establishment for sentenced prisoners. However, prisoners cannot simply be left to languish for weeks, possibly months, locked up in their cells, and this regardless of how good material conditions might be within the cells. The CPT considers that one should aim at ensuring that prisoners in remand establishments are able to spend a reasonable part of the day (8 hours or more) outside their cells, engaged in purposeful activity of a varied nature. Of course, regimes in establishments for sentenced prisoners should be even more favourable.

48. Specific mention should be made of outdoor exercise. The requirement that prisoners be allowed at least one hour of exercise in the open air every day is widely accepted as a basic safeguard (preferably it should form part of a broader programme of activities). The CPT wishes to emphasise that all prisoners without exception (including those undergoing cellular confinement as a punishment) should be offered the possibility to take outdoor exercise daily. It is also axiomatic that outdoor exercise facilities should be reasonably spacious and whenever possible offer shelter from inclement weather.

49. Ready access to proper toilet facilities and the maintenance of good standards of hygiene are essential components of a humane environment.

In this connection, the CPT must state that it does not like the practice found in certain countries of prisoners discharging human waste in buckets in their cells (which are subsequently "slopped out" at appointed times). Either a toilet facility should be located in cellular accommodation (preferably in a sanitary annex) or means should exist enabling prisoners who need to use a toilet facility to be released from their cells without undue delay at all times (including at night).

Further, prisoners should have adequate access to shower or bathing facilities. It is also desirable for running water to be available within cellular accommodation.

50. The CPT would add that it is particularly concerned when it finds a combination of overcrowding, poor regime activities and inadequate access to toilet/washing facilities in the same establishment. The cumulative effect of such conditions can prove extremely detrimental to prisoners.

51. It is also very important for prisoners to maintain reasonably good contact with the outside world. Above all, a prisoner must be given the means of safeguarding his relationships with his family and close friends. The guiding principle should be the promotion of contact with the outside world; any limitations upon such contact should be based exclusively on security concerns of an appreciable nature or resource considerations.

The CPT wishes to emphasise in this context the need for some flexibility in the application of rules on visits and telephone contacts vis-à-vis prisoners whose families live far away (thereby rendering regular visits impracticable). For example, such prisoners could be allowed to accumulate visiting time and/or be offered improved possibilities for telephone contacts with their families.
52. Naturally, the CPT is also attentive to the particular problems that might be encountered by certain specific categories of prisoners, for example: women, juveniles and foreigners.

53. Prison staff will on occasion have to use force to control violent prisoners and, exceptionally, may even need to resort to instruments of physical restraint. These are clearly high risk situations insofar as the possible ill-treatment of prisoners is concerned, and as such call for specific safeguards.

A prisoner against whom any means of force have been used should have the right to be immediately examined and, if necessary, treated by a medical doctor. This examination should be conducted out of the hearing and preferably out of the sight of non-medical staff, and the results of the examination (including any relevant statements by the prisoner and the doctor's conclusions) should be formally recorded and made available to the prisoner. In those rare cases when resort to instruments of physical restraint is required, the prisoner concerned should be kept under constant and adequate supervision. Further, instruments of restraint should be removed at the earliest possible opportunity; they should never be applied, or their application prolonged, as a punishment. Finally, a record should be kept of every instance of the use of force against prisoners.

54. Effective grievance and inspection procedures are fundamental safeguards against ill-treatment in prisons. Prisoners should have avenues of complaint open to them both within and outside the context of the prison system, including the possibility to have confidential access to an appropriate authority. The CPT attaches particular importance to regular visits to each prison establishment by an independent body (eg. a Board of visitors or supervisory judge) possessing powers to hear (and if necessary take action upon) complaints from prisoners and to inspect the establishment's premises. Such bodies can inter alia play an important role in bridging differences that arise between prison management and a given prisoner or prisoners in general.

55. It is also in the interests of both prisoners and prison staff that clear disciplinary procedures be both formally established and applied in practice; any grey zones in this area involve the risk of seeing unofficial (and uncontrolled) systems developing. Disciplinary procedures should provide prisoners with a right to be heard on the subject of the offences it is alleged they have committed, and to appeal to a higher authority against any sanctions imposed.

Other procedures often exist, alongside the formal disciplinary procedure, under which a prisoner may be involuntarily separated from other inmates for discipline-related/security reasons (eg. in the interests of "good order" within an establishment). These procedures should also be accompanied by effective safeguards. The prisoner should be informed of the reasons for the measure taken against him, unless security requirements dictate otherwise, be given an opportunity to present his views on the matter, and be able to contest the measure before an appropriate authority.

56. The CPT pays particular attention to prisoners held, for whatever reason (for disciplinary purposes; as a result of their "dangerousness" or their "troublesome" behaviour; in the interests of a criminal investigation; at their own request), under conditions akin to solitary confinement.

The principle of proportionality requires that a balance be struck between the requirements of the case and the application of a solitary confinement-type regime, which is a step that can have very harmful consequences for the person concerned. Solitary confinement can, in certain circumstances, amount to inhuman and degrading treatment; in any event, all forms of solitary confinement should be as short as possible.

In the event of such a regime being imposed or applied on request, an essential safeguard is that whenever the prisoner concerned, or a prison officer on the prisoner's behalf, requests a medical doctor, such a doctor should be called without delay with a view to carrying out a medical examination of the prisoner. The results of this examination, including an account of the prisoner's physical and mental condition as well as, if need be, the foreseeable consequences of continued isolation, should be set out in a written statement to be forwarded to the competent authorities.

57. The transfer of troublesome prisoners is another practice of interest to the CPT. Certain prisoners are extremely difficult to handle, and the transfer of such a prisoner to another establishment can sometimes prove necessary. However, the continuous moving of a prisoner from one establishment to another can have very harmful effects on his psychological and physical well being. Moreover, a prisoner in such a position will have difficulty in maintaining appropriate contacts with his family and lawyer. The overall effect on the prisoner of successive transfers could under certain circumstances amount to inhuman and degrading treatment.

58. Health care services within prisons (including dietary matters and food in general) is, of course, an additional matter to which the CPT pays the closest attention. This is a vast subject, which the Committee hopes to explore in depth in a future general report. However, persons particularly interested in this subject can already refer to the relevant sections of the reports drawn up by the CPT following its visits to Austria, Denmark and the United Kingdom (as regards the publication of these reports, see paragraph 25). In this report, the CPT would only stress that it is highly desirable for prison medical services to be closely aligned with the mainstream of health care provision in the community as a whole.

59. Finally, the CPT wishes to emphasise the great importance it attaches to the training of law enforcement personnel* (which should include education on human rights matters — cf. also Article 10 of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment). There is arguably no better guarantee against the ill-treatment of a person deprived of his liberty than a properly trained police or prison officer. Skilled officers will be able to carry out successfully their duties without having recourse to ill-treatment and to cope with the presence of fundamental safeguards for detainees and prisoners.

60. In this connection, the CPT believes that aptitude for interpersonal communication should be a major factor in the process of recruiting law enforcement personnel and that, during training, considerable emphasis should be placed on developing interpersonal communication skills, based on respect for human dignity. The possession of such skills will

*)The expression "law enforcement personnel" in this report includes both police and prison officers.
often enable a police or prison officer to defuse a situation which could otherwise turn into violence, and more generally, will lead to a lowering of tension, and raising of the quality of life, in police and prison establishments, to the benefit of all concerned."

II. B. 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
(CPT/Inf (93) 12), (page 13-21)

"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 combating 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 prison 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 arrangement 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.

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 on-going 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 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 postnatal 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.

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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 the 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 prisoners 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 them 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.

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

7th General Report on the CPT’s activities, covering the period 1 January to 31 December 1996
(CPT/Inf (97) 10), (page 11-14)

“III. FOREIGN NATIONALS DETAINED UNDER ALIEN LEGISLATION

A. Preliminary remarks
24. CPT visiting delegations frequently encounter foreign nationals deprived of their liberty under aliens legislation (hereafter “immigration detainees”): persons refused entry to the country concerned; persons who have entered the country illegally and have subsequently been identified by the authorities; persons whose authorisation to stay in the country has expired; asylum-seekers whose detention is considered necessary by the authorities; etc.

In the following paragraphs, some of the main issues pursued by the CPT in relation to such persons are described. The CPT hopes in this way to give a clear advance indication to national authorities of its views concerning the treatment of immigration detainees and, more generally, to stimulate discussion in relation to this category of persons deprived of their liberty. The Committee would welcome comments on this section of its General Report.
B. Detention facilities

25. CPT visiting delegations have met immigration detainees in a variety of custodial settings, ranging from holding facilities at points of entry to police stations, prisons and specialised detention centres. As regards more particularly transit and “international” zones at airports, the precise legal position of persons refused entry to a country and placed in such zones has been the subject of some controversy. On more than one occasion, the CPT has been confronted with the argument that such persons are not “deprived of their liberty” as they are free to leave the zone at any moment by taking any international flight of their choice.

For its part, the CPT has always maintained that a stay in a transit or “international” zone can, depending on the circumstances, amount to a deprivation of liberty within the meaning of Article 5 (1)(f) of the European Convention on Human Rights, and that consequently such zones fall within the Committee’s mandate. The judgement delivered on 25 June 1996 by the European Court of Human Rights in the case of Amuur against France can be considered as vindicating this view. In that case, which concerned four asylum seekers held in the transit zone at Paris-Orly Airport for 20 days, the Court stated that “The mere fact that it is possible for asylum seekers to leave voluntarily the country where they wish to take refuge cannot exclude a restriction (“atteinte”) on liberty .... and held that “holding the applicants in the transit zone ....” was equivalent in practice, in view of the restrictions suffered, to a deprivation of liberty”.

26. **Point of entry holding facilities** have often been found to be inadequate, in particular for extended stays. More specifically, CPT delegations have on several occasions met persons held for days under makeshift conditions in airport lounges. It is axiomatic that such persons should be provided with suitable means for sleeping, granted access to their luggage and to suitably-equipped sanitary and washing facilities, and allowed to exercise in the open air on a daily basis. Further, access to food and, if necessary, medical care should be guaranteed.

27. In certain countries, CPT delegations have found immigration detainees held in **police stations** for prolonged periods (for weeks and, in certain cases, months), subject to mediocre material conditions of detention, deprived of any form of activity and on occasion obliged to share cells with criminal suspects. Such a situation is indefensible.

The CPT recognises that, in the very nature of things, immigration detainees may have to spend some time in an ordinary police detention facility. However, conditions in police stations will frequently – if not invariably – be inadequate for prolonged periods of detention. Consequently, the period of time spent by immigration detainees in such establishments should be kept to the absolute minimum.

28. On occasion, CPT delegations have found immigration detainees held in **prisons**. Even if the actual conditions of detention for these persons in the establishments concerned are adequate – which has not always been the case – the CPT considers such an approach to be fundamentally flawed. A prison is by definition not a suitable place in which to detain someone who is neither convicted nor suspected of a criminal offence.

Admittedly, in certain exceptional cases, it might be appropriate to hold an immigration detainee in a prison, because of a known potential for violence. Further, an immigration detainee in need of in-patient treatment might have to be accommodated temporarily in a prison health-care facility, in the event of no other secure hospital facility being available. However, such detainees should be held quite separately from prisoners, whether on remand or convicted.

29. In the view of the CPT, in those cases where it is deemed necessary to deprive persons of their liberty for an extended period under aliens legislation, they should be accommodated in **centres specifically designed for that purpose**, offering material conditions and a regime appropriate to their legal situation and staffed by suitably-qualified personnel. The Committee is pleased to note that such an approach is increasingly being followed in Parties to the Convention.

Obviously, such centres should provide accommodation which is adequately-furnished, clean and in a good state of repair, and which offers sufficient living space for the numbers involved. Further, care should be taken in the design and layout of the premises to avoid as far as possible any impression of a carceral environment. As regards regime activities, they should include outdoor exercise, access to a day room and to radio/television and newspapers/magazines, as well as other appropriate means of recreation (e.g. board games, table tennis). The longer the period for which persons are detained, the more developed should be the activities which are offered to them.

The staff of centres for immigration detainees have a particularly onerous task. Firstly, there will inevitably be communication difficulties caused by language barriers. Secondly, many detained persons will find the fact that they have been deprived of their liberty when they are not suspected of any criminal offence difficult to accept. Thirdly, there is a risk of tension between detainees of different nationalities or ethnic groups. Consequently, the CPT places a premium upon the supervisory staff in such centres being carefully selected and receiving appropriate training. As well as possessing well-developed qualities in the field of interpersonal communication, the staff concerned should be familiarised with the different cultures of the detainees and at least some of them should have relevant language skills. Further, they should be taught to recognise possible symptoms of stress reactions displayed by detained persons (whether post-traumatic or induced by socio-cultural changes) and to take appropriate action.

C. Safeguards during detention

30. Immigration detainees should – in the same way as other categories of persons deprived of their liberty – be entitled, as from the outset of their detention, to inform a person of their choice of their situation and to have access to a lawyer and a doctor. Further, they should be expressly informed, without delay and in a language they understand, of all their rights and of the procedure applicable to them.

The CPT has observed that these requirements are met in some countries, but not in others. In particular, visiting delegations have on many occasions met immigration detainees who manifestly had not been fully informed in a language they understood of their legal position. In order to overcome such difficulties, immigration detainees should be systematically provided with a document explaining the procedure applicable to them and setting out their rights. This document should be available in the languages most commonly spoken by those concerned and, if necessary, recourse should be had to the services of an interpreter.
31. The right of access to a lawyer should apply throughout the detention period and include both the right to speak with the lawyer in private and to have him present during interviews with the authorities concerned.

All detention facilities for immigration detainees should provide access to medical care. Particular attention should be paid to the physical and psychological state of asylum seekers, some of whom may have been tortured or otherwise ill-treated in the countries from which they have come. The right of access to a doctor should include the right - if a detainee so wishes - to be examined by a doctor of his choice; however, the detainee might be expected to cover the cost of such a second examination.

More generally, immigration detainees should be entitled to maintain contact with the outside world during their detention, and in particular to have access to a telephone and to receive visits from relatives and representatives of relevant organisations.

D. Risk of ill-treatment after expulsion

32. The prohibition of torture and inhuman or degrading treatment or punishment englobes the obligation not to send a person to a country where there are substantial grounds for believing that he would run a real risk of being subjected to torture or ill-treatment. Whether Parties to the Convention are fulfilling this obligation is obviously a matter of considerable interest to the CPT. What is the precise role that the Committee should seek to play in relation to that question?

33. Any communications addressed to the CPT in Strasbourg by persons alleging that they are to be sent to a country where they run a risk of being subjected to torture or ill-treatment are immediately brought to the attention of the European Commission of Human Rights. The Commission is better placed than the CPT to examine such allegations and, if appropriate, take preventive action.

If an immigration detainee (or any other person deprived of his liberty) interviewed in the course of a visit alleges that he is to be sent to a country where he runs a risk of being subjected to torture or ill-treatment, the CPT's visiting delegation will verify that this assertion has been brought to the attention of the relevant national authorities and is being given due consideration. Depending on the circumstances, the delegation might request to be kept informed of the detainee's position and/or inform the detainee of the possibility of raising the issue with the European Commission of Human Rights (and, in the latter case, verify that he is in a position to submit a petition to the Commission).

34. However, in view of the CPT's essentially preventive function, the Committee is inclined to focus its attention on the question of whether the decision-making process as a whole offers suitable guarantees against persons being sent to countries where they run a risk of torture or ill-treatment. In this connection, the CPT will wish to explore whether the applicable procedure offers the persons concerned a real opportunity to present their cases, and whether officials entrusted with handling such cases have been provided with appropriate training and have access to objective and independent information about the human rights situation in other countries. Further, in view of the potential gravity of the interests at stake, the Committee considers that a decision involving the removal of a person from a State's territory should be appealable before another body of an independent nature prior to its implementation.

E. Means of coercion in the context of expulsion procedures

35. Finally, the CPT must point out that it has received disturbing reports from several countries about the means of coercion employed in the course of expelling immigration detainees. These reports have contained in particular allegations of beating, binding and gagging, and the administration of tranquillizers against the will of the persons concerned.

36. The CPT recognises that it will often be a difficult task to enforce an expulsion order in respect of a foreign national who is determined to stay on a State's territory. Law enforcement officials may on occasion have to use force in order to effect such a removal. However, the force used should be no more than is reasonably necessary. It would, in particular, be entirely unacceptable for persons subject to an expulsion order to be physically assaulted as a form of persuasion to board a means of transport or as punishment for not having done so. Further, the Committee must emphasize that to gag a person is a highly dangerous measure.

The CPT also wishes to stress that any provision of medication to persons subject to an expulsion order must only be done on the basis of a medical decision and in accordance with medical ethics.

III. VISITS TO PRISONS IN GENERAL

III. A. A practical guide

1. The mandate

The course of a visit will depend on the mandate (the word mandate taken in the broadest sense of the word) of the persons undertaking the visit.

Difference in mandate

The following aims at describing the value of the various mandates – the most far-reaching being described first.

An international group has

a. a treaty right to undertake inspection visits to “persons deprived of their liberty by authorities”, and there:
   • talk in private with all persons
   • see all premises (not only where the cells are)
   • see all papers
   • come unannounced
   • repeat the visits unannounced.
b. an obligation to undertake periodical visits to the country in question.
c. an obligation to report to the State on prison conditions in general (e.g.: the CPT).

It should be mentioned that inspections, also comprising prison conditions, are undertaken ad hoc, done by official institutions or regional institutions such as the OSCE and the Council of Europe. This is always done after having obtained specific permission from the country concerned and in cooperation with that country.

Furthermore, international non-governmental organizations (NGOs), first of all Amnesty International, Helsinki
Watch and Physicians for Human Rights, undertake visits to countries, and also get permission to visit prisons. However, prison visits by such organizations can only be made after specific permission by the country concerned and in cooperation with the country.

**ICRC (International Committee of the Red Cross), please see page 28.**

**Between international and national**

The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (hereinafter: the Convention) was adopted by consensus by the General Assembly of the United Nations on 10 December 1984 and went into force on 26 June 1987. By July 1997, it had been ratified by 102 nations – out of around 190 possible.

In connection with prison visits, two articles are of special interest.

The Convention's article 11 reads:

“Each State Party shall keep under systematic review interrogating rules, instructions, methods and practices as well as arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment in any territory under its jurisdiction, with a view to preventing any cases of torture.”

The Convention's article 16 reads:

“1. Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.

2. The provisions of this Convention are without prejudice to the provisions of any other international instrument or national law which prohibits cruel, inhuman or degrading treatment or punishment.”

Thus, it is the obligation of the State Party to undertake "systematic review of ... arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment in any territory under its jurisdiction, with a view to preventing any cases of torture - and other cruel, inhuman or degrading treatment or punishment". (Italics added by the author as a consequence of article 16).

The Convention establishes a Committee Against Torture (hereinafter: the Committee), which consists of ten experts. The Committee shall control that the State Parties observe the provisions of the Convention. This means, to introduce the necessary and requested amendments in the domestic law for it to be in accordance with the provisions of the Convention, and furthermore also that the provisions are observed in practice.

After having ratified the Convention, each State Party must forward an initial report to the Committee, and then reports every four years, on the initiatives taken, please cf. above.

The State Parties have an obligation to introduce systematic control. When reporting, they must give an account of how the control is done, the legal basis for the control, and how it is done in practice. The authorities in the State Parties are free to decide how it should be done; please see the following examples:

**a. A national group from a special state institution** has a right, which is laid down in the domestic law, to

- undertake visits, noticed or unnoticed, to any establishment mentioned in the law.
- has an obligation to cover all the institutions of the country (most often prison) at regular intervals.
- has an obligation to report to the relevant ministry or the parliament on the conditions in each single establishment (prison), but of course with a possibility to present general conclusions (e.g.: HM Prisons Inspectorate in the United Kingdom).

**b. A special group of civil servants** (but not from a special state institution) is by law

- called upon to visit one or more establishments (most often prisons), in a jurisdiction limited district. Prosecutors and special judges are often called upon to fulfil this obligation.
- the frequency of the visits is often prescribed (e.g: monthly visits).
- the group reports to the prison governor, possibly with a copy to the central authorities.
- the aim of the reports is to give specific instructions to the governor in the concrete situations that might arise, and furthermore to give the prisoners a possibility for a court of appeal.
- prison conditions in principle may also be dealt with, but this is not the main object (e.g.: the Visiting Magistrates in Spain).

**c. In several countries, the Ombudsman institution is to a larger or smaller formalized degree requested to undertake such an inspection obligation.**

**d. The states may give special groups, NGOs, an authorization to undertake visits to prisons - with various degrees of mandate:**

- NGOs, whose prison functions are laid down centrally by law or statutory orders.

These NGOs are often called upon to fulfil obligations in the form of:

- regular visits
- appointed possibilities for prisoners to have contact with the NGO
- an obligation to report to and negotiate with the governor
- an obligation to publish a public annual report (e.g.: Board of Visitors (BOV) in the United Kingdom and various "Länder" in Germany).

**Importance of the credentials of the mandate**

The contents of the mandate of course influence the nature and course of an inspection visit, especially as regards access to "everything". However, there ought not in principle to be any substantial difference between inspection visits, apart from the specific problems: possibility for prisoners to use visitors as a sort of court of appeal - the latter holds a complex of problems which is markedly different from other problems when inspecting prisons.
The ideal mandate is described under the CPT:
• access to all places where persons are deprived of their liberty
• possibility to talk in private with everybody
• see all premises
• see all papers
• unannounced visits
• repeated visits.

Regardless of the mandate of the group, it is of paramount importance that
• the group itself knows its mandate thoroughly, and respects it.
• that the authorities before the visit starts have:
  - acknowledged the mandate of the group.
  - informed the relevant institutions about the group and its mandate.
  - given credentials to the group in order to facilitate immediate access to the institutions.

Often, or at least at times, high ranking officers within the institutions know about the visiting group – but “the man at the gate” has to know about it also, so that he at least will give information higher up in the hierarchy that a group wishes to talk to the governor or the chief of staff.

Experience has shown that many difficulties arise when passing this first link. Thus, the credentials of the visiting group and information about the arrival of the group have a great impact on a successful inspection. Firstly, delaying at the gate wastes time. Secondly, it contributes in creating a bad atmosphere both for the group and for the staff of the institution. Finally, a long delay provides a possibility for disguising evidence, e.g. removal of specific groups of prisoners, emptying special kinds of cells.

2. Preparatory work prior to an inspection visit

The better prepared, the easier the visit, and the more valuable the outcome.

Composition of the visiting delegation
• COMMITMENT (by many NGOs considered to be the crucial factor). It is of course important, but inspection visits demand more of the members of the visiting delegation: knowledge, experience, the ability to express themselves in writing, ability to talk to “everybody”, ranging from prisoners to ministers, in short:
• COMPETENCE is the decisive factor.
• CONFIDENTIALITY is necessary. If confidentiality is requested according to the mandate, it is of utmost importance to respect it.

The ideal composition of the delegation depends upon the goal and targets of the visit. Some mandates describe in detail the composition of a delegation, other mandates give a more free hand, at times in the form of assistance by experts.

From experience it will always – or nearly always – be appropriate and practical to have doctors, sometimes specialists of psychiatry, in the visiting delegations.

The first task of the delegation is to appoint or ascertain the head of the delegation. Only he/she may have contact to the press (if any), and the head of the delegation conducts all official negotiations, or he/she may delegate this task to a specific person in a subgroup.

Before the visit starts, it is useful to have as much information about the places to be visited as possible.

Before the visiting delegation starts working, it also decides upon which main areas should be investigated:
• prisons?
• police?
• mental institutions for convicted persons who are considered not responsible for the crime they have committed (normally under the Ministry of Justice)?
• other mental institutions?
• centres for refugees/asylum seekers?
• juvenile institutions?
• military prisons?
• other prisons?

However, these guidelines focus on prisons. Before the visit starts, it is useful to decide on which prisons to visit.

Before the visit starts it is also useful to obtain as much information about the places to be visited as possible:

Information from NGOs
- in written form or at a meeting.

Explain at first:
• a. The mandate of the group. Especially the question about confidentiality, including the press.
• b. After that, the NGO might participate in the discussion as to which prisons should be visited.
• c. Information about each of the prisons:
  - A short description (please cf. the paragraph on official information).
  - What are the special problems in this specific prison (country)?
  - Which persons would it be of special interest to interview? – Where are they to be found?
  - What are the pitfalls?
  - Possibilities to get more information during the visit?
• d. Finally, agreement on the confidentiality: What may be known by the NGO and what are they allowed to say, and what may the visiting delegation know about the NGO?

Official information
Can be obtained either before the visit in the country/the prison, or during the first talk with the governor. The information given will of course be corrected, controlled and evaluated during the visit – this among other things being the aim of the visit.

The following information is necessary:
• a. The name, address, telephone and fax numbers of the prison.
• b. Name of the governor.
• c. The organization plan for the personnel.
• d. Specific conditions of the particular prison – information on this point should not be given only from an official source, but should also be controlled in practice.

General description of the prison
The prison was built in the year …

Constructed as a prison or constructed for another purpose and re-built?

The general outline:
• Victorian prison
• Many small units
• One big building, etc., etc.
3. The visit

The above last point constitutes, as mentioned, part of a visit: In practice, the visit will always start with a talk with the responsible person (the governor).

Notice

It is practical to be able to find the governor. Thus, notifying of the visit is essential. From experience, this is done the evening before the visit, or if this is not possible, a few hours before. A prison is so large an institution that the possibilities to disguise relevant things, with such a short notice by the delegation, are very small, if not nil.

The preliminary talk with the governor may contain the following agenda

The head of the visiting delegation:

a. Courtesies.

b. Presentation of the group.

c. Mandate of the visiting group.

d. Giving the floor to the governor: A short description of the prison and what are your major problems?

e. The head of the visiting delegation: Practical points:

- The delegation may split up into subgroups, we will always try to inform the governor or any liaison person appointed by him/her of "who is going where, when".
- Special meetings to be arranged, e.g.
  - chaplains
  - doctors/nurses and other health staff
  - P.O. Associations/Unions
  - Visitors' Board.
- "Papers": Map of the prison, breakdown of the population: Males/females, remand, sentenced, juveniles, etc.
- We would like to have copies of the different forms, and we intend to inspect and look into all protocols, registers, etc.
- We would like to have a room for the delegation to meet in private.
- Arrangements for lunch.

Going back to the mandate:

f. We are allowed to speak in private, alone, with the detainees, out of hearing and preferably out of sight.

g. Before we leave, we will report back to the governor for a final talk.

The function of the visiting delegation in a prison

Immediately after the preliminary talks with the governor:

a. a guided tour of the prison for the whole visiting delegation, then

b. meeting of the visiting delegation in a previously requested room:

- Splitting up into subgroups?
- Who does what?
- When do we meet again?

In the evenings of the following days, the head of the visiting delegation makes a "deficiency list" and distributes the work for the following half day, or day, making sure who goes where? when do we meet? when do we leave the prison?

The premises

a. For cells/dormitories (and related rooms), it is necessary to have:

- Information on the fixtures
  - The measurements, including height, if the cell or room has a very low ceiling
  - Ventilation/heating
  - The windows: number, size, possible to read by natural light?
  - Artificial light: normal, dim. Who controls the light? the prisoner or the prison staff?
  - The observation hatch/hole: size, can you observe the whole cell, (including toilet)?
  - The alarm system – call-bell (does it work)? If yes, where is the signal? With light or with buzzer? Where is the light/buzzer turned off?
  - Possibilities of suicide (window bars, etc.)
- Sanitation:
  - Inside:
    - in a separate room
    - in part of the cell:
      - with a screen
      - without a screen.
    - Is it a flushing lavatory?
    - If a bucket serves as a toilet – one for each prisoner?
    - Washbasin: cold water/hot water?
  - Outside:
    - Number of toilets
    - Number of washbasins
    - Number of showers (per cell and per prisoner).

- Information on "movables"
  - Beds: number. Bunk-beds? Size. Quality
  - Mattress
  - Blankets/pillows/sheets (how many? How often changed?)
  - Chair/table/cupboard
  - Water-container – one for each prisoner? How big?
  - Number of towels. Special cloth to clean your utensils (spoon, fork, etc.)?

b. Other general rooms

- Association rooms
  - Ratio of rooms: prisoners
  - Size?
  - Equipment: TV – snooker – table-tennis, etc.?
- Library
  - Size
  - Number of books – Number lent.
  - Books in different languages?
- Exercise yards
  - Number
  - Size
  - Shelter
c. The reception
- Description of the premises.
- Follow a prisoner through the whole system.
- Description of the procedure. ("We process up to 140 a day").
- The attitude of the Prison Officers (POs).
- The medical screening: done by nurses? If so, seen by the doctor the next day?
- done by the doctor?
- Screening for suicidal behaviour. If it is done: how?
  - Do you use a special form?
  - Search: Where is it done? by whom?
- The time spent in the reception. Especially: does anybody stay overnight?
  - If so, how are the premises: blankets, etc.?
- Food service.
- Registration.

d. Visits and visiting areas
- Description of premises for:
  - closed visits
  - open visits
  - family visits
  - Vis-a-vis visits
  - visits from lawyers/social workers, etc.
- Is there a possibility to buy drinks and food?
- Area for children. If so, supervised by the staff or by volunteers?
- The furniture
- The general atmosphere
- The state of hygiene
  - The privacy, including level of noise. Is there a special centre for visitors outside the prison?
  - If so, who runs it? How does it function?
- Waiting room for visitors:
  - Inside the prison? Or waiting outside (in the rain)?
  - Is there a special house for waiting visitors?
  - If yes, who runs it?
- Rules
  - How often?
  - For how long, for: sentenced remand.
  - Are children allowed? (possible age limit).
- Is there a booking system, and if so, can this possibly function as a screening procedure?
- Restrictions possible? If yes, an accurate description of such restrictions, including if they can be used as punishment.
- The flexibility
  - If visitors have to come from far away, can they have less frequent visits but longer visiting hours?
  - What is the procedure followed by the prison officers overseeing the visits, if “something” is passed from a visitor to a prisoner?
  - Is there an immediate interruption or body search after the visit.

e. Work and workshops
- The number: How many places in all?
- Do they always function, or do e.g. court escort duties have a priority, as a result of which prison officers can be taken away from workshops to perform such duties? In other words: What is the actual number of prisoners working?
  - and not only the theoretical number of places.
- The quality: Is it "constructive" work? - or classical prison work: sewing of mail bags. Short description required.
- Do the prisoners have to choose?:
  - "either you go to work, or you have exercise outdoors, you can’t have both".
- Which prisoners are offered work:
  - Sentenced only?
  - Remand?
  - Also vulnerable prisoners, who are protected and segregated from other prisoners?
  - Also "dangerous" life-sentenced (in many countries grade-A) prisoners?
- Is it possible to continue to work if you are in hospital for long-term treatment and medically fit for working?
  - In short: Are there restrictions on work, written or unwritten?
- The salary for work?

f. Education
- Many of the problems about education are the same as those about workshops.
- The quantity
- The quality:
  - Up to normal school levels?
  - Foreign languages?
  - Higher education?
  - Open University?
  - Computer service?
- Are the prisoners free to choose? (e.g. it should not be obligatory for a foreign prisoner to learn the country’s language if it is a small country, and the prisoner by a court decision is also going to be extradited after release).
- Special opportunities for foreigners?

g. The library
- Size
- Number of books
- In which languages?
- If possible, how many books do they lend out, is the library used?
- Do all detainees have access to the library?

h. The gym
- Design of the premises, and especially: The relation between the number of prisoners and the size of the gym.
- How often per week can an ordinary prisoner go to the gym?
- Again, (see workshops and education): are there possibilities for special groups (the vulnerable, the “dangerous”, the segregated, etc.) to go to the gym?
- Is admittance to the gym used as a privilege? and denied as a sentence?

i. The kitchen
- The premises: Is it possible to maintain a satisfactory level of hygiene in the premises?
  - The amount of deep-freezers, if any?
- How do they keep the vegetables?
- Other stores?
- The cooking system?
- Do they keep samples of the food for some days?
- When was the last outbreak of epidemic diarrhoea? (a question to be put to the medical service)

j. The food
- Quantity: Is there enough food, for instance is bread free?
  - (counter-check officers/detainee - do they use most of their pocket money for extra food - not sweets, but food as such)?
The functioning of the prison/regime

a. Description of the time-table
On week-days and on Sundays.

The visiting delegation should always be able to answer:
- For how many hours is the prisoner out of his cell weekly?
- That goes for all kinds of prisoners (in different wings, in segregation, in different grades, etc.).

b. How does the medical service function?
(See under cells/dormitories, and take very careful full details.)

c. Discipline and punishment
Description in detail of:
- Who is responsible for imposing disciplinary sanctions/punishments?
- The punishment itself:
  - Loss of privileges? If so, which? (Detailed description very important)
  - Is reduction of food or denial of outdoor exercise laid down in the prison regulations?
  - Segregation? for how long?
  - Review of time in segregation?
- The function of the medical doctor in punishment (going to the segregation unit every day, for the benefit of the governor? or only if called by the prisoner, for his benefit?)

d. The chaplaincy
- How many different religions are being served?
- What is the possible function of the chaplains besides specific religious problems?

e. Inspection systems
- BOV (Board of Visitors)
- Inspectorate of Prisons appointed by the Government
- Magistrate
- Central authorities (Minister of Justice for instance).
For all groups:
- what are the rules? – and
- do they function in practice:
  - according to the inspectors?
  - according to the governor?
  - according to prison officers?
  - according to prisoners?
- How often do they inspect?

f. Contact with the outside world
- Telephone:

The technical evaluation of the telephone system is very fast. A card-phone system should make it much easier for the prisoners to have access to telephones.

Describe in detail the possibilities, especially:
- Is it at all possible to telephone?
- Restrictions in telephone time?
- Restrictions in number of phone calls?
- Possibilities for monitoring?
- Registration of calls?

• Letters:
  - Any restrictions in numbers?
  - Censorship rules
  - Possibility of confidential access to MPs, Minister of Justice (or senior officials in the Prison Service)

N.B. Mail to and from lawyers, and the relevant international and regional official bodies, (the Council of Europe’s Commission, the Court of Human Rights, the CAT, etc. and to CPT), should not be censored.

g. Operation of the canteen (prisoners’ shop)
- For all prisoners?
- How often?
- Easy access?
- Reasonable variety?
- Reasonable prices?

h. The attitude of the POs
- Are they key-keepers, or do they have a personal relationship with the prisoners?
- Are there any “black spots” in the prison (normally the segregation unit)?
- What are the legal (and also the actual, real) possibilities to make disciplinary/legal complaints against prison officers on the grounds of misconduct?
- What is the number of complaints per year?

Talks/Interviews
The preliminary talk with the governor has been described (p. 21, point 2).
At the end of the visit, based on the facts found, a final talk with the governor should be undertaken. It should be prepared at a delegation meeting. Normally it only contains the main points.
The head of the visiting delegation leads, and may give the floor to the members of the group on special issues.

Agenda
- Courtesies (sometimes we have been working at late hours, on Saturday mornings, etc.) and apologise if this has inconvenienced prison staff.
- Cooperation.
- The main problems
  - Problems where the governor in our opinion should take urgent or immediate action.
  - Problems which will be raised at the final talks with the central authorities – if any.
  - Other problems.
  - The governor will almost certainly find other matters dealt with in the final report, not mentioned here.
  - Are there any further problems to which the governor feels attention should be given?

a. General remarks on talks
The talks described above have been official. Their main pur-
pose has been to inform others about the mandate of the visiting delegation. Therefore, the head of the delegation leads the talks.

The talks described below are quite different. They are an important element in fact-finding procedures.

There are as many methods of interviewing as there are individuals. Still, there exist some very basic (and in many people's opinion self-evident) facts, which by the way are not always easy to stick to:

- The main principle is: When "the other" (the POs, detainees, etc.) speak, you get information.
- On the other hand, sometimes he/she doesn't speak at all. Then confidence is needed. Foremost you may say: "Everything you say here is confidential. Furthermore, it is for your own benefit. Of course it will be used, but only to improve the conditions, and nobody can be identified later if you don't wish. And furthermore, the fact that you talk to me cannot be used against you. When we leave we will take care of that with the governor."
- In this connection, you ask if you may make notes: for your own memory only, it will never fall into the hands of others.
- At other times he/she speaks like a waterfall, but not about the relevant issues. Then it is time for questions, although never leading questions which can render the answers given completely invalid.

- Check and double-check. Therefore you have interviews at all levels:
  - Governors
  - Prison officers
  - Health personnel
  - Chaplains
  - Detainees.
- Ask for his/her own experience, not what they have heard (that goes especially for detainees). Try to get first-hand evidence, not hearsay from detainees. Such second-hand evidence can be of more value if given by medical officers, etc.
- In this connection, written evidence, especially medical records, can confirm the findings. If the lawyers in the delegation have heard some allegations of ill-treatment; if then, the medical doctors in the delegation have observed objective findings; and if then it is confirmed by the medical evidence in the records, the triad is very convincing.

- Interview one at a time. Avoid group pressure. If you, on the other hand, talk with a group, then have a discussion on a general issue. Personal matters (such as any form of ill-treatment!) are for private interviews: ideally one detainee with one interviewer - (possibly with somebody taking notes).

  If there are personal matters, it is better to agree on an interview with the person concerned in private, either in a corner of the cell or in the guard’s room – possibly on another day.

- Do not be too many persons present during the interview, and be quite sure who is doing the interviewing. See to it that the interpreter translates correctly, so that the detainee understands that you are the one who is interviewing, and not the interpreter. Ask if a third person, if present, may take notes (please cf. point 3).

  The third person must not interrupt an interview. Wait until the interview is finished, and then ask: "May I ask for a little further information?" Never interrupt the interviewer.

These were just a few general remarks. Knowledge is good, experience a must, a little knowledge is very dangerous.

b. Prison Officers' (P.O.) Associations

- Very important, often boring.
- In some countries the accusation is levelled at the delegation that "You are only interested in these damned terrorists. You never show interest in the normal policeman or prison officer or their wives or children who are killed by terrorists."
- One or (preferably) two persons from the delegation make the interview in each prison – often there are different opinions.
  - Check and double-check.
  - Interview also prison officers individually, not only the officers in the association. (This can be done quite informally, e.g. while walking round the establishment).

**Agenda**

- Let them talk, especially: "What are your problems?"

**Special**

- Recruitment/education/training
- Special education in communication?
- Continuous training?
- Their view on the role of other groups of personnel
- Prisoners who present particular problems.

**Try to find out:** Who is really governing the prison?
- The central authorities (Ministry of Justice)?
- The governor?
- The trade unions?
- The prisoners?

c. The Visitors' Board

This is different in different countries, and can also vary inside the countries. Therefore one or (preferably) two from the delegation should interview the Visitors' Board in all the different prisons visited.

**Agenda**

- Again, let them talk – what are their problems? - NB! can be very, very dangerous. Visitors’ Boards are nearly always very talkative! Try to bring them back to facts:

**Special**

- Your legal background?
- Composition?
- Independence?
- Who elects you?
- Do you have announced visits? – that is the possibility for the detainees to ask to be seen by the Board.
- Do you have unannounced visits?
- Do you have a double role? (in some countries the Board is involved in punishment matters).
- Do you produce an annual report and, if so, to whom is it addressed and is it made public?
- Can you act on your own initiative?
- Can you go to the governor?
- Can you bypass the governor and go directly to the Ministry of Justice – or other relevant authorities?
- Can you go to the press?
- Do you have any special training?

**In practice**

- How often have you been in the prison during the last three months?
- How many detainees did you talk to?
- Future: what would you like to have changed?

**d. Chaplains/School teachers/Probation officers**

- Let them talk.
- Try to make a double-check:
  - in your head you remember the information from the governor about various questions? – Are there any differences?
e. Prison officers
- Describe your duties, your shifts, etc.
- Ratio prisoners/prison officers (there are always too many prisoners to too few prison officers, but get the figures anyway!).
- Your work: are there priorities? Who takes the prisoners outside the prison (to court, hospital, etc.)? – Does this have a higher priority than e.g. staffing workshops?

About the regime: What are you lacking in the regime?
- In the general/normal units?
- Your opinion on education (please see talk with the Prison Officers Association).
- Have you received any vocational education or training?

f. Detainees
Interviews with detainees are probably the most important part of any fact-finding mission.

Selection
- Some detainees are identified beforehand
  - Most important here are the names found in registers in prisons. Detainees normally spend a rather short time in police stations. On the other hand, it is the experience that the risk of severe ill-treatment is highest in police stations. For that reason delegations rather often identify the names of the latest arrivals in the register book at the prison and seek to interview these persons.
  - Names given by NGOs: It is the experience that these names are often too “old”. Allegations of ill-treatment are old, and any possible marks of ill-treatment have disappeared.
- Selection in the prison
  Normally, a broad, representative spectrum is aimed at:
  - Men/women.
  - “Political” (e.g. race, religion, region)/normal prisoners/ sex offenders/juveniles and other groups.
  - Remand/sentenced.
  - Young/old.
- Cross-reference between delegation members: Typical: Prison experts have interviewed a prisoner and want a medical person to interview and examine.
- Sometimes it is valuable to examine all prisoners in a special unit – thus avoiding a special prisoner to be identified by the authorities: “That was the detainee who talked to the Visiting Group!”
  If you find “exciting” evidence, do not react immediately – then the detainee might be identified. It is better to walk on to the next detainee, and discuss it later with the group.
- Often some prisoners ask to be examined.

N.B: Be careful in promising interviews. It should be the rule of the delegation “to keep its promises”. Don’t be overwhelmed by others, but try to keep the selection in the hands of the delegation.

- When you then are in the ward, realize:
  - Where are you?
  - What kind of prisoners are here?
  - What do you expect to find here?
  - Do not rush in. In nearly all wards, there is an officer’s room where you will find a diagram of the inmates. Study it. It often gives much information about whom it is worth visiting, where there is overcrowding, for how long they have been here, whether there are any special remarks on singular inmates, etc.
  - Moreover, it facilitates later identification of the prisoner, if others are going to interview him as well.

WHERE TO INTERVIEW
Depends a lot on the circumstances. The cell is normally the first choice – but be alone with the prisoner whenever possible.

In some countries there are dormitories. Then a special room is to be preferred (the guard’s room just beside, or an office in the administration. In that case you can make a list and have the prisoners brought to you). Be careful if the interview and examination are done in a corner of the room. There are always other prisoners who will intervene.

When you enter a cell, remember that you are entering another person’s home. Behave accordingly. Furthermore, you shall present yourself, not the prison officers. Shake hands (if you are in a country where you shake hands). Ask for permission to enter. Distance yourself from the prison staff – they are waiting in the corridor far away.

g. Ethical problems for medical personnel
The doctor interviewing a detainee with a view to later on working out a report about the conditions in the prison, is in an ethical dilemma. There are “three layers” in the medical function:
(1) Treating
(2) Examining (forensic medicine)
(3) Judicial authority (conclusions).

Re 1: (treating doctor)
The doctor should from the very start of the interview make it quite clear to the detainee, that he is acting as a forensic doctor and not as a treating doctor:
- the examining doctor is not allowed to be a treating doctor (this would interfere with the health service in prisons),
- there is not time enough. What takes place is an interview, and a follow-up is not possible.

It takes a lot of tact, insight into the detainee’s mental condition and diplomacy to end an interview in such a way that the detainee at least does not consider his condition to be worsened after the visit of the interviewing doctor.

Re 2: (forensic medicine)
This is the doctor’s main role, however:
- (problem doctor/detainee):
  The doctor’s forensic examination is not directly going to be used to the advantage of a specific detainee. The detainee is anonymous, and his “case” is “only” going to be used for illustrative and preventive purposes.
  - The doctor’s report is not going to be used in court, therefore:

Re 3: The doctor’s last ethical dilemma:
A medical forensic report is normally given to authorities (Refugee boards, social authorities, courts, etc.), and these authorities are the ones who evaluate the report and make a judgement, and not the examining doctor.

In the prison situation, however, it is the examining doctor who makes the judgement, most often with the remark: “consistency between the allegations and the objective fin-
The photos on these pages were taken by Bent Sørensen during a non-CPT visit to a country in Europe

1. Double fencing.

2. Overcrowded dormitory.


4. The medicine cabinet for 400 prisoners. For surgery see photo 13.

5. Dining hall. It also used during the winter months. Good ventilation: there is a hole in the roof.

6. Washing facilities for 40 prisoners.

7. Family exits are difficult as it takes two hours by four-wheel drive car to travel from the main road to the prison.

8. The total outdoor facilities.


11. Toilet for the prisoners. One toilet for 40 prisoners.

12. Toilet for the prison guards.

13. The surgical equipment for 400 prisoners.

dings". Thus, very great demands are put on the objectivity of the examining doctor – in principle, no-one is "looking over his shoulders".

Fixed guidelines for the function of the doctor can hardly be given. It is however important that each single doctor is aware of the ethical dilemma in the "three layers" described above. He should act as appropriately as possible, taking each single case, each single detainee, each single prison and each single country into consideration.

h. The spokesman
In some prisons it is a must to talk with the spokesman, among other things to have his blessing for talks with the prisoners in private. Never try to by-pass the spokesman.

Try to avoid speaking with a group chosen by the spokesman. That normally only leads to political manifestations. You can tell the spokesman that you are willing to talk to some selected persons, but one by one (if appropriate, refer to medical confidentiality: this is a matter between one person and the doctor).

When talking to the spokesman:
• Who elects him?
• What is his mandate?
• Does he have regular meetings with the governor?
• Can he see the governor if he so wishes?
• How many spokesmen do you have in this prison?

If the talk with the spokesman is done in a positive atmosphere, you can use this by asking him to give information about the visiting delegation to the other detainees, then stressing that you cannot deal with individual cases. You can also take the opportunity to have him select the detainees who have "something to show or tell".

On the other hand, be careful: Sometimes it happens when persons from the delegation have talked with a special spokesman, that another group of prisoners will not speak with delegation members.

Also be aware of problems with prison officers. Check your questions to the spokesman and his answers with the answers given by the prison officers and the governor.

But again, try to avoid the spokesman's using the presence of the visiting delegation politically, both inside the prison and outside.

III. B. Visits to prisoners by the ICRC
Hernan Reyes

ICRC preliminary sine qua non conditions
Access to all/any detainees/prisoners.

Talks in private with all/any detainees/prisoners chosen by the ICRC delegates

Registration allowed of all/any detainees/prisoners (identities, etc.)

Repetition of visits when ICRC deems necessary

The present outline explains some of the specific points relating to ICRC visits to prisoners. The more general information on the context of these visits, and of the ICRC mandate in particular, is detailed elsewhere (Chapter 7 in


Before the ICRC visits prisoners, it has to reach an agreement with the detaining authorities on several conditions that must be agreed sine qua non. Access to all prisoners and detainees means that the ICRC should be allowed to see any and all persons. No prisoner should be withheld or hidden from its delegates. If the ICRC obtains information about a person that has not been seen, it can immediately ask to see that person. In any given place where detainees and prisoners are held, the ICRC may choose to see all of them, or only those it may select, without any restriction from the authorities.

The second condition is the "pillar" of ICRC visits. It is the possibility to talk to any detainee or prisoner in private, in a place of ICRC's choosing and, if necessary, with an interpreter again chosen by the ICRC. In some cases, the ICRC may decide to hold preliminary interviews in groups, so as to introduce its work, get general information on prison conditions and also to "break the ice" during a first visit. ICRC delegates will then proceed to talk to prisoners in private, to all or to any it chooses to see. No detainee or prisoner shall be denied the right to talk in private with the ICRC. In private means without the presence of anyone else, so as to avoid any and all untoward influences during the interviews.

The two final conditions go together. It must be agreed before the visit begins that a subsequent follow-up visit shall be allowed; this is not only to ensure continuity, but also to see that there have been no reprisals or coercion of any kind after the ICRC visit. As the ICRC visits people and not prisons, it is essential that the names of detainees and prisoners be registered in ICRC filing, so as to be able to look individuals up the next time. For this reason, the ICRC shall either be given lists of prisoners which it can verify and check independently during its interviews, or be allowed to draw up its own lists of detainees and prisoners. These lists will also include information on family contacts, so as to be able to follow up detainees and prisoners when they are released.

The purpose of ICRC visits

To prevent or put an end to forced disappearances and extrajudicial killings.

To prevent or put an end to torture and ill-treatment.

To have conditions of detention improved when and where necessary.

To restore contact between prisoners and their families.

The purpose of ICRC visits to detainees and prisoners can be summarized as mainly four:

First, to try to prevent people who are arrested from disappearing, either by summary or extra-judicial executions, or into unacknowledged detention. Information on such cases will be obtained from many sources, among which the interviews with detainees and prisoners.

Second, the ICRC will try to put a stop to any practices of ill-treatment and torture it may encounter. The ICRC will at the same time also undertake any demarches necessary to ensure that victims of torture or ill-treatment are treated. The intrinsic value of visits from the outside to all persons who have been submitted to torture has to be underlined.

Third, the conditions of detention will be objectively assessed during the visit, and any improvements necessary be demanded from the authorities. Sometimes the ICRC will also assist in improving such conditions, without how-
ever relieving the detaining authorities from their responsibilities to keep detainees and prisoners alive and in good health.

Fourth, the visit shall also allow prisoners and detainees to reestablish contact with their families. This may be done in various ways, such as through Red Cross messages, arranging for family visits to those in detention, or direct contacts with the families via ICRC delegates.

The general tour: watch out for ...

... Signs of discrimination (“economy, business, first class”)

... The prison “jungle” (groups, castes,...)

... “Warning signals”...

(Seeing the whole prison doesn’t mean you understand everything...)

The general tour of the premises is an essential moment of the visit. It should be carried out by all members of the visiting team so that they all can get a complete overview of the living conditions in the prison environment. Living quarters, kitchens, latrines and other hygienic facilities, courtyards and other recreational places, visiting areas, punishment blocks, and any and all other places that relate to prison life should be thoroughly visited.

In any prison, and particularly a large one, the differences between sections should be duly noted. Differences in infrastructure, in accommodations, in the general appearance of the premises should be noted. Even more important, differences between the aspect of the people in different sections should be observed and noted for further assessment during the systematic interviews later on. Detainees and prisoners always have internal hierarchies, and differences and inequalities may be observed during the general tour. Warning signals are sometimes given indirectly by the prisoners themselves during the tour. (It should be noted that the tour is usually done accompanied by personnel from the administration – sometimes even the director himself. This is for reasons of access, as visitors don’t know their way around and obviously do not have the keys to open cells and corridors!). Prisoners may try to convey anxiety or fear, or communicate in other ways with the visiting team. Provocative behaviour or, on the contrary, obsequious attitudes must never be taken face value. All these signals warrant further scrutiny during the interviews in groups and in private!

After the general tour, the authorities often tend to think that the visiting team has “seen everything”. On the contrary: it is just the beginning. It is essential to exchange impressions and information after the tour, amongst the team members, and “rethink the visit” accordingly.

General tour – difficulties

Having sufficient time ...

Tour before talking ...

Who should be the guide? ...

How to know where you are? ...

Role distribution within the team ...

Introductory speech to inmates ...

Not stigmatizing any specific inmate ...

Specific “hints” on how to get the most information out of the general tour without mishaps can be given here:

- Always make sure there is sufficient time for the whole tour. Prisons can be very complex, and gates and doors tend always to be closed with the missing key when you are in a hurry. Don’t allow the team to be “coerced” into shortening the tour because of lack of time!
- It is essential for the general tour to take place before the beginning of the interviews; otherwise the team members will not be familiar with the premises. This may not only make it difficult to understand certain situations, but may also give prisoners the impression that the team is not professional ...
- The general tour may be difficult to plan if the layout of the prison is not known in advance. The layout should be explained to the team during the initial talk with the authorities. With this information, the team may suggest an itinerary. Whatever course the tour actually takes, the team should keep in mind that they should see all the places that are relevant to life within the prison.
- Prisons are often labyrinths. It may be useful, if this is an issue, to designate one member of the team to take specific notes on the layout as the tour proceeds, and to ensure that all places have been visited, and that no section has been “forgotten”. It may not be possible (or allowed!) to draw up a map of the premises during the actual tour. The notes taken should, however, allow such a map to be drawn up after the tour, so that all team members understand the layout of the prison. It may not be possible to repeat the tour, so it is important to get it right: the first time.
- Role distribution between members of the team is also important on other issues. One member may keep track of actual occupancy: taking down the numbers of prisoners per cell or ward (the number announced by the ward leader and any other figure that may be given by another prisoner) so as to compare with official numbers. Another (preferably the doctor) will make clinical observations on all factors relating to health, and specifically evaluate the clinical state of the prisoners in their different sections. Yet another member may concentrate on any particular aspect of detention relevant to that prison. It must be remembered that the team leader will often be “taken up” by the accompanying official, and will not be able him or herself to evaluate any great deal.
- In all sections where prisoners are encountered, the team should introduce itself and its work. It should also explain the purpose of the visit, and particularly the general tour. (Often prisoners do not understand why an outside team is accompanied by the prison director or other officials ...). Of paramount importance is to state clearly that interviews in private with prisoners will take place afterwards. In the, it is hoped, unlikely event that the visit has to be suspended after the tour, at least the intention was clear, otherwise the prisoners will think that the whole visit was centred on the accompanied general tour!
- Particular care must be taken not to stigmatize any individual during the tour. Sometimes prisoners may decide to be “daring” and make denunciations of the very director accompanying the team! It should be clearly explained, in such a situation that the team will come back and talk to anybody who has anything to say, but that the tour is not the place for such talks. This reassures the authorities about the team’s way of working, and it may prevent the “daring” prisoner from getting himself into serious trouble. On the other hand, if the outburst was a provoca-
The interpreter is arguably one of the most important members of the team. He/she is the person who gets the information "first hand" from the detainee or prisoner. Inversely, the interpreter must be able to convey the purpose and the reasons for the visit. Team members may not be fully knowledgeable on customs and local ethnic considerations: the interpreter has to know about them so as to convey the true meanings of what is said.

As a general rule, local personnel should never be used for interviews with detainees and prisoners. The reasons should be obvious. Even though such personnel may be totally trustworthy, the people visited in custody do not know this, and have no reason to trust anyone local. They may therefore refuse to talk to the visiting team. Much worse, they may not dare to object, and consequently not tell the team members about the real problems they fear to say in the presence of local personnel they have no reason to trust.

Locals may furthermore be put under pressure by police or others, security forces for example, to give information on the people seen in prison. Using local interpreters may lead to such situations, which is furthermore totally unacceptable for their own safety!

Co-detainees or fellow prisoners should also, whenever possible, be avoided. The exception may be when a prisoner (for example speaking only a dialect for which no interpreter can be found) clearly demonstrates that he/she wants to call up a friend to ensure the translation. Otherwise, "friendly" prisoners knowledgeable in languages should be avoided. They may be collaborators with the authorities, and even if that is not the case, he/she may be simply from a different clan or group that does not have the full trust of the person to be interviewed. So as to avoid any misunderstanding or mistrust, the best solution is always to use expatriate interpreters, who are visibly members of the team, and not local!

III. C. The problems of hostage taking

Gerard Rooney

Interview guidelines and precautions
It is always important to be aware of how you might be perceived when interviewing someone being held in a secure situation and that your good intentions might not always be immediately appreciated. Common sense dictates that some sensible precautions will minimize any possible difficulties.

Personal considerations
Many people are detained in situations with minimum standards of comfort or hygiene and anything that reminds them of these conditions can be the focus of anger and frustration.

Simple things like the type or style of the clothes you wear will create an immediate impression and establish or detract from your level of credibility. Clothes perceived as expensive or flamboyant, jewellery etc. can make prisoners very self-conscious of how they might look – especially if they are poorly dressed or wearing prison issue apparel. Other styles of dress can be perceived as expressing an attitude of superiority or power. This perception can become the focus of anger and trigger an aggressive reaction. Also, it should be remembered that some clothes can be potentially dangerous. For example, ties or scarves can be used as a weapon or means of restraint; brooches or badges with a pin clip can become a weapon; earrings, if grabbed, can cause painful injury. Personal possessions carried in a bag such as a comb, nail file or scissors are all potential weapons. Be aware of these factors and exercise sensible precautions.

The situation in which the interview occurs should be given serious consideration. Make sure someone knows where you are, that you can be contacted immediately and, if appropriate, set up a checking system with a colleague or member of staff. Ask if there are "personal alarms" available and carry one at every opportunity. Remember, if you have any reservations and think that your safety could be compromised, ask for or insist on an alternative location.

Contextual considerations
Once you have decided to conduct the interview, sensible precautions can minimize the possible escalation of violence.

1. Try to ensure that anything that could be used as a weapon is removed from the room. If this is not possible, then at least move them out of sight or away from the place where the interviewee will be sitting.

2. If interviewing in an allocated room, then ease of access to and egress from the area for yourself, the interviewee and others are important. It may be that not only would you like to ensure that you can exit the room quickly, but the interviewee would also like to be able to do the same. It is crucial, therefore, that he/she has the option of leaving the room easily without feeling obstructed by pieces of furniture or even yourself.

3. Try to organize any furniture in the room, e.g. table, chairs, desk ... in such a way that it does not seem like a barrier between yourself and the interviewee. Barriers not only inhibit the interview but can be perceived as a means of restriction and control.

4. Determine where and how you want to sit. Nearest to the door is usually a sensible precaution. Whether standing or sitting always position yourself roughly at a 90 degree angle to the interviewee. Sitting face to face is a powerful non-verbal message suggesting confrontation and can inhibit clear communication. Another worthwhile tactic is to ensure that both you and the interviewee are at the same eye-level. If you are standing or sitting in such a way that you are at greater height, this may give the impression of dominance or superiority. In some cases it may even be perceived as intimidation. A further advantage of maintaining the same eye-level is that it helps to facilitate appropriate eye contact during conversation. By monitoring your body position and adjusting it accordingly, a context of clear communication will be enhanced.

5. Also of importance is the distance between you and the interviewee – especially if in a confined space. Sitting too
close creates personal discomfort and can be perceived as threatening, whereas too much of a distance can be viewed as indifference. The non-verbal signals from the interviewee will quickly indicate what is appropriate, and you should adjust yourself accordingly. Remember different nations and cultures have different "personal zones" in which they feel comfortable. What can be socially appropriate for yourself may be regarded as too personal by another and vice versa. In general, those who are more predisposed to act violently require greater personal space, and research has shown that intrusion into a person's personal space is one of the significant triggers of violent or aggressive behaviour.

In many cases individuals are interviewed in a cell that they have "personalized". It is their territory, and it is not possible, therefore, to rearrange furniture or remove objects. However, the same principles apply and the issue is one of assessing the situation, locating yourself appropriately and, by monitoring the reactions of the interviewee, adjusting your position when necessary.

The hostage experience

Self-preparation
If the nature of your work means that you are at risk of being taken hostage, it is crucially important to prepare yourself for the reality of such events. Everyone is different and, therefore, will react differently to such a threatening set of circumstances. Good preparation requires taking the risk seriously, doing a little homework and some honest self-awareness.

1. Determine what sort of person you are. Under conditions of high stress, certain aspects of your personality become more accentuated. In normal everyday life these parts of your character may be regarded as very positive but, in a hostage situation where you have little control over what is happening, they can be counterproductive. Know yourself and how you have to adjust to survive.

2. Use your imagination to mentally rehearse the different circumstances with which you could be confronted. When doing this, always imagine yourself coping successfully. Such mental exercises not only build up mental and emotional resilience but also reduce the impact when confronted with the real thing. Preparing for the lack of privacy, food, sanitation and all the things we take for granted in everyday life is important.

3. Plan your survival strategy now. Do not leave it until you are confronted with the reality when your mental capability can be impaired by the trauma of events.

4. Make arrangements which will minimize the effects of your abduction on other people in your life. For example, calmly talk to your partner/family about the risk and discuss how they would cope. Have arrangements in place for the care of dependent relatives. The resistance of many hostages is worn down by hours of worry about how their families are coping.

5. Inform yourself about hostage incidents and the experience of others. This will help you to know what to expect. Follow this up by seeking appropriate training specifically aimed at your personality and status.

Hostage reaction
It is suggested that there are a number of distinct phases of psychological response in reaction to being taken hostage. The duration and intensity of each phase, however, varies according to the type of contact between perpetrator and victim.

Initial adaptation
This is to do with the experience of the immediate situation and is characterized by a benign interpretation of what is happening, disbelief or denial and an inability to act. Victims report feeling "numb" and in a state of shock.

Frozen fright
When the victim begins to perceive the reality of the situation, they are pervaded by feelings of hopelessness, entrapment and powerlessness resulting in what is described as a terror induced "pseudo-calm". There is often a brief period of belief that release is imminent and that the authorities will intervene. Hostages often engage themselves in some activity as if keeping themselves busy pending such intervention.

Inventory
It is very common, at this point, for hostages to take stock of their lives vowing to change themselves for the better. In extreme cases, individuals experience guilt about various aspects of their lives in which they regard themselves to have been a failure. An intense anxiety of death gradually recedes to be replaced by a calm acceptance of the possibility. There is often spontaneous recall of information or memories which were thought to be long forgotten.

Adjustment
During this phase, the hostage attempts to adapt physically and psychologically to the stressful conditions. Often there is recourse to familiar activities such as reading, writing, mentally carrying out work requirements, e.g. preparation of reports. However, faced with the vulnerability and unpredictable nature of their situation, profound changes in attitude and behaviour can occur. This can be best understood in terms of a continuum ranging from total identification and sympathy with the perpetrators to total rejection of them and their aims. The former end of the continuum is typified by acts of overt appeasement, submission and compliance. These can be accompanied by attitudes reflecting sympathy with the perpetrators and regarding survival or release as dependent on their goodwill. Increasingly, the authorities are regarded as interfering and threatening. The other end of the continuum is typified by the hostage maintaining a sense of their own identity and an attitude of compliance appropriate to the transient demands of the situation. Most hostages will find themselves at some point between these extremes.

During this phase, the "Stockholm syndrome" can develop. This is usually associated with incidents which are more prolonged.

Depressed mood
At some point, most hostages have an intense feeling that they have been abandoned and that there is no hope of rescue or escape. Occasionally this is lifted when it appears that release may be imminent, but any delay results in a severe lowering of morale. There can also be renewed anxiety associated with the perception that the perpetrators are losing control of the situation. The effects can be quite intense.

Resolution and rehabilitation
After release much of the experience, which has been regis-
tered at an unconscious level, is relived in one form or another—often in an involuntary way. It may be necessary that the process of coming to terms with these emotions requires to be facilitated by professional help.

Minimizing the danger
1. Follow any instructions given
The first 45 minutes are the most dangerous. Perpetrators are highly emotional and reactive to every little detail. The least non-compliance will be regarded as a direct challenge to their self-perception of power. Do NOT hesitate. Although you might think of physically resisting, this requires strength and a willingness to use extreme force. Any half-hearted or ill-conceived attempt to escape should be immediately rejected.

2. Accept the situation and be prepared to wait
Time is on your side. Although nothing may seem to be happening, in a hostage situation the authorities usually have operational procedures involving trained negotiators to ensure the safety of all concerned. Remember any attempted “drastic” action evokes an extreme response.

3. Do not speak unless spoken to
Only speak when necessary. Conversation will only add to the perpetrator’s already highly volatile state. If it is necessary to speak, attempt to be as natural as possible, show little emotion and monitor what you say to detect anything which could be perceived as challenging. Be neither friendly nor hostile.

4. Try to rest
Try to sit down as much as possible, even try to doze. When in a situation which provokes high levels of anxiety we can quickly become extremely fatigued. Resting as much as possible helps to combat this and maintain a level of emotional stability, especially if the situation becomes protracted. Another advantage is that sitting down is a non-threatening body position which allows you, without speaking, to demonstrate to the perpetrator that you are not challenging his/her position.

One piece of advice is, when sitting or lying, always do facing the perpetrator. Turning your back may be interpreted negatively. It is also easier for the perpetrators to treat you as an “object” rather than a person if they cannot see your face.

5. Do not make suggestions
If you give advice or make suggestions and things go wrong, you will be blamed. Your intentions will be taken as deliberately obstructive. You will be perceived as the “enemy” rather as someone caught in the middle. Your role as “hostage” will be diminished and, therefore, you will be regarded as less valuable.

6. Deciding whether or not to attempt an escape
Do not attempt to do so unless absolutely certain of success. Also think about the implications if there is more than one hostage. If you succeed, they could be the object of a violent response. If you are unsuccessful, violence may be used to ensure you adopt a more compliant role.

7. Be observant
This is important in two crucial ways. Firstly, it keeps your mind active and offers the opportunity to constructively use the time on hand. This will help you to exert some control over your situation by remaining alert and functioning. As such it helps protect against some of the emotional effects usually associated with being held hostage. Secondly, if you are released, any information you have can be used for intervention or negotiation purposes. The type of information which can be gathered will include physical descriptions, conversations, names, weapons, indication of motives, routines, etc.

8. Be prepared to speak to the negotiators
One of the crucial tasks of those negotiating is to speak to the hostage. Prepare yourself for this so that you can communicate as much as possible in a short space of time. When given the opportunity, speak clearly and precisely about things which are relevant. It may be worth speaking to the perpetrator about what you are going to say. This will reduce his/her suspicion and guard against any unexpected reactions. Also try to communicate more than the actual words. For example, if you are being made to lie about how you have been treated, you might say, “Tell my boss in Paris that I am being well treated,” when, in fact, your superiors are in Strasbourg. Negotiators are trained to pick up such inconsistencies.

9. Do not be argumentative
Research on hostage incidents indicates that those hostages who are more argumentative are more likely to be the first injured or even killed by the perpetrators. Any defiant or intransigent attitude increases the risk of physical harm. This can be difficult for those individuals who are used to challenge and conflict situations as part of their everyday work situation. Try to blend into the background. Standing out means being singled out.

10. Treat perpetrators with appropriate deference
Never turn your back on them unless ordered to do so. Maintain normal eye-contact when speaking to the perpetrators and never stare. Never exhibit any attitude which could be interpreted as rude or impolite. Perpetrators do not want hostages to be troublesome so maintain a sense of dignity without arrogance or aggression. Dealing with the perpetrators in a mature, non-condescending way is a way of keeping levels of tension within tolerable limits.

11. Medical attention
Inform the perpetrators of any medical condition you may have. They will not want the liability of an ill hostage or being held responsible for an unexpected or uncontrolled change in health. The knowledge that a hostage needs medical attention can pressurize the perpetrators into resolving the situation as quickly as possible.

12. Look after yourself
Take every opportunity to eat, drink, sleep and use toilet facilities. Circumstances can change and what is available at one moment can alter radically for reasons that are totally out with your control.

13. Prepare for intervention
If intervention occurs, it will be without your knowledge and without any prior warning. In all probability, your immediate reaction will mean that you are unable to think quickly or clearly. Lie on the floor immediately as the rescuers may not be able to tell you from the perpetrators. Everyone will be treated as a potential threat until the situation is clarified. Be prepared for rough handling. Any resistance will be met with force. Unfortunately there are many examples of hostages being killed by intervening forces. It is a very dan
The literature on the hostage experience would suggest that there are certain types of coping strategies which enable individuals to survive the ordeal. These strategies focus on avoiding unnecessary conflict with people who, through violent means, have placed themselves in a position of control over you. This involves adopting a role in which you present externally to the perpetrators in one way and deal with issues internally in another.

Maintain belief
It is important to maintain the belief that the authorities have mobilized an appropriate response and that trained personnel will be designated to monitor the situation, negotiate with the perpetrators and, if necessary, intervene. It is also important to believe that the perpetrators will be prosecuted after the situation has been resolved.

Contain hostility
Refuse to engage in senseless arguments or confrontation. This will only result in greater danger to yourself, tension will mount making the management of the situation more difficult and the perpetrators will be more predisposed to use violence.

Keep a superior attitude
Maintain a positive self-image no matter how demeaning or degrading your treatment. Perpetrators will use all kinds of methods to confuse, terrorize, depersonalize, and create dependency. When hostages are subjected to such treatment it is essential to keep a sense of self-worth and be resolute in a positive self-image. Despite varying circumstances, hostages consistently report that this is the crucial mental attitude to adopt in order to make sense of what is happening and to survive with minimum damage – both physically and emotionally.

Fantasize
This is the mental activity which deals with the real enemy – boredom. Fantasy gives a sense of inner control which cannot be touched by the perpetrators. It is a means of escaping from the immediate circumstance and keeping alive the positive aspects of your life.

Rationalize the situation
Focus on the present and especially the fact that you are still alive. That is your real worth to the perpetrator, and it is in his/her best interest to keep you this way. Remind yourself, despite everything, of how things could be worse. Content yourself in the knowledge that you cannot change your status as hostage, only adjust to it, so make the best of it. Do not preoccupy yourself with thoughts of how you could have avoided the situation. Never be too optimistic nor too pessimistic about anything which happens. In hostage situations it is often the case that there is more to circumstances than is immediately apparent.

Develop a routine
To combat the effects of being in a position of powerlessness, it is important to impose some of your own organization into the situation. This is particularly necessary if the situation becomes protracted. One way is to quickly establish a daily routine which involves setting tasks for yourself no matter how simple. These can include physical exercise, reading, writing, making yourself think constructively about unresolved problems at work, etc.

Maintain a mature stability
It is important to present the perpetrators with an image of someone who has self-control. Perpetrators expect hostages to be "traumatized" or difficult to control. That is why excessive threats are made to ensure compliance. A hostage who is in control of himself/herself, therefore, can be a calming influence in the situation.

Blend in with your peers
If there is more than one hostage, try to blend in with the crowd. Comply within appropriate limits and only do the minimum necessary. In a recent paper about hostage-taking in America, it was reported that the only hostage shot on a dead-line given by a perpetrator was someone who had been overly compliant. Never volunteer to do anything unless you regard this as absolutely necessary, i.e. it is a matter of life and death.

Helping a colleague
If you are in the situation of witnessing a colleague being taken hostage, the best piece of advice is to calmly remove yourself from the area and do nothing which could inflame the situation, e.g. shouting for help. This not only ensures your safety but helps minimize the risk to your colleague. Immediately report what you have seen to the appropriate authorities who should then put an organized response into action. It is crucial that you relay as much information as possible, no matter how trivial it may seem to you. However, it may be that you are forced into the position of having to speak to the perpetrators. If this happens, there are a few tactics which can be used. Remember, it is highly unlikely that you will be able to resolve the situation so your actions should be aimed at preventing any escalation.

Calming the perpetrator
In all probability the perpetrator will be extremely tense. Thoughts and actions will be determined by this high state of mental and physical arousal. Calming the perpetrator down, therefore, is a crucial step. Some of the ways to do this are:

Encourage talking, ask about any demands, his/her background, reasons for this course of action, etc. Ask open-ended questions and be prepared to listen rather than talk.

Show understanding – by tone of voice, facial expression and gestures it is possible to communicate an understanding of what the perpetrator may be feeling. In this situation words alone are insufficient.

Model calmness – by controlling the pitch, volume and tone of your voice, the rate at which you speak and displaying a relaxed posture, you can present a very calm picture to the perpetrator. This can have a very powerful calming effect on someone who is agitated or emotional.

Offer reassurance – despite the seriousness of the situation, suggest that it is possible to resolve it without matters getting worse.

Use distraction – take the focus away from the hostage incident by asking questions which are seemingly irrelevant. The switch of focus often defuses the tension.
Avoid provocation – avoid comments or attitudes which might offend, humiliate or annoy.

Slow the process down
The attitude of perpetrators is such that they expect their demands to be met immediately. From the very outset, it is important that they begin to realize that nothing will happen quickly. It is crucial, therefore, that you do not become directly involved.

Do not negotiate – trained personnel will carry out this function when they arrive.

Do not make promises – if demands are made, tell the perpetrators that you will convey these to the appropriate authority, but make no promises about getting back to them with an answer.

Do not make decisions – structure the expectation that decisions will take time. If a decision is made in response to a threat, this increases the probability that further threats will be made.

Do not give guarantees – negotiators will be placed in an impossible position if they have to deal with guarantees given to the perpetrators which cannot be honoured.

Build rapport
The most successful and safest way of resolving a hostage incident is through negotiations. This assumes a willingness on both sides to communicate in order to reach some mutually agreed compromise. The quality of this communication is based on the rapport built up between the perpetrators and the negotiators. Anything which you can do to facilitate this process will be invaluable.

Self-disclose – people relate more quickly and more positively to others whom they know something about. Be careful, however, not to give any personal information which could be used against you.

Structure expectations – demonstrate to the perpetrators that they can be listened to without having to threaten the hostage.

Show empathy – this is the ability to demonstrate to the perpetrators that, without sympathizing with their actions, you can see things from their perspective. This is done by i) restatement of content, i.e. saying back, in words different from their own, the essence of what has been said to you, and ii) commenting on not only what is said, but how it is said. The understanding of feeling sends a very powerful message to the perpetrators that they are being taken seriously.

Emphasize areas of mutual concern – recognize that the perpetrator has a contribution to make in resolving the situation.

Gather information
It is crucial, particularly at the start of a hostage incident, that as much detailed information as possible is obtained. As first person to witness these events your ability to collect and accurately recall information will contribute significantly to a safe resolution of the incident. However, it is important to recognize that in such a stressful situation, memory is often affected. It is, therefore, worth thinking about the information you gather in terms of facts, assumptions and impressions.

Facts – these include any information obtained through looking, listening, touching or smelling. If possible, facts should be supported by evidence. Details, no matter how trivial or unrelated they may seem, are of immense importance.

Assumptions – these are the interpretations made of events and which, to a greater or lesser extent, involve taking certain things for granted. The validity of an assumption depends on the degree to which it is based on facts. For example, you may hear a hostage cry out that he/she is being assaulted. The words you hear are facts, but the assault is an assumption which requires to be verified. Many problems in hostage incidents are the result of making assumptions for facts.

Impressions – these are the instinctive and intuitive judgments which are made when new or changing circumstances are confronted. Very often they are based on past experience. In the context of hostage situations, they can be important when assessing motives, intentions, frames of mind, honesty, etc.

III. D. Wounds

Derrick Ponder

A wound is a “disruption of the continuity of tissues produced by external mechanical force” (from the old English wund and the old Norse und). There is no statutory definition of a wound but some English case law developed in relation to the offence of “wounding”. This case law is to the effect that to constitute a wound there must be a breach of the full thickness of the skin involving both the epidermis and the dermis (R. v. Wood, 1830; R. v. M'Loughlin, 1838); it is also a wound if the inner lining of the lip is broken (R. v. Smith, 1837; R. v. Warman, 1846). By this definition bruises and abrasions are not wounds, and neither are internal injuries such as fractures, contusions of the brain and lacerations of the viscera. Consequently, this legal definition is not accepted in medical practice.

The term injury is used synonymously with wound, but can have a wider meaning and encompass not only damage produced by physical force, but also damage produced by heat, cold, chemicals, electricity and radiation. An injury is “a hurt, or damage to the body” (from the Latin injuria; in, not and jus, the law).

The term lesion originally meant an injury but it has now come to be more widely applied to include “any area of injury, disease, or local degeneration in a tissue causing a change in its function or structure” (from the Latin laesio, a hurt).

Wounds may be classified as follows:
1. bruises (or contusions or ecchymoses)
2. abrasions (or grazes or scratches)
3. lacerations
4. incised wounds
5. puncture (or stab) wounds
6. gunshot wounds.

A bruise is “a haemorrhage into tissues produced by the escape of blood from blood vessels”. Bruises may be found in the skin, muscles, and internal organs. A simple bruise of the skin, not associated with any other type of wound, is “a hae-
morrhage beneath the skin producing discolouration without any associated break in the skin surface”. A bruise to the skin of a person is directly analogous with a bruise to a fruit (from the old English brysan, to crush, and the old French bruser, to break). The word contusion is synonymous with bruise (from the Latin contundere, to thump). Ecchymosis (plural ecchymoses) is another synonym for bruise (from the Greek ek, out of, and chymos, juice). Haemorrhage or bleeding is “the escape of blood from any part of the vascular system” (from the Greek haima, blood, and rhegnymei, to gush). Haemorrhage or bleeding is the process which produces a bruise in tissues, but the term haemorrhage also encompasses bleeding which may not be associated with bruising, e.g. a bleeding nose, or a bleeding stomach ulcer. Very small haemorrhages (ranging in size from a pinpoint to a pinhead), which occur in tissues, may be described as petechia, or petechial haemorrhages (from the Italian petecchia, which has the Latinized plural petechiae). These haemorrhages may also be described as punctate (from the Latin punctum, a point).

An abrasion is “a portion of body surface from which the skin or mucous membrane has been removed by rubbing” (from the Latin ab, from, and radere, to scrape). Graze is synonymous with abrasion (the etymology of graze is dubious). A scratch is a linear abrasion produced by drawing a sharp point over the surface.

A laceration is “a tear in the tissues” (from the Latin, lacerare, to tear). The botanical term lacerate, means having irregular edges. An incised wound is “a cut or gash” (from the Latin incider; in, into, and caedere, to cut). The incisor tooth, or fore-tooth is a cutting tooth.

A puncture is “a small hole made with a sharp point”. Similarly a stab is “piercing made by driving in a pointed object”. A perforating stab wound is one which passes through the whole thickness of a tissue or organ (from the Latin perforare; per, through, and forare, to bore). Perforation is synonymous with transfixion (from the Latin trans, across, and figere, to fix). A penetrating wound is one which enters, but does not pass through an organ or tissue (from the Latin penetrare, to penetrate).

**Abrasions (grazes, scratches, brush burns)**

Loss/crushing of outer skin layer due to impact with a rough surface.

1. Tangential impact produces a moving abrasion
   a. Indicates direction
   b. Trace material (e.g. grit)
2. Direct impact produces an imprint abrasion
   a. Pattern of causative object
   All abrasions reflect site of impact (contrast bruises)

Assessment of age difficult

Post-mortem abrasion – brown, leathery

**Lacerations (tears, splits)**

Splitting of the skin by the direct crushing of blunt trauma

Typically over bone, e.g. scalp, eyebrow, cheekbone

Distinguished from incised wounds by

1. Adjacent abrasion/bruise
2. Ragged edge
3. Tissue bridges in depth

**Forensic importance**

1. Not related to object shape
2. Trace evidence
3. Relatively little blood loss (except scalp)
4. Rarely suicidal

**Typical examples**

1. Stellate pattern from poker end
2. Circles/crescents from hammer
3. Y-shaped from metal rod
4. Inside lips from blow to mouth
5. Stretching lacerations in vehicular accidents.

**Incised wounds (cuts)**

Breach of the full thickness of the skin due to contact with a sharp edge

**Forensic importance**

1. Reflects sharp edge not weapon type
2. No trace evidence
3. Bleeds profusely
4. Haemorrhage and air embolism

**Direction of cut**

Deeper at the start

**Suicidal or homicidal?**

1. Site, e.g. neck, wrist, face
2. Tentative wounds – suicide

**Penetrating wounds (puncture wounds)**

Breach in full skin thickness and depth is greater than length

Long, thin, sharp or blunt object

If sharp object then equals “stab wound”

**Forensic importance**

1. Haemorrhage internal rather than external
2. Weapon size/shape
   a. Double or single edged blade: ellipse or “fish tailing”
   b. Blade width: wound length (beware rocking)
   c. Blade length: deepest wound (beware partial thrust and tissue compression)
3. Force – sharpness of tip
   - bone or cartilage?
4. Patterns
   a. Homicide: multiple, defence wounds, scattered, different directions, same force, several potentially fatal
   b. Suicide: multiple, elective sites, grouped, tentative wounds, not clothing, one fatal.

Single wounds
   1. Accident/homicide/suicide?
   2. Position/direction of wound
   3. Scene very important

Kicking assaults ("the shod foot")
   Gangs, individuals without weapons
   Target areas - chin, neck, ears, groin, kidneys
   Bruises, abrasions, lacerations - patterns
   Internal haemorrhage - unusually severe
   Blood group victim - very important

Bite marks
   Double crescent of abrasions and bruises
   Early examination, loss of definition
   Swab for saliva, photograph
   Comparative value
   Child abuse, sexual assault.

Interpretation of wound patterns
   Common questions
   1. ?CAUSATIVE OBJECT OR WEAPON
      - Imprint type abrasions
      - Trace material in lacerations
      - Stabbing weapon
   2. ?MANNER OF INFLECTION
      - History and scene of death
      Self-inflicted
      - Incised or stab wounds
      - Target sites
      - Parallel, same direction
      - Tentative wounds
      - Accessible sites
      - Scars
   Assault
      - Any type of wound, combinations
      - Scattered, multiple directions, uniform force
      - Defence injuries
      - Several potentially lethal
      - Clothing
      - Secondary injuries
   Accidental
      - Any area, single, clothing
      - Defence injuries
      - Secondary injuries
      - Check history (suicide attempts, assaults)
   3. ?BLOOD SPATTER
      - Bruises and abrasions, none
      - Lacerations, not much
      - Incised and stab wounds, often profuse
   4. ?ORDER OF INFLECTION
      - Tentative or scattered first
      - Fatal and grouped last
      - Distant shots before close shots

Bruises
   Bruises (synonyms: contusions, ecchymoses) are areas of tissue discolouration produced by haemorrhage from ruptured blood vessels.

   Bruises can be confined to the deep tissues and therefore not visible on the skin surface; the discussion following relates to bruising of the skin and subcutaneous tissues which is apparent from examination of the skin surface.

   Bruises are typically produced by a blunt force impact, such as a blow or a fall; they may also be produced by squeezing or pinching, where the force is applied gradually and then maintained; "love-bites" are superficial bruises produced by the negative pressure of mouth suction. Bruises may occur in a variety of natural diseases in which there is an abnormality of the clotting mechanism of the blood, e.g. scurvy (vitamin C deficiency), leukaemia, alcoholic liver disease; such bruising is said to occur "spontaneously" because the injury which produces it is so insignificant as to typically pass unnoticed. The presence of such natural disease will exaggerate the bruising effects of any trauma.

   Florid spontaneous bruising (purpura) may be seen in children with fulminating meningococcaemia.

   In an uncomplicated bruise there is no breach in the skin surface; however, bruises may be associated with other blunt force injuries such as abrasions and lacerations. As a general rule bruising is not associated with incised wounds or stab wounds where there is a free flow of blood from the cut blood vessels rather than extravasation into the tissues. Generally, the extent of bruising is inversely proportional to the sharpness of the impacting object.

   The blood vessels ruptured are typically the capillaries and small veins rather than arteries. After the impact bleeding may continue for some time under the circulatory pressure of the blood. If the volume of haemorrhage is sufficient, a swelling may result; if the extravasated blood collects as a discrete tumour-like pool, the lesion is referred to as a haematoma.

   Site of trauma
   By contrast with abrasions, the location of a bruise does not necessarily reflect the precise point of injury. Extravasated blood will follow the path of least resistance and seep along natural or traumatic planes of cleavage of the tissues under the influence of gravity and body movements. For example, in the elderly, intense and widespread bruising of the outer aspect of the lower thigh may follow a fracture of the hip; a bruise of the temple may gravitate down to the cheek; a fractured jaw may result in bruising appearing on the neck.

   Delayed appearance
   Gravitational shifting of deep bruises may result in their appearance at the skin surface being delayed. The more superficial the source of bleeding, the sooner the discolouration will be apparent on the skin surface. Deep bruises may require as long as 12 or 24 hours to become apparent and some may never do so. In a living victim, a second examination after an interval of one or two days may disclose bruising where previously there had been only swelling or tenderness on pressure. Similarly, in the dead, a further examination one or two days after the original autopsy may disclose bruises which were not previously evident as well as revealing more distinctly bruises which previously appeared faint. This may be particularly the case with "fingerpad bruises" produced by handgrips. Ultraviolet (UV) light may disclose bruises which are not otherwise identifiable at the time of examination.

   Degree of force
   The size of a bruise is an unreliable indicator of the degree of
force causing it. In general a heavy impact is likely to pro-
duce a large bruise and a light impact to produce a small
bruise. If bruising is slight then it is reasonable to assume,
unless the contrary is clear from other findings, that the
degree of violence was slight.

In assessing the degree of violence from the appearance of
bruises, several factors must be taken into consideration:

1. LOCATION
Some areas of the body bruise more easily than others,
e.g. the face with its vascular and more abundant lax
subcutaneous tissues bruises more readily than the hands.
Bruising occurs more readily in loose tissues, e.g. around
the eyes and genitals and where there is a large amount of
subcutaneous fat, e.g. buttocks and thighs, but less easily
where the skin is strongly supported by fibrous tissue, e.g.
palms, soles and scalp, or if the muscle tone is good, e.g.
abdominal wall of boxers.

2. AGE
Infants and the elderly tend to bruise more easily than
young and middle aged adults; the former because of the
looseness and delicacy of the skin, and the abundant sub-
cutaneous fat; the latter because of degenerative changes
in the tissues which support the small blood vessels of the
skin and subcutaneous tissues.

3. SEX
Women bruise more easily than men because they have
more subcutaneous fat and this is particularly true of
obese women.

4. NATURAL DISEASE
Individuals with diseases affecting the blood clotting
mechanism (see above), e.g. chronic alcoholics, tend to
bruise more easily, as do individuals with degenerative
disease of the blood vessels and high blood pressure.
Bruises may also heal more slowly in these individuals.

5. SKIN COLOUR
This does not modify the extent of bruising but does
influence the appearance. Bruising is more easily seen in
blondes and redheads than in more swarthy persons; in
blacks extensive bruising can be completely masked by
the natural skin colour.

Causative object
Bruises tend not to reflect accurately the shape of the causa-
tive object because the bruise tends to change its shape and
location with time under the influence of the factors enume-
rated above. The shape of the bruise is most likely to reflect
the shape of the causative object when the object is small and
hard and death supervenes soon after injury (limiting the
extension of the bruise normally produced by the pressure of
blood in the circulation).

A doughnut bruise is produced by an object with a
rounded contour, e.g. cricket ball. Two parallel linear bruises
("tramline bruises") result from a blow with a rod or stick;
the pressure of the blow from the rod displaces blood to the
sides to produce the bruises on either side of the line of
impact. If the blow with the rod is struck against the buttocks,
- a particularly pliable, curved, soft surface - the tissues are
compressed and flattened under the impact; the resulting
bruise will follow the curved contour of the buttocks. A pli-
able weapon such as a strap or electric flex may produce a
similar appearance as it wraps around the body on impact.

Bruises produced by fingertips as a result of gripping
are usually larger than the fingertips themselves, but their
pattern and location suggest the mechanism of causation, e.g.
on the neck in throttling and on the upper arms in restraint.

A bruise which bears the imprint of the shape or contour of
the impacting object is said to be patterned. With pat-
terned bruises, a tracing of the pattern may be made to
match to the causative object, or photographs of the injury
and object may be superimposed. Patterned bruises of this
type may be associated with patterned (imprint) abrasions.
Examples of patterned bruises may be seen from ligatures
around the neck in strangulation; the headlight, grill or
bumper of a vehicle impacting a pedestrian; and the muzzle
or foresight of a gun in contact gunshot wounds.

Occasionally clothing or jewellery may leave a patterned
bruise on a body when it is crushed into the skin surface by
an impacting object, e.g. motor vehicle striking a pedestrian,
or a kick through clothing.

Ageing of bruises
Immediately after infliction a bruise will be dark red, the
colour of capillary blood, turning fairly soon to a dusky
purple; the bruise subsequently appears brown, green and
yellow before finally fading away from a pale straw colour.
The colour changes progress from the periphery of the
bruise towards the centre. The majority of bruises have
disappeared within one to four weeks of infliction, but this
time frame is extremely variable depending upon the size and
depth of the bruise, its location and the general health of the
individual. In general a green discoloration appears after
four to five days or later, a distinctly yellow change after
seven to ten days or later, the final disappearance of the
bruise occurs in fourteen to fifteen days. "Love bites" which
are small and superficial, typically complete this sequence in
seven days. While accurate estimation of the age of a single
bruise is not possible, a fresh bruise can be distinguished
easily from one which is several days old. Establishing that
bruises are of different ages may be of medical importance
where there is an allegation of repeated assaults, e.g. child
abuse and wife battering, or where pre-existing injuries need
to be distinguished from those produced by a recent assault,
e.g. a chronic alcoholic who was assaulted. A patterned
bruise with a sharply defined outline infers that death oc-
curred shortly after infliction, for otherwise the bruise would
be less well defined. It is not possible to distinguish a bruise
sustained at the time of death from one which occurred some
minutes earlier; such bruises are best described as having
occurred at or about the time of death.

Post mortem bruises
Bruising is essentially a vital phenomenon in which the extra-
vasation of blood into the tissues occurs under the pressure of
the circulating blood. After death the rupture of blood ves-
sels as a result of blunt force impact may lead to the extra-
vasation of blood. For so long as fluid blood is present in the
capillaries and veins, any injury that crushes these vessels will
allow blood to extravasate into the surrounding tissues.
However, the extent of blood spread is limited since the pres-
sure of blood within the vessels is only physical. In practice it
requires considerable violence to produce a bruise post mor-
tem; the bruise is invariably disproportionately small relative
to the degree of force used. Such post mortem bruises are
most readily produced in areas of hypostasis (post mortem
lividity, liver mortis) or where tissues can be forcibly com-
pressed against bone, e.g. over the occiput. In practice post
mortem bruising is unlikely to be confused with ante mortem
injury except perhaps in the case of occipital bruises where a
lesion an inch in diameter may be produced by careless
handling of the body during removal from a scene of death
or in the mortuary. In assessing the possibility that bruising
may be post mortem, consideration must be given to the findings and circumstances as a whole; against this background quantitative differences between ante mortem and post mortem bruises are usually so great that confusion is unlikely. It is seldom difficult to distinguish between injuries with vital bruising resulting from a vehicle running over a live body, and the tearing and crushing of dead tissues.

**Post mortem lividity**

Post mortem lividity (synonyms: hypostasis, livor mortis) is the settling, after death, of blood within the blood vessels under the influence of gravity. This results in a purplish discoloration of dependent parts of the body with sparing of areas of pressure contact – contact pallor. The pattern and distribution of lividity distinguishes it from bruising. In doubtful cases incision of the skin will disclose blood oozing from the cut ends of vessels in instances of hypostasis, in contrast to extravasated blood within the tissues in bruises. Washing of the cut surface with running water will remove the blood from hypostasis but not the blood infiltrating the tissues in bruises. Confirmation of the distinction may be made by microscopic examination.

Post mortem decomposition with its initial green discoloration of the anterior abdominal wall is readily distinguished from bruising. Putrefactive haemolysis of blood within the vessels and decompositional breakdown of the vessel walls results in extravasation and diffusion of haemolysed blood into the adjacent tissues; existing bruises are enlarged by this process; later, putrefactive haemolytic staining of tissue may mask ante mortem bruising, e.g. in the neck muscles in cases of throttling.

**Deep bruises**

Bruises of the deep tissues, even when fatal, may not be evidenced by any injury to the skin surface. Fatal head injuries, e.g. subdural haematoma, may be encountered without recognizable superficial bruising. Fatal strangulation with extensive bruising of the muscles of the neck may be accomplished without obvious bruising of the skin. Blows to the abdomen, although producing ruptures of internal organs, may not produce any external bruising. Bruising is more likely to be confined to deep structures and spare the skin surface when produced by blows with a wide and smooth object.

Focal necrosis of subcutaneous fat may occur at the site of a bruise; secondary aseptic inflammation in response to the irritant effect of fat liberated from the ruptured cells produces a hard chronic lesion. This is more of medical than forensic importance as a common site is the breast where it may be mistaken for a carcinoma.

**Classical examples**

Bruises on the nose raise the suspicion of throttling, particularly if the bruises are round or oval and approximately fingerpad size. Similar fingerpad-type bruising from gripping may be seen on the limbs of battered babies, e.g. gripping the arms or legs to forcibly swing the child or twist the limbs, or on the cheeks, in forceful gripping of the face, or on the trunk, bilaterally, in forceful shaking. Fingerpad-type bruises on the upper arms near the armpits suggest forceful restraint but may also be seen when an unconscious or semi-conscious person is lifted by persons rendering assistance. Fingerpad bruising of the thighs of a woman suggests forceful intercourse and may corroborate an allegation of rape. These bruises in themselves would be medically inconsequential, but are of considerable medico-legal significance since they constitute objective evidence, from their location and pattern, which can corroborate an allegation of assault.

Bruises to the knuckles of the hands, together with bruises of the eyelids, bridge of the nose, cheeks and lips, are suggestive of a fist fight. Bruising around the eyes – so-called spectacle haematoma - may be produced by direct blows, but also commonly results from a fracture of the base of the skull, e.g. in vehicle collisions or gunshot wounds to the head; they may also follow blunt impact of the forehead producing jolting of the eyeballs in their sockets with tearing of small orbital blood vessels.

Bruising of the genitalia and around the anus suggests sexual assault. Severe bruising of the genitalia, with or without laceration, can be produced by kicks.

Counter-pressure bruising, with or without abrasion, to the bony prominences of the back, i.e. the shoulderblades, sacrum and pelvis, suggests pressure against a firm surface as in forceful restraint on the ground, e.g. in rape or throttling. Similar bruising may be seen on bony prominences of the front of the pelvis in attempted anal rape.

Elliptical bruises, up to 1" long and up to 3/4" broad on the sides of the neck or the breasts, suggests "love-bites" produced by mouth suction. (A "hickey" in American slang). A double crescent of bruises with or without abrasions, suggests a bite mark and is most commonly associated with sexual assault or child abuse.

In kicking assaults with the shod food bruises are invariably associated with multiple abrasions and lacerations. The bruises and abrasions may be patterned by the boot. Bruising is typically extensive and targeted on the face, neck, ears, groin, and kidney area. Internal bruising is usually severe.

Bruising of different ages may suggest repeated assaults, e.g. child abuse and wife battering. Multiple bruises of different ages are also seen in individuals who have natural disease affecting blood clotting and/or sustain repeated falls, e.g. chronic alcoholic, and elderly persons with poor balance. Bruises of different ages scattered on the forearms are often seen in the elderly.

Bruising of the anterior chest may be produced during attempted resuscitation by medical personnel and others. During hospitalization bruises are commonly produced by multiple needle punctures, and occasionally pinching the person to test the degree of loss of consciousness.

Bruises are painful and therefore not commonly self-inflicted; extensive bruising creates a presumption of assault. Accidents generally are unforeseen and the injuries they produce tend not to follow a recognizable pattern; however, some accidents are sufficiently stereotyped and common as to produce patterns e.g. bruises on the shins of young children from play, falls and walking into objects, and bruises on the hips of women from bumping into drawers, cupboards and other objects about the home. Injuries in motor vehicle collisions almost invariably include abrasions and lacerations as well as bruises; patterns of injury may allow reconstruction of incidents involving pedestrians or allow distinction between driver and front seat passenger.

III. E. The report

Bent Sørensen

1. Name and address of the organization to receive the report:
2. Preface:
III. F. Ethical and practical aspects of medical opinions

Derrick Pounder

Providing a medical opinion for judicial and quasi-judicial authorities provides both ethical and practical problems for a doctor. The ethical issues arise because in agreeing to provide an opinion a doctor takes on ethical responsibilities to the adjudicating authorities and these responsibilities differ from those in a typical doctor-patient relationship. The practical difficulties arise as a consequence of the ethical issues and also because medical opinions formulated for legal proceedings must comply with legal requirements. Consequently the structure and content of a medical opinion for these purposes differs in many significant respects from medical opinions given within the health care system.

The ethical principles governing the doctor-patient relationship are well known and well understood by doctors. The normal doctor-patient relationship is governed by the principle of confidentiality and is based upon the primary interest of both the doctor and the patient in promoting the health and well being of the patient. The preparation of a report for medico-legal purposes breaches normal doctor-patient confidentiality and this must be explained to the patient at the start of the medical examination. Furthermore, in preparing a medico-legal report a doctor has an ethical obligation to produce an opinion which is full, frank and fair irrespective of the consequences of that opinion for the patient in the subsequent proceedings. Thus in preparing a medico-legal report a doctor is an advocate for the objective truth and cannot at the same time serve as an advocate for the patient. Where the doctor has had no care-giving relationship with the patient this ethical standpoint is easier to adopt. Even so the doctor must be scrupulous in avoiding bias. On the other hand, doctors employed by government agencies need to consciously resist the tendency to adopt a bias influenced by the culture of that agency. It is improper for a doctor in preparing a medico-legal report to have an interest in the outcome of the proceedings. It is not surprising that doctors who provide health care for asylum seekers or who are active in human rights organizations and similar NGOs produce opinions influenced by their bias, but it is unethical to do so. Similarly it is understandable that doctors employed by the governmental agencies produce reports which reflect a bias of extreme skepticism towards asylum seekers based upon the culture of the governmental agency, but to do so is unethical. Doctors, like all members of society, are entitled to hold views on social and political matters, but it is improper for a doctor to permit such a viewpoint to influence a medico-legal report.

In preparing a medico-legal report a doctor is privileged to be asked for an opinion. The sole reason for the adjudicating authorities to ask for an opinion is that such an opinion requires special knowledge and skills which are beyond the knowledge and skills of the adjudicators. It follows from this that an opinion offered by a doctor should be within the specific area of expertise of that doctor, so that specialists should not offer opinions outside their own area of specialty. Furthermore, in offering an opinion a doctor should not stray into an area outwith medicine and within the competence of the adjudicators, because the adjudicators have no need of such an opinion. Above all the doctor should remember that an opinion is only advice. Whether or not the adjudicators act upon that advice is not a matter which a doctor should view as reflecting on his/her personal and professional status. All of

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this is made easier if a doctor can appreciate that, although still respected, a doctor has a quite different role and status in these proceedings than within the health care system.

All medico-legal reports fall into three broad sections, namely an introduction, a statement of facts and a statement of opinion. The introduction should give all the necessary administrative details including the name, qualifications and authority of the doctor performing the examination together with an explicit statement that the subject has waived the right to confidentiality and consented to the examination. The time, length of time, place and circumstances of the examination should be stated. The method of formal identification of the patient is also required. Other individuals present during the examination should be named.

The factual element of the report falls into two parts, namely information provided to the doctor but not otherwise known to the doctor, and the direct observations of the doctor. This distinction has legal importance. Information provided to the doctor includes any documentary material and any statements of the subject, that is what would normally be called the patient history. Because legal processes generally flow upon leading questions, that is to say questions which suggest their own answer, it can be helpful if a doctor distinguishes between a spontaneous account given by a patient as contrasted with answers to specific direct questions. This can be done by using quotation marks and, whenever possible, the words of the subject should be recorded verbatim. Importantly the information provided by the patient should not be interpreted but merely reported. The observations of the doctor should be factual and not at this stage include any interpretative opinion. The structuring of the account of the medical observations should follow usual medical practice except where this needs to be modified for ease of reading by a lay person. The language of this section of the report should be technical because medical terminology is more precise than lay language. In setting out the factual information, both that provided and that observed, the doctor has an ethical obligation for accuracy of observation and accuracy of description. The detail of recording of the facts should be sufficient that another doctor would have all the necessary and relevant information to offer an independent opinion.

The third section of the report, the opinion, is inevitably the most difficult to formulate. It will be scrutinized in detail by the adjudicating authorities and therefore time and effort should be invested in formulating it and crafting the language. The overall opinion will comprise a series of minor opinions which taken together lead towards the final conclusion. Each individual opinion has two elements, namely a statement of the opinion and a statement of the degree of certainty with which a doctor holds that opinion. These two elements are intermixed in the language of the opinion, but it is helpful in formulating the opinion if a doctor considers carefully both of these two elements of statement and certainty. The overall opinion should be structured so as to provide a logical hierarchy. The fact or facts upon which an opinion is based should be clearly stated in lay language (with technical language in parenthesis if necessary). These facts should represent the essential facts crucial to that opinion without any irrelevant adorning facts. The medical logic applied to those facts to derive the opinion should be stated transparently. In this way the adjudicators should be able to understand clearly what facts must be assumed to be true in order to arrive at the opinion, how the opinion is arrived at logically, and the degree of certainty with which the opinion can be asserted. In formulating the opinion a doctor should recognize that facts may be disputed in the later proceedings and this is particularly likely to be so with the statements made by a subject. Clearly if the assumed facts change then a doctor is entitled to change the opinion, and this does not reflect adversely on the doctor. Anticipating what facts may be challenged and consequently how this will influence the resultant opinion is a skill which the doctor should nurture but which can only come with experience. No opinion is perfect and the doctor should freely concede any challenges which are reasonable while at the same time standing by that which is scientifically sound. Most importantly a doctor should avoid arrogant dogmatism based upon personal assertion.

In summary, the preparation of medical reports for judicial and quasi-judicial proceedings is a privilege which confers on doctors ethical obligations as well as the requirement to develop specific reporting skills. When the cases subject to adjudication are emotionally charged and lie within areas of contentious social and political policy, as with e.g. asylum seekers, it is particularly important for the doctor to consciously set aside all personal bias and to serve the adjudicating authorities by providing an opinion which is full, frank and fair. In doing so the doctor acts as an advocate for the truth and scrupulously avoids acting as an advocate for one side or the other in the proceedings.

IV. Official literature

United Nations


Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984/87.

Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment", 1982.


To be found in:


Council of Europe


European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. 1987.


Can be obtained from:

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Ethical and legal aspects
of working as a doctor
in the Danish prison system

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Ethical and legal aspects of working as a doctor in the Danish prison system

In June 1988 a committee, struck by the Ministry of Justice, published a report on the health care related treatment of the clients of the Danish prison services (referred to in this article as the Prison Health Services). The report dealt with the legal background of the health care related services of persons detained in the institutions of the Danish prison service and in detention centres with respect to possible changes in existing regulations. The report discussed *inter alia* the health care functions of prison doctors in relation to the existing medico-ethical rules. The committee concluded that the existing rules for the work of doctors were largely in agreement with existing medico-ethical standards. On this background, the committee found no reasons for essential changes of the present work description and employment contracts of prison doctors. However, the committee did not comment on possible problems of impartiality and the strain of the doctor/patient relationship that might be caused by the present employment of the prison doctors by the Ministry of Justice. However, it seems obvious that several of the tasks of the prison doctors may conflict with the existing medico-ethical rules. This means that a doctor, through his functions in the health care service of the Danish prison service, may, according to the circumstances, find himself in a serious dilemma in balancing his employment obligations against medico-ethical rules. This dilemma exists not only within the Prison Health Services, but also, and to the same extent, in cases involving the use of force, for instance in connection with police investigations.

At the same time one should realize that there will always be – and probably should be – a confrontation between a profession’s ethical rules and the legal regulation of society. The reason for this is within the function of the ethical rules, which must not only interpret existing regulations by presenting supplementary obligations, but must also set certain limits to what each profession must take on with respect to interventions against people in general. These limitations are set by the profession itself, independent of what the legislature might decide, and this may be the cause of a dynamic tension. Of course this does not mean that the legislature should accept all proposals, simply because they are called “medico-ethical”, but the confrontation will often take a fruitful course by leading to a reconsideration of the legislation.

The present article deals mainly with the question of the duty of doctors in connection with coercive measures by prison authorities with respect to prisoners under medical treatment. It is an analysis of the relationship between the legal basis, and the ethical standards for the work of medical officers. The focus is mainly on safeguarding public security in general, and consequently most of the proposals deal largely with changes of regulations. The main idea throughout the article has been to make the Danish legal system serve as a model for international improvements.

Considerations on the background of existing regulations for doctors

Medico-ethical rules are not the result of legislation. They are and should be part of the medical profession’s self-regulation such as takes place both in private national professional organizations, and in private international medical associations, especially the World Medical Association. The passing of rules in these fora expresses the participating organizations’ common attitude to the content of medico-ethical principles, which are applied only by the organizations that adopt the same principles, and not by others, for instance the national authorities that employ doctors and make decisions on their field of work. Thus, the professionally adopted medico-ethical rules do not follow the ordinary principles of legislation.

It is generally accepted that professional organizations play an important role in democratic societies. It is important that these organizations are and remain independent of the State. With this independence follows an obligation to adopt a code for their members’ professional behaviour in accordance with reasonable quality requirements from the community at large. Through their work, doctors – in line with judges – constantly meet situations in which they have to make decisions on questions concerning the life and well-being of fellow human beings. For these two reasons alone, it is necessary to maintain certain basic ethical rules for all medical activities: a kind of ethical constitution for doctors, to keep the individual doctor on the humane and health-care oriented path throughout his professional life. The voluntary aspect is not decisive for what can be characterized as medico-ethically responsible. It does not in all cases exempt a doctor from his medico-ethical responsibility that the patient himself is asking for help, if it is otherwise clear to the doctor that in this way he is allowing an inhuman treatment to continue. In such situations it is difficult to define the problems, and it is in the light of these complicated and difficult dilemmas that the medico-ethical rules should be considered. Despite the fact that health care rules, as already mentioned, do not have proper legal status in Denmark, they set, and should set, the standards for the work of doctors in reality. The medico-ethical rules express fundamental principles concerning a doctor’s respect and care for his patient, and they are an essential codification of ordinary guidelines for the medical professions to support the individual doctors. The medico-ethical rules are enforced by several recommendations and similar resolutions that have been passed by international organizations such as the UN and the Council of Europe. These are not only aimed at the medical profession; their primary aim is to improve conditions in prisons and to limit the risk of violations of the prisoners by the authorities, including medical assistance in inhuman and degrading treatment. The legal importance of recommendations is different from that of treaties and other binding international obligations in which the Danish State takes part, since they should mainly be considered as guidelines for interpretation of the use of national laws. However, this does not mean that national authorities can simply ignore these rules. The fact that a state (in this case Denmark) has approved a set of guidelines creates a certain expectation that the state in question will adhere to them.

One of the conditions that complicates the lack of agreement between the medico-ethical rules and the administrative regulations for doctors’ work within the prison service, is the uncertainty concerning the legal basis within both sets of rules.

The legal (judicial) status of the set of rules of the Danish prison service

The condition of people detained in Danish prisons, as already mentioned, depends to a large extent on rules laid down by the administration, primarily circulars and instructions, that are traditionally used to give the authorities a certain flexibility so that existing rules can be adapted contin-

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vously to the present needs within a section of the judicial system. In addition, political interest in the conditions at the national prisons is relatively small, and therefore it is difficult for the detained persons to mobilize necessary public opinion to bring about changes. Recent human rights practice contains requirements about accessibility and predictability. The former is mainly a question about the interference in the life of the citizens by public authorities being based on titles that have been published and are easily accessible and, as far as possible, understandable for everyone. In practice, it will often involve a demand for a regulation in the form of legislation, and not as now of circulars. As far as possible, the legal system must be based on an inner understandable logic. The predictability requirement means that the citizens should be able to predict their legal position with a reasonable degree of certainty, i.e. that legal provisions should be precise and clearly formulated, particularly if they involve interference in the legal position of the citizens.

In principle, regulations via circulars should not have legal effect on the legal position of private citizens, and in particular should not be a justification for infliction of bodily harm. Legislation is recommended, partly to clarify the legal rules for the deprivation of liberty, and partly to distinguish more clearly between laws that concern the prisoners' conditions and those that only serve as internal guidelines for the institutions.

**Selected medico-ethical rules**

For a description of the medico-ethical conflicts that may arise in connection with some of the functions of the prison doctors, it is necessary to give a general view of the standard sets of rules for medical ethics: international obligations and recommendations, national legislation, and professional (national and international) sets of rules.

The UN International Covenant on Civil and Political Rights, The UN Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, and the European Convention on Human Rights are not mainly concerned with medico-ethical aspects of the deprivation of liberty. However, these conventions regulate some aspects of the detainees' conditions while serving a sentence, such as the basic civil rights, and in particular questions about torture or inhuman and degrading treatment. Thus, they define the limits for medical participation and for what may be considered as medically ethically responsible. In 1987, the Ministerial Committee of the Council of Europe passed the European Rules of Imprisonment, a revised European edition of the UN Standard Minimum Rules for the Treatment of Prisoners. These rules, though not legally binding, aim at the establishment of some minimum norms for all aspects of the prison administration, including the health services for prisoners. It is a very detailed set of rules that aim at the regulation of all aspects of life in prison. Furthermore, the Ministerial Committee has passed several resolutions and recommendations concerning the conditions of prisoners. In 1987, the member states of the Council of Europe passed the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, involving the creation of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CPT, with the right to make inspections at all prisons. Through these inspections and subsequent recommendations, the CPT helps to make standard improvements. In 1982, the UN General Assembly passed Principles of Medical Ethics. These principles, though not legally binding, are aimed at protecting prisoners against violations. Principle 3 states that it is a violation of medical ethics for health personnel, in particular doctors, if they in their relationship with prisoners or other persons deprived of their liberty become involved in matters other than diagnosing, protecting, or improving the physical and mental health of those deprived of their liberty. The World Medical Association (WMA) is a professional organization, independent of state institutions, that deals with non-clinical matters, including medical ethics, training of health personnel, questions of social medicine, etc. Throughout the years, WMA has passed several recommendations that in reality set the standards for doctors around the world. Essential recommendations are the International Code of Medical Ethics, 1949, the Regulations in Times of Armed Conflict ("Havana Declaration"), 1956 about the obligations of doctors in armed conflicts, the Declaration of Helsinki, 1975, about biomedical research including the demand for informed consent, the Declaration of Tokyo, 1975, about the ban on doctors' participation in torture or other forms of cruel, inhuman or degrading procedures, and the Declaration on Hunger Strikers ("Malta Declaration"), 1991. In 1989 the Standing Committee of Doctors in the European Community (Comite Permanent) passed a declaration concerning doctors, ethics, and torture, the Statement of Madrid.

**The doctor/patient relationship**

A basic principle for the work of doctors is that the right of the individual to make his own decisions should be respected. An able adult person cannot be examined or treated by a doctor without his own consent. The basic idea behind the Declaration of Helsinki is that there should be no doubt about the basic character of the therapeutic and non-therapeutic function of medical officers. The patient's confidence in and acceptance of the doctor are essential preconditions for the function of the doctor.

**Health care services in prisons**

Through his work in the Danish prison service, the medical officer may come to play an unfortunate double role: at the same time as he objectively adheres to his obligations as therapist, he may legitimate measures to which the prisoner has been subjected against his will, and which in certain cases may be directly harmful for the prisoner, the doctor's patient. In principle, the prison inspectors are the doctor's immediate superiors. It may be difficult to distinguish between medical tasks and other medical functions. In acute situations, e.g. giving medical care to a security prisoner who may have been forcefully restrained, there is a certain risk that the prisoner, as well as the doctor himself, may consider the doctor a part of the prison service and not as the prisoner's medical advisor. There is thus a need to define the role of the doctor in the Danish prison service in order to decrease the risk of violations of the medico-ethical rules. The following deals with some concrete situations in which the task of the doctor conflicts with medico-ethical rules, and with some suggestions for changes to the present legal position. In its "Ethical Rules" from 1989 the Danish Medical Association has stressed that less comprehensive rules cannot be applied to special groups of doctors, i.e. that the same rules must apply to all groups of doctors, and that there must be no doubt about the basis for both therapeutic and non-therapeutic medical work. The same principle is also expressed in the WMA's Regulations in Times of Armed Conflict. Internationally, the expression "especially exposed professional groups" is often used about people who can easily be in-
volved in situations where violations of human rights may occur, e.g. "journalists at risk", or "doctors at risk", i.e. especially police and prison doctors. In particular, these doctors risk being forced to take part in human rights violations as a result of their special employment conditions. To counteract this pressure it is of vital importance for these groups of doctors to be bound by the same medical ethical rules as all other groups of doctors. A still more efficient preventive step would probably be to introduce an international ban on police and prison doctors being employed by their respective services. A change of the doctors' professional dependence on the prison authorities must be considered an essential and necessary improvement on the present state of affairs. With respect to employment and hierarchy, medical prison personnel should not be part of the Danish prison service or the Ministry of Justice. By contrast, such doctors should be employed by the national health service. This would make the basis for their work clear and improve their possibilities for helping – independently – to prevent violations. At the same time the aim should be, as far as possible, to make sure that detainees get the same health services as ordinary citizens, e.g. that the doctor's loyalty towards his patient should not be under any threat. Prison doctors risk being caught between the conflict that is bound to occur in certain situations between the detainee and the prison authorities (the doctor's superior), and this may well have a negative influence on the doctor/patient relationship. In some states, ill prisoners are treated by national health doctors. In Sweden, for instance, there have been problems in making these doctors sufficiently interested in their prison work, probably for reasons related to their careers. In Berlin the same value has been given to training in hospital and prison services, resulting in a good exchange between prisons and national health service. The prison doctors' professional independence of the prison authorities is also more in agreement with the Declaration of Tokyo (point 4), according to which "A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible". Employment of doctors by the Danish prison service should therefore be stopped, and instead the responsibility for medical services should be transferred to the local hospital and general practitioners, but probably not to the local district medical officer because he should not lose his independence. Furthermore, CPT recommends the establishment of special courses of "prison pathology", and of the use of taking preventive measures against conflicts.

The ordinary health care treatment by the Danish prison service

Detainees whose detention is estimated to last less than three months have the right to claim the services of the national health service, e.g. to see a general practitioner from outside the prison. The same law applies to people in custody until they have been sentenced, though with the qualification – usually unnecessary – that the right to consult a general practitioner may be refused by the police because of ongoing investigations. According to international experience it is mainly people in custody who have the need to see an independent doctor. As a first step therefore the ability of the police to refuse medical assistance from outside should be limited as much as possible – and in any case it should be based only on the ruling of a judge. By contrast, detainees whose detention is estimated to last three months or more have no rights to the national health services, and, together with those with limited rights, they have to follow the rules of the health care service laid down by the Ministry of Justice for the institutions and detention centres under the Danish prison service. According to these rules it is usually the institution's doctor, i.e. the prison doctor or possibly the local district medical officer who will treat the prisoners.

The medical therapeutic obligations

The prison doctor looks after the detainees and gives medical treatment within his field of competence. He estimates the need for laboratory tests and for consulting specialists. Furthermore he shall write reports and certificates concerning the sanitary conditions of the prison as well as certificates for the prisoners in connection with their stay, release, and disciplinary matters. In certain cases the doctor shall write certificates concerning the staff. When needed for health reasons, the prisoners must submit to a medical examination, vaccinations, or other prophylactic measures. A special circular states that a concrete evaluation should determine which examinations should be performed at the start of detention.

Medical-ethical problems in the absence of a free choice of doctor

According to the principle in the UN Standard Minimum Rules for the Treatment of Prisoners and articles 26-32 of the European Prison Rules of the Council of Europe that Denmark adopted in 1987, prisoners – with the modifications that follow from the special prison conditions – should be offered the same health care services as other citizens in the society at large. The considerations behind these principles are that detainees as far as possible should be safeguarded the same civil and social rights (the same standard of treatment) as other citizens, and that the doctor in charge of treatment should be able to carry out examinations and treatment in a medico-ethically responsible way, i.e. in a way that inter alia safeguards the patient's integrity and right of self-determination, but the rules do not recommend free choice of doctor. The most recent legislative changes in the field of health, however, contain very few changes concerning matters of the prisoners' health insurance. As a main rule, the prisoners are still not allowed self-determination with respect to health insurance. The lack of a really free choice of doctor results in a difficult situation for a large group of detainees in Danish prisons and detention centres. Their doctor is the institution doctor, and it is not possible for the detainees to change doctor if they feel that the treatment has been poor or wrong, or if they have no confidence in the doctor in question.

Informed consent for detained patients

The examination and treatment situation is characterized by the detainee's lack of self-determination. The prison staff are obliged to call a doctor if the detainee wants them to. Furthermore, the detainee is obliged for example to have blood tests taken if the doctor thinks it necessary. In practice, blood tests are not taken against the will of the detainee, but it is regrettable that a warrant for this can still be given. Thus, not long ago, certainly in one case, a blood test was taken without the consent of the detainee. It was, however, a special case, since the detainee, a Gambian, had bitten a prison officer, who feared that he might have been infected with HIV in this way. The doctor was criticized by the local prison authorities. Even if the regulations about an obligatory medical check have been cancelled, it is up to the doctor to evaluate whether a proper medical examination is needed. The doctor may get into a situation in which he has to treat a detainee against his wishes. This is against current
medical ethical rules according to which the most essential principles are voluntary consent. The doctors' code concerning the patients' right to self-determination, and the WMA's International Code of Medical Ethics from 1949 which deals with the duties of physicians in general and states that the doctor must be completely loyal towards his patient, a principle also expressed in Article 5 in the World Psychiatric Association's Declaration of Hawaii from 1977. With respect to participation in medical trials, consent is required according to Article 7 of the UN Covenant on Civil and Political Rights. Today this requirement must be interpreted as a demand for voluntary informed consent. In general it may be questioned whether it is at all possible to obtain this in a satisfactory way under prison conditions. In all circumstances, doctors should be reticent if it comes to involving prisoners and others in scientific research, and they should refrain from taking part if any risk for the participants is involved. Research with the aim of clarifying the damaging effects of long-term imprisonment, etc., should probably be accepted even if it may cause fundamental concerns.

It is unavoidable that the imprisonment itself will to a certain extent limit the self-determination of the imprisoned patient. It also results in some restrictions in the individual's rights, such as the right to walk around freely, and the right to self-determination, e.g. limitations of the detainee's possibilities for action, including the possibility for taking the responsibility for his own health. The potential damaging effect on health from this should be limited as far as possible.

The Third Annual Report from CPT (point 73) stresses that "a prison doctor acts as a patient's personal doctor. Consequently, in the interest 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 emergency, when no other doctor can be called in". In Denmark, physical examination of detainees can only be carried out with their consent.

**Suggestions for solutions:**

There is a lot to be said for changing the health care services of detainees. A group of general practitioners should be established in the neighbourhood of all major institutions of the Danish prison service to take care of the health care services of the institution. Each medical group should consist of 5-6 doctors, rotating, to ensure fixed consultation periods corresponding to the present services of the prison doctors. The prisoner could then choose a doctor he would like as his personal doctor. Consequently, in the interest 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 emergency, when no other doctor can be called in". In Denmark, physical examination of detainees can only be carried out with their consent.

**Doctors' special prison tasks**

**Doctors' assistance in the use of force and placement in security cells:**

The Directorate of the Danish prison service has the power to determine the detailed rules concerning the use of security measures and the use of force. The use of security measures in Danish prisons may comprise security cell, with or without fixated, observation cell, as well as fixation alone.

**Placing in security cell with fixation:**

A doctor should be called immediately in order to allow a medical examination to take place as soon as possible unless the doctor has made sure that such an examination is obviously unnecessary. The present routine of calling a doctor has been abandoned, but it should be assumed that a doctor has to come in most cases. The circular states that it is not the task of the staff to evaluate possible diseases or injuries of the prisoner. The staff should only give the doctor the factual information, after which an evaluation of possible signs of disease should be left to the doctor.

Fixated detainees in security cells should be under continuous observation.

**Placing in security cells without fixation or in an observation cell:**

A doctor should be called if there is a real suspicion about disease or if the detainee asks to see a doctor. If detention in a security cell lasts for more than 24 hours, the doctor has to be informed daily in order to evaluate the need for his service, based among other things on his knowledge of the detainee. At the same time similar rules have been introduced with respect to the use of handcuffs and force. In questions concerning the use of a fixation belt for more than 24 hours, the doctor should be informed daily so that his services can be used, unless he finds it obviously unnecessary. When a detainee is handcuffed, a doctor should be consulted if there is suspicion of disease, including injury caused by the handcuffs, or if the detainee himself asks for a doctor. The use of force may include manual power by pushing and holding and the use of sticks and tear gas. A doctor should be consulted if there is real suspicion of disease or of injuries caused by the use of force, or if the detainee himself asks to be seen by a doctor.

**Health care services seen in the light of the medico-ethical rules:**

The new set of rules is a great improvement on the previous ones, since the doctor is no longer called routinely in connection with the use of force and the placing in security cells. It will probably be very seldom that a doctor will find his presence obviously unnecessary in connection with the use of security cells with fixation. It would have been even better in such cases if the doctor was called on suspicion of disease, injury or at the request of the detainee.

Previously, detainees in security cells had to be seen daily by a doctor. It is an essential step forward that the doctor's visits are left to the doctor's evaluation of need. Just because a doctor's visit in the above mentioned situations can safeguard that measures taken happen under medically acceptable forms, it may cause problems of medico-ethical concern. It is against the ethical rules for health personnel, in particular doctors, to confirm prisoners' suitability to endure any form of treatment or punishment that may have an unfavourable effect on their physical or mental health. The Ethical Committee of the Danish Medical Association has stated that a doctor should not be brought into situations in which the doctor's decision decides whether coercive measures should be started, continued, or stopped, because the doctor in this way in reality legitimates the carrying out or continuation of these measures. The Danish Medical Association has established that "medical participation in the use of force against individuals who are detained according to the penal code is in principle incompatible with medical ethics and can therefore only take place on the responsibility of the prosecution and the law court. Doctors cannot take on the role of guarantors with respect to detainment in security cells/isolation, possibly the use of belts, gloves, hand and foot
straps or the use of handcuffs”. Despite these principles, the detainee can easily consider the visit of a doctor as part of the prison authorities’ interference when he/she is exposed to security measures or other forms of force. The doctor’s evaluation is of importance in deciding whether current measures should stop, and in reality the doctor’s presence is sanctioning continued detention in a security cell or previous use of force. The detainee in such situations will therefore seldom see the doctor as independent of the prison authorities. It is thus possible that the role of the doctor in the eyes of the prisoner will shift, in relation both to the given function of the doctor and to other roles that the doctor may have vis-à-vis the detainee. It is hardly sufficient in these cases to give information about the doctor’s employment conditions. The detainee will probably be able to complain to the board for patients’ complaints of possible shortcomings of the doctor’s “therapeutic” efforts.

**Suggestions for solutions**

In the case of implementation or continuation of the above mentioned measures, the consideration for the detainee can, in our opinion, only in rare and very serious cases be more important than the consideration for the above mentioned medico-ethical principles (for instance if the detainee is unconscious), since the risk of more serious injuries is considered so great that complete omission to call a doctor would be too risky. The ethically dangerous conditions should be minimized as much as possible just as the detainee’s confidence in the basic doctor/patient relationship should be protected as much as possible. A crucial precaution in this connection is that the doctor’s employment situation guarantees the necessary independence. However, the doctor should continue to take care of the general medical treatment of the detainee in the security cell, but only at the detainee’s own request. This, however, with the exceptions that are a consequence of the rules about forcible treatment within psychiatry. On suspicion of mental disease, the Danish prison service always calls a doctor according to its information. There is, however, quite some uncertainty with respect to treatment of detainees who, without being insane, still suffer from mental disease or disorders. According to Article 100 of the European Prison Rules from 1987, Denmark is obliged to safeguard responsible psychiatric treatment of serious psychiatric cases. A person whom the staff considers insane should not be put in a security cell or be fixated, but a medical examination should suggest appropriate treatment, including possible admission to a mental hospital.

**Doctors’ presence at disciplinary punishments**

Fines and confinement, used as disciplinary punishment, do not, according to Danish regulations, directly require the presence of a doctor; this is therefore not routine practice, according to information from the Directorate of the Danish prison service. However, Denmark has adopted the international regulations, according to which the presence of a doctor is a precondition for disciplinary punishment. Thus, the European Prison Regulations, Article 38, paragraphs 1 and 3, read as follows: (1): “Punishment by disciplinary confinement and any other punishment which might have an adverse effect on the physical or mental health of the prisoner shall only be imposed if the medical officer, after examination, certifies in writing that the prisoner is fit to sustain it.” (3): “The medical officer shall visit daily prisoners undergoing such punishment and shall advise the director if the termination or alteration of the punishment is considered necessary on grounds of physical or mental health.” However, Denmark has made reservations with respect to paragraph 3, the reason being more appropriate “use of the medical resources” rather than apparent respect for medical ethics. Medical assistance according to both paragraphs 1 and 3 would be in conflict with Article 3 of Principles of Medical Ethics and current medical ethics, including the basic standards for the doctor/patient relationship. Thus, Article 4 of the Declaration of Tokyo states: “A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor’s fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective, or political, shall prevail against this higher purpose.” The Danish government should therefore, without delay, have made a proper reservation with respect to Article 38, paragraph 1 because of Article 3 in Principles of Medical Ethics. The Danish Medical Association found that Denmark should have made reservations with respect to both paragraphs since medical assistance would be contrary to current medical ethics, and the committee also finds that reservations should have been made with respect to both paragraphs in Article 38. In practice, Denmark does not follow paragraph 1; CPT and the Council of Europe for Penological Co-operation have been informed of this in a letter of 27 May 1993, which reads as follows: “The Danish prison service does not find that the imposing of punishment should be on the condition of a certification from the medical officer. Such medical certification might be understood to mean that the punishment is made legitimate by medical doctors, which is incompatible with medical ethics”.

**Suggestion for solutions**

These considerations seem well founded, and there were therefore good reasons for the government to inform the relevant international organizations about the non-adherence and fundamental reservations to Article 38, paragraph 1. At the level of the Council of Europe, initiatives should be taken to revise the above mentioned regulations as soon as convenient.

**Isolation of people in custody and persons serving a sentence**

This section deals mainly with questions concerning isolation of people in custody. There will hardly be any mention of the other cases of confinement in isolated rooms, e.g. of persons who want this confinement or are put there to prevent unrest or escape, or for disciplinary reasons. However, the following considerations concerning isolation of people in custody are also relevant for other categories of confinement in isolation. Isolation of people serving a sentence is generally of shorter duration than that of people in custody. Those serving a sentence are typically placed in isolation because they will not work or because they do not want to be together with one or more detainees because of harassment, e.g. from sexual offenders or, if drug addicts, from being dependent on other addicts because of owing them money. Denmark differs from most other Western European countries by having an alarmingly frequent use of custody periods in isolation, periods which sometimes last for a long time. CPT’s report contains extremely critical remarks concerning this practice².

According to the Ministry of Justice, medical supervision of isolated prisoners and isolated people in custody is the same as for people in custody and prisoners in general with respect to visits by the prison doctor, who should pay atten-
tion to both physical and mental conditions and if necessary prescribe medication or other relevant treatment, including the referral to a specialist if necessary. The prison doctor's treatment of diseases should not depend on what is considered the cause of the condition, such as mental conditions that might have been provoked or impaired through isolation. It is pointed out that the prison doctor has no authority to terminate a period of isolation. However, the doctor can state in writing whether he considers a psycho-pathological symptom to be provoked or impaired by isolation and how he considers the prognosis of the detainee to be under continued isolation. In practice, the medical examination and the resulting medical certificate will influence the overall evaluation of the termination of isolation. Critics have pointed out that this entails a great risk that the prison doctor will in practice become responsible for deciding how long a suspected person can sustain isolation. As a consequence the doctors are thus assisting in the legitimation of investigation and interrogation methods within the judicial system; isolation above all is a particularly serious intervention. How serious the consequences of isolation are has been the subject of an extensive debate since the 1970s. In 1979, the Ministry of Justice asked the Medico-Legal Council to make a statement about possible mental sequelae of isolation, but the Council could not find any material on which to base such a statement. However, the Council expressed the wish that "the period of isolation should be limited as far as possible". The Council recommended an investigation into the sequelae. A research group was established in 1993 and the results were published in 1994.

The Danish Medical Association has stated that a systematized, routine medical examination can never be taken as a medical guarantee or acceptance of medical responsibility for placing prisoners in isolation. Furthermore, in relation to long periods in isolation, the Association has stated that it cannot rule out serious damaging effects on the health of the detainees. The policy of the Danish Medical Association in all agreements about doctors' working conditions is to introduce rules to make sure that doctors can in no circumstances be forced, actively or passively, to act against recognized medical principles, and that doctors should not be brought into situations where they have to decide whether forcible measures should be started or terminated, since the doctor in this way in practice helps to legitimate the carrying out and continuation of these measures. There are good reasons to point out that the standard of CPT is higher than the minimum standards of the Human Rights Commission.

Suggestions for solutions
Even if it is difficult to evaluate the possible damaging effects of long-lasting confinement in isolation, there is a strong assumption that it is in fact harmful, and doctors should therefore not be part of it, provided it either is, or can be interpreted as assistance in the carrying out or the maintenance of the isolation intervention. It should therefore be recommended that the conditions under which isolation takes place are considerably changed, and that the use of isolation is limited as much as possible, perhaps by a change of the present legal basis of the law concerning the administration of justice. Doctors should not, directly or indirectly, sanction such a harmful intervention as isolation of a person in custody, and doctors should be recommended to refuse involvement. Considering the general risk of mental and physical damaging effects from confinement in isolation, a maximum limit to the permissible length of such confinement should be fixed by legislation.

Body searches, including recto-vaginal examination
Fortunately, the latest agreement for doctors in prisons and detention centres concerning the examination of detainees with respect to this situation states the following:
"Physical examination (including recto-vaginal examinations) can only take place with the consent of the detainee following the doctor's information about the purpose of the examination".

Denmark is here ahead of the World Medical Association's Statement on Body Searches of Prisoners, which does not state that such an examination only can take place with the consent of the detainee, but only that it should be carried out by a competent physician.

Hunger strikes in Danish prisons
A hunger strike is a form of demonstration that one or more persons resort to when they want to protest against conditions they find unsatisfactory. As a form of demonstration hunger strikes are characterized by being non-violent and non-harmful to other than the persons themselves. The purpose of hunger strikes is to create awareness and thus to influence the authorities against which they are directed. In a few cases hunger strikes have resulted in death of the striking person. According to the Medical Code (Hippocratic oath), the doctor is obliged to show care and conscientiousness, and the doctor should not institute or continue any treatment against the will of the patient. According to the National Board of Health a doctor should not terminate an ongoing refusal to eat when the refusal was without doubt started by an adult, able person, well aware of the consequences. The role of a prison doctor in connection with a hunger strike is given in the WMA's Declaration of Tokyo of 1975, Article 5: "Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner." The Danish Medical Association was actively involved in the drawing up of the Declaration of Tokyo, which is part of the ethical rules of the members of the Association. The medico-ethical principles concerning hunger strikes are more precise in the WMA's Declaration on Hunger Strikers of 1991, revised September 1992. This Declaration confirms the right of self-determination of hunger strikers and rules that the doctor must not "apply undue pressure of any sort on the hunger striker to suspend the strike". Article 3 maintains that the doctor shall evaluate the patient's decision to refuse nourishment daily, and should the patient become comatose because of the hunger strike, it is left to the doctor to decide the appropriate treatment with due regard to the patient's wishes during the strike. The uncertainty reflected in the above quotation about the doctor's obligations in connection with hunger strikes, following Danish legislation, is formally clarified by the change of the Medical Code's and the National Board of Health's circular about information and consent. The clarification by law of the legal basis for the treatment of hunger strikers has not changed the fact that the Danish authorities, including the institutions of the Danish prison service, still seem to be in considerable doubt about how to cope with hunger strikers.

A recent case concerns a Moroccan who had refused to take nourishment for some time in protest against a prison sentence. There was no doubt that the man in question was
sane. The case was reported in several Danish newspapers, and it was obvious that the prison authorities were uneasy because of the situation, and that many people felt that the detainee should be transferred to a hospital in order to get “treatment”. “They can’t be left to die in a prison. It is unethical to keep them in a situation where they strike because of the prison sentence. Therefore, they should be transferred to a general civil hospital which can treat the striker according to law and conscience”. The Moroccan was transferred to a general hospital, where a doctor persuaded him to stop the hunger strike. This example makes one wonder whether the latest changes of the Medical Code have had the desired effect, namely to make sure that the wish of sane persons to hunger strike is respected.

Suggestions for solutions
The National Board of Health's circular about information and consent represents an acceptable and, from an international point of view, advanced legal situation. With regard to the above mentioned legal uncertainty that can be caused by administratively fixed regulations, the principles of the circular should be incorporated in the Medical Code. Hunger striking detainees should have access to medical advice inside the prison and after their own choice, as also stated in the WMA's declarations of Tokyo and Malta.

Deaths and serious accidents in prisons
The law on coroner's inquests, post-mortem examinations, and transplantation, etc. defines the cases of deaths for which it is not enough for the doctor just to examine the body and to write a death certificate. Deaths in detention centres and prisons must, according to the law on coroner's inquest, always be reported to the police. (Parliament's Ombudsman takes the initiative to investigate all deaths in detention centres and in the institutions of the Danish prison service). The police, in collaboration with the local district medical officer, will decide whether the death shall involve a coroner's inquest, to be carried out by the district medical officer together with a policeman, usually the district police commissioner. The inquest is based on a police report with information about the circumstances of the death, including an interrogation of the persons who last saw the deceased alive, information about the death itself and possibly about preceding symptoms of disease, drug intake, consultation and treatment by doctors, as well as information from family members about the deceased's condition during the last 24 hours of his life. Based on the police report and the external examination of the body, the police and the district medical officer will decide if it is necessary to perform a medico-legal autopsy to clarify the manner and cause of death, or whether a death certificate can be written immediately and the body buried or cremated. The purpose of a coroner's inquest is to safeguard an impartial evaluation of deaths that cannot immediately be considered as obviously being from natural causes, and that the deaths will possibly be further investigated by an autopsy. However, neither a medico-legal inquest nor a medico-legal autopsy are obligatory for deaths in detention centres and prisons. The law on coroner's inquests states that the police and the district medical officer can decide that a death certificate should be written by the medical officer who was responsible for the treatment, the prison doctor, without further investigations and thus without a medico-legal inquest. Suggesting changes to the present law on medico-legal inquests, the government's forensic experts point out that the law should have a paragraph requiring that all deaths in prisons or detention centres should result in a medico-legal inquest and a medico-legal postmortem examination. This suggestion was not included in the present law. The decision to hold a medico-legal inquest is made by the district medical officer and the police. The former's impartiality can be questioned, since he is often the doctor in charge of treatment/supervision in the local detention centres and at the same time the advisory/deciding authority in cases of death in detention centres. The larger prisons have their own prison doctors who cannot make decisions with respect to medico-legal inquests. Detainees cannot freely choose their own doctor and therefore depend on the prison staff's obligation to call a doctor. It is true that the regulations concerning the prison service's use of force require an obligatory medical examination, for instance after the use of sticks, handcuffs, or security cell, but the decision depends on the prison staff's interpretation of the rules and there is no safeguard that a suspicion of violence resulting in death will always be fully investigated. There are no statistics of all the deaths in prisons and detention centres, nor of omitted medico-legal inquests, but it is a general impression of Danish practice that most of these deaths are investigated by a medico-legal autopsy.

 Suggestions for solutions
A legal provision would further support this practice, which is of decisive importance for the legal status of the detainees, and it would prevent the suspicion of medical errors or shortcomings, and for instance about the detainee having been beaten to death. It is still desirable to introduce a provision in the law concerning medico-legal inquests to the effect that all deaths in detention centres and prisons should be investigated by a medico-legal inquest and a medico-legal autopsy. This is the only way to make sure that all the circumstances surrounding the death are clarified. In the same way, there should be a provision about obligatory medical inspection by an impartial medical officer from outside of all serious lesions or on suspicion of the use of violence against detainees.

Conclusion
The recent years have shown increasing awareness of the problems facing doctors in connection with authority measures, including deprivation of liberty and physical interventions. This increased awareness has resulted in a revision of international and national regulations and of professional medico-ethical rules. In many fields, the Danish prison service has accepted this development positively, and has sometimes been actively involved in it. There is, however, a need to continue this necessary development. The next step should be to define the basis for the regulations, not least with respect to what could be called the quality of the basis of warrants. The medical services in prisons and detention centres should be sufficiently independent of the authorities, with increased awareness and information about the importance of doctors' employment conditions and other institution-related conditions. No doctors should be employed under the Ministry of Justice, but their employment should be transferred to the national health service. At the same time steps should be taken to improve the detainees' possibility for having a free choice of doctor. This would not cost anything. Finally, the legislation should make provision for an obligatory medical examination in connection with suspected violations by the prison staff, and with deaths in detention centres and prisons.

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References


An extended edition of this article is available in Danish from IRCT upon request.
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RCT (The Rehabilitation and Research Centre for Torture Victims) is an independent, humanitarian, non-political organization established in 1982 to help victims of torture and to contribute to the prevention of torture. Its main objectives are to rehabilitate persons who have been subjected to torture, to rehabilitate their families, to instruct Danish health professionals in the examination and treatment of persons who have been subjected to torture, and to carry on research into the nature, the extent and the consequences of torture.

IRCT (The International Rehabilitation Council for Torture Victims) is a private non-profit foundation, created in 1988 by the RCT. The objectives of the foundation are, on an international basis, to support research into all aspects of torture, to support education and training of health professionals and of other relevant personnel in the medical, social, legal and ethical aspects of torture, and to serve as an international clearing house for information about torture activities.
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