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The fate of critically ill detainees in Europe

Report[1]
Committee on Legal Affairs and Human Rights
Rapporteur: Mr Andreas GROSS, Switzerland, Socialist Group

Summary

Nobody should die in detention and member States should ensure that every detainee is afforded the basic human dignity of dying outside of prison. However, there exist significant legal and practical barriers to prisoners' access to critical medical care, including unavailability of trained medical and psychological staff, the lack of prompt and efficient communication between prison staff and medical personnel, and failure to promptly transfer detainees to public hospitals. There are also reports regarding the disproportionate physical restraint of ill detainees who are physically incapable of escaping or harming others. Member States should ensure that all persons in detention receive the same level of medical care obtainable by other members of society.

Moreover, practices across Europe for granting compassionate release to elderly and seriously ill persons in detention are too restrictive and should be deplored as they are often based on unsettled and subjective criteria or recommendations from medical professionals who are not independent from the prison system. Member States are thus urged to provide fair and speedy processes for requesting compassionate release, permitting seriously ill prisoners to receive specialised medical attention and elderly or terminally ill detainees to die with dignity, outside prison.

The Committee of Ministers is invited to elaborate a comprehensive study on the legislation and practice in member States relating to the compassionate (temporary and indefinite) release of prisoners and other categories of persons in detention, with a view to identifying best practices and adopting guidelines for the compassionate release of critically ill and elderly persons.

1. Reference to committee: Doc 13573, Reference 4080 of 3 October 2014.

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A. Draft resolution[2]

1. The Parliamentary Assembly considers that nobody should die in detention. All member States should ensure that every detainee is afforded the basic human dignity of dying outside of prison.

2. In this vein, the Assembly is concerned about legal and practical barriers to detainees' access to critical medical care and to the compassionate release of elderly or terminally ill detainees.

3. Despite international standards stating that a detainee must enjoy the same right of access to health care as any other member of society, the Assembly is concerned that the prison health-care system does not always provide for timely access to vital medical treatment, particularly for critically ill detainees.

4. Practical barriers, such as the unavailability of trained medical staff, the lack of prompt and efficient communication between prison staff and medical staff, failure to transfer detainees to a public hospital, and the disproportionate physical restraint of detainees, create obstacles to a detainee's ability to obtain adequate medical care, especially in instances in which the detainee's condition is so severe that he or she must seek care at an off-site hospital.

5. The Assembly is also worried about reports regarding the inappropriate use of handcuffs on immobile, comatose, dying or even dead detainees, which draw attention to the alarming practices in some member States insisting on the use of means of restraint even when it is obvious that a detainee is physically incapable of escaping or harming those around him.

6. The Assembly also expresses concern with respect to restrictive practices for granting compassionate release. These are often based on unsettled and subjective criteria or recommendations from medical professionals who are not independent from the prison system or the executive. Moreover, the final decision sometimes rests with a government official, without possibility for judicial review.

7. The aging trend in society is mirrored in the prison population. As the population of detainees grows older, the need for appropriate medical care and compassionate early release becomes critical for humanitarian reasons.

8. People in detention tend to age prematurely and are often subject to more health concerns than people living in freedom. The resulting need for geriatric-friendly features in detention centres should be taken into account in the construction and renovation of facilities.

9. The lack of end-of-life or palliative care plans in many detention centres, or their misuse or poor implementation where they do exist, leads to situations in which detainees suffer undignified and painful deaths, often still in a cell or prison hospital and without the presence of family or friends.

10. The Assembly therefore urges the Council of Europe member States to:

10.1. bring their domestic law and practice into line with international standards that establish the right to equivalent medical care for detainees;

10.2. ensure that processes exist by which seriously ill detainees can apply for temporary compassionate release in order to receive specialised medical attention, subject to review of the decision by an independent judicial body;

10.3. ensure that processes exist by which elderly or terminally ill detainees can apply for permanent compassionate release in order to die with dignity, subject to review of the decision by an independent judicial body;

10.4. ensure that the relevant authorities:

10.4.1. authorise treatment and efficiently provide transport in the event that an ill detainee requires special medical care at an outside facility;

10.4.2. undertake a risk assessment to determine the necessary level of restraint, if any, when a detainee requires treatment at an outside facility, considering primarily the detainee's state of health and how it is changing;

10.4.3. expedite decision making with respect to applications for temporary or permanent compassionate release, keeping in mind the medical urgency of the situation;

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2. Draft resolution adopted unanimously by the committee on 2 November 2015.

10.4.4. set up palliative and end-of-life care plans that address the specific needs of an elderly detainee population in order to provide the most humane and comfortable environment possible until a detainee's release.

11. In addition to the above, the Assembly invites:

11.1. Turkey to:

11.1.1. adopt a national policy stipulating that the use of restraints on detainees in medical settings must be exceptional and at all times proportionate to the security risks that the person can realistically pose;

11.1.2. entrust the responsibility for transporting detainees to outside hospitals to a body other than the Gendarmerie, and take all necessary measures to safeguard the detainee's dignity prior to and during such transfers, in particular by making sure that they take place without undue or discriminatory delays and by avoiding any ill-treatment of detainees during the transfers;

11.1.3. amend its legislation on suspension of prison sentences for medical reasons in such a way as to ensure that:

11.1.3.1. decisions on granting or revoking the suspension of a prison sentence are taken by an independent authority established by law, other than the public prosecutor's office, in order to avoid any risk of conflict of interest or political bias;

11.1.3.2. a petitioner's eligibility for compassionate release is evaluated based on medical reports from doctors who are independent from the prison administration and the executive branch of government;

11.1.3.3. the eligibility criterion that the person to be released does not pose a threat to public security is not applied in a discriminatory manner, so that all prisoners who are eligible for release on medical grounds are released, whilst imposing whatever conditions may be needed to avoid reoffending;

11.1.3.4. national law and practice is compliant with the case law of the European Court of Human Rights on whole-life prison sentences, by providing for a possibility for prisoners serving an aggravated life sentence to apply for conditional release as well as for suspension of a sentence for medical reasons;

11.2. Romania to:

11.2.1. increase the number of medical staff in places of detention, including by creating incentives for qualified medical staff to work in prison establishments;

11.2.2. significantly increase the daily food allowance for detainees and ensure that they are provided with nutritious food;

11.2.3. redouble its efforts to combat overcrowding in prisons and guarantee conditions of detention conducive to good health and recovery from illness;

11.3. Montenegro to undertake to further increase the number of medical staff in its prisons, and enhance co-operation with medical services outside the prison system, especially as concerns psychological care and treatment for mental illness.

12. Lastly, the Assembly notes that the situation of people in detention with severe disabilities raises similar concerns as those outlined above and considers that these should be explored separately.

B. Draft recommendation[3]

1. The Parliamentary Assembly, referring to its Resolution ... (2015) on the fate of critically ill detainees in Europe, stresses the paramount importance of guaranteeing adequate health care and medical treatment to persons deprived of their liberty, the absence of which may result in violations of Articles 2 (right to life) and 3 (prohibition of inhuman or degrading treatment) of the European Convention on Human Rights (ETS No. 5).

2. The Assembly recalls the established international standards in this field, and in particular the United Nations Basic Principles for the Treatment of Prisoners and Standard Minimum Rules for the Treatment of Prisoners, Committee of Ministers Recommendation No. R (98) 7 concerning the ethical and organisational aspects of health care in prison and Recommendation Rec(2006)2 on the European Prison Rules, as well as the guidelines developed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).

3. Reiterating its conviction that nobody should die in prison, the Assembly underscores the need for member States to provide for possibilities of compassionate (temporary or permanent) release from detention on medical grounds. It invites the Committee of Ministers to:

3.1. encourage member States to systematically collect and share statistics on:

3.1.1. the percentage of requests for compassionate release granted and refused in respect of terminally ill detainees, detainees suffering from a severe illness requiring treatment outside the place of detention and detainees of advanced age;

3.1.2. the illnesses of those released from detention for medical reasons;

3.1.3. the remaining length of sentence of those found eligible for compassionate release; the type of offences for which they had been found guilty; and the time served prior to release;

3.1.4. the average duration of the review process;

3.1.5. the number of persons who died pending the examination of their petition for compassionate release;

3.2. undertake a comprehensive study on the legislation and practice in all member States relating to the compassionate (temporary and indefinite) release of prisoners and other categories of persons in detention, with a view to identifying best practices and adopting guidelines for the compassionate release of critically ill and elderly detainees.

3. Draft recommendation adopted unanimously by the committee on 2 November 2015.

C. Explanatory memorandum by Mr Gross, rapporteur

1. Procedure

1. The motion for a resolution[4] on "The fate of critically ill prisoners in Turkish prisons", tabled by Mr Nazmi Gür and other members of the Assembly, was referred for report to the Committee on Legal Affairs and Human Rights on 3 October 2014.

2. At its meeting on 30 October 2014, the committee appointed me rapporteur on this topic. It subsequently held an exchange of views with the outgoing President of the European Committee on the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Mr Lətif Hüseynov, at its meeting in Paris on 18 March 2015. It had an opportunity, on this occasion, to obtain some general information relating to the treatment and possibility of release of critically ill persons in detention in Council of Europe member States.

3. I was authorised to carry out fact-finding visits to Montenegro, Romania and Turkey at the committee's meeting in Strasbourg on 21 April 2015. On the same occasion, the committee decided, on the basis of the overview of the situation provided by Mr Hüseynov and upon my suggestion, to change the title of the report to "The fate of critically ill detainees in Europe". The committee found it appropriate to expand the scope of the report in order to examine the situation in all Council of Europe member States. The committee also decided to expand the scope of the report in order to examine the situation of not only prisoners serving a sentence after having been convicted of a crime by a court of law, but also other "detainees" such as those held in pretrial detention, immigration detention, or any other form of detention that is not a result of a criminal conviction. Last but not least, I also obtained the committee's authorisation to send out a questionnaire via the European Centre for Parliamentary Research and Documentation (ECPRD) to ask national delegations for information concerning national law and practice on the treatment or release of critically ill persons in detention.

4. On 20 May 2015, at its meeting in Yerevan (Armenia), the committee considered a background note.

2. The issues at stake

5. There have been reports from a number of Council of Europe member States about neglect and lack of treatment for persons in detention who are seriously ill – either physically or mentally, or both. Many prisons and other places of deprivation of liberty are ill equipped to look after detainees with certain diseases or illnesses or to provide end-of-life care, which is likely to result in a deterioration of their condition and, in some instances, may even be fatal. Likewise, reports suggest a (sometimes routine) inappropriate use of measures of restraint (handcuffs or the like) on elderly, infirm and dying detainees, including those transferred to a hospital to receive treatment.[5] It moreover appears that, quite often, detainees have no possibility to effectively challenge inadequate treatment, for example because they are not entitled to legal aid for such purposes.

6. I will examine these and related issues more closely. However, there is an even more fundamental question underlying my rapporteur mandate, which relates to the appropriateness of keeping a critically ill or dying person in detention at all. The competent national authorities allegedly too often deny compassionate release on grounds of advanced age or illness. Reportedly, the risk of re-offending is routinely cited as a reason for denying a request for compassionate release, even though logic suggests that a terminally ill, physically weak elderly person is unlikely to (still) pose a security risk if released.

7. My report addresses three of the four categories of detainees – including both convicted prisoners and persons in pretrial detention – which the CPT considers to be unsuited for (continued) detention,[6] namely:

– detainees suffering from a severe illness requiring treatment outside of the place of detention;

– terminally ill detainees (i.e. detainees who are the subject of a short-term fatal prognosis);

– detainees of advanced age.

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4. Doc. 13573.
5. See, for example, *The Guardian*, "Dying in chains: why do we treat sick prisoners like this?" (9 November 2013).
6. See below, footnote 11 and accompanying text.

8. I consider that the fourth category referred to by the CPT, persons in detention with (severe) disabilities, is outside the remit of my report. Undoubtedly, however, the situation of detainees with disabilities deserves further investigation. During my fact-finding visits, I learnt about a number of worrisome cases of prisoners who were unable to look after themselves due to (mostly physical) disabilities. A recent judgment handed down by the European Court of Human Rights ("the Court") against France[7] confirms my concerns about violations of the rights of prisoners with disabilities. In light of this, I encourage the Parliamentary Assembly (and perhaps its Committee on Equality and Non-Discrimination) to prepare a separate report on that issue.

9. The issues surrounding critically ill detainees deserve special attention because the prison sentence – and thus, the deprivation of a person's physical freedom – is in itself meant to be the proportionate and appropriate punishment for those convicted of a criminal violation in a court of law; any further deprivation of rights, including the right to health care, extends beyond the scope of the State's mandate to impose punishment. The situation may be even more disturbing for those held in pretrial detention who have not been convicted of any crime, and are still denied access to medical attention.

10. My report also focuses specifically on the practices of three countries: Romania, Montenegro and Turkey, which I identified, on the basis of CPT reports and other available sources, as potentially experiencing significant problems in terms of the treatment of critically ill detainees. In order to obtain further information from member States which I could not visit, I distributed a questionnaire via the ECPRD to request information on the laws of each member country relating to the compassionate release of ill or elderly detainees. The questionnaire can be found in Annex 1 to the present report. Of the 47 member States petitioned, 29 returned responses,[8] with a further State declining to provide information.[9] I am grateful for the co-operation of the relevant countries' parliamentary research divisions for helping to build a picture of the Europe-wide situation of critically ill detainees.

3. Relevant international standards and related work of the Council of Europe – a brief overview

3.1. Medical care for critically ill detainees

11. The United Nations has three main documents that relate specifically to the rights of detainees. First, the Basic Principles for the Treatment of Prisoners establish that "prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation", and that "prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights". Second, the Standard Minimum Rules for the Treatment of Prisoners[10] recognise the importance of independent health-care staff and state that "the medical services should be organised in close relationship to the general health administration of the community or nation". Finally, the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment establishes first and foremost that "all persons under any form of detention or imprisonment shall be treated in a humane manner and with respect for the inherent dignity of the human person".

12. The CPT devoted a section of its 3rd General Report to health care in prisons.[11] Moreover, the CPT standards (document CPT/Inf/E(2002)1 Rev. 2006) establish the fundamental principle that all detainees are entitled to the same level of medical care obtainable by other persons in the community at large. Lastly, as I mentioned above, the CPT, aside from clarifying member States' responsibility to provide adequate health care to persons detained within their jurisdiction, has also clearly stated that there are certain categories of prisoners who are unsuited for (continued) detention. It asserted that:

> *"Typical examples of this kind of prisoner are those who are the subject of a short-term fatal prognosis, who are suffering from a serious disease which cannot be properly treated in prison conditions, who are severely handicapped or of advanced age. The continued detention of such persons in a prison*

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7. See Helhal v. France, Application No. 10401/12, judgment of 19 February 2015 (available in French only).
8. Albania, Austria, Bosnia and Herzegovina, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Italy, Lithuania, Luxembourg, Montenegro, Netherlands, Poland, Portugal, Republic of Moldova, Romania, Serbia, Slovak Republic, Spain, Switzerland and Turkey, as well as Israel (whose parliament has observer status with the Parliamentary Assembly).
9. Denmark
10. Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.
11. CPT, 3rd General Report on the CPT's activities covering the period 1 January to 31 December 1992, CPT/Inf(93)12 (4 June 1993), at paragraphs 30 et seqq.

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."[12]

13. Committee of Ministers Recommendation No. R (98) 7 indicates recommendations for the "ethical and organisational aspects of health care in prisons", which include access to a doctor at any time and without undue delay, and professional independence of doctors who treat detainees.

14. Similarly, the Council of Europe's manual on "Prison health care and medical ethics" stresses the importance of the professional independence of prison health-care workers, noting that "it is essential that prison doctors' clinical decisions are governed only by medical criteria and that the quality and effectiveness of their work are assessed by a qualified medical authority".

15. Also worth mentioning is Assembly Recommendation 1418 (1999) on protection of the human rights and dignity of the terminally ill and the dying, which recalled, referring to Resolution 613 (1976), that "what dying patients most want is to die in peace and dignity, if possible with the comfort and support of their family and friends".

16. The European Court of Human Rights has also clarified that issues relating to the health rights of persons in detention may engage Article 3 of the European Convention on Human Rights (ETS No. 5, "the Convention"), which enshrines the prohibition of torture, inhuman or degrading treatment or punishment. Severe situations in which a detainee dies as a result of inadequate medical care may also engage the right to life protected in Article 2. The Court has pronounced itself, on several occasions, on the (alleged lack of) medical assistance provided to detainees suffering from illness. The following cases are relevant examples.

17. Since its Grand Chamber judgment in the case of Kudła v. Poland,[13] the Court has consistently affirmed that a State's failure to provide "requisite medical assistance" to a person in detention may violate Article 3 of the Convention. In particular, it noted in this case (at paragraph 94) that:

"the State must ensure that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and well-being are adequately secured by, among other things, providing him with the requisite medical assistance."

18. In its Article 3 assessment, the Court will take into account, as it clarified in Mouisel v. France,[14] elements such as the medical condition of the prisoner, the adequacy of the medical assistance and care provided in detention, and the advisability of maintaining the detention measure in view of the state of health of the applicant. This test was further elaborated in the case of Gelfmann v. France,[15] where the Court took into account, among other relevant factors, the dynamics of the applicant's health condition, the possibility of conditional release or parole for a seriously ill detainee if his health deteriorated, and the applicant's own attitude.

19. The Court also found violations of Article 3 in various cases against several States Parties in which detainees were denied access to critical medical care or were provided with severely inadequate treatment. These cases include, but are by far not limited to, the following:

– Testa v. Croatia,[16] due to inadequate medical care of the detainee's Hepatitis C;

– Dirdizov v. Russia,[17] due to a failure to provide "comprehensive, effective and transparent medical treatment" in detention for the applicant's arthritis and progressive Bechterew's disease, despite doctors cautioning that failure to provide adequate medical assistance would endanger the applicant's life and would lead to his becoming disabled;

– Romokhov v. Russia,[18] on account of the delays and defects in the applicant's medical treatment while in detention, which led to his losing his eyesight

12. CPT, CPT standards, CPT/Inf/C(2002)1 [Rev. 2015], 21 January 2015, Section: 31/86, paragraph 70 (at p. 46). The CPT Standards, as well as all reports and public statements made by the CPT, can now be accessed and searched by means of the newly established HUDOC CPT database.
13. Application No. 30210/96, judgment of 26 October 2000 (Grand Chamber).
14. Application No. 67263/01, judgment of 21 May 2003.
15. Application No. 25875/03, judgment of 14 December 2004.
16. Application No. 20877/04, judgment of 30 January 2008.
17. Application No. 41461/10, judgment of 27 November 2012.
18. Application No. 4532/04, judgment of 16 December 2010.

– Khudobin v. Russia[19] and Salakhov and Islyamova v. Ukraine,[20] on account of the failure of the respective detention centres to provide adequate medical treatment to HIV-positive detainees;

– Grori v. Albania,[21] due to the detention centre's denial of proper treatment to a detainee suffering from multiple sclerosis;

– McGlinchey and Others v. United Kingdom,[22] due to the failure of the detention centre to provide adequate medical care to a detainee experiencing severe withdrawal symptoms, even when her condition worsened.

20. In severe cases in which the detainee died as a result of his or her inadequate or inefficient treatment, the Court has also found a violation of Article 2 (right to life). These cases include:

– Tarariyeva v. Russia,[23] because the detainee's inadequate medical care and his premature transfer from a civil hospital back to a prison hospital contributed to his death;

– Salakhov and Islyamova v. Ukraine,[24] due to the inadequate care and unwarranted delays with respect to a HIV-positive detainee, who died as a result.

21. Given the urgency of issues concerning the medical needs of detainees, the Court has also on several occasions ordered interim measures pursuant to Rule 39 of the Rules of Court. In the case of Tymoshenko v. Ukraine,[25] the Court ordered an interim measure under Rule 39 and requested that the government ensure that the applicant, imprisoned former Ukrainian Prime Minister Yuliya Tymoshenko, receive adequate medical care for her various ailments. In Paladi v. Moldova,[26] the respondent government was ordered not to transfer the applicant, who suffered from neurological disorders, from the specialised hospital where he was receiving treatment back to the prison hospital.

3.2. Detainees receiving treatment outside the place of detention

22. Committee of Ministers Recommendation Rec(2006)2 on the European Prison Rules indicates that when a detainee requires specialised care that is not available at the prison hospital, he or she should be transferred to a civil hospital to receive such care. Similarly, the United Nations Standard Minimum Rules for the Treatment of Prisoners state that sick prisoners who require special treatment should be transported to an outside hospital, and that prison directors should take immediate steps to accommodate the recommendations of medical staff.

23. The CPT standards indicate that "if recourse is had to a civil hospital, the question of security arrangements will arise. In this respect, the CPT wishes to stress that detainees sent to hospitals 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."

24. This is reflected in the Court's case law. To name but two examples, the Court found violations of Article 3 of the Convention on account of (repeated) delays in a detainee's admission to a (specialised) hospital in the cases of Poghossian v. Georgia[27] and Andrey Gorbunov v. Russia.[28]

3.3. Use of restraints on detainees in medical settings

25. On a related note, the European Court of Human Rights requires that the use of handcuffs in a medical setting be justified objectively, in order to be in line with medical ethics and the person's dignity. It found violations of Article 3 in a number of cases, including those listed below, where the national authorities failed to strike a fair balance between legitimate security concerns and the rights of detainees:

– Mouisel v. France (cited above), due to physical restraints on the detainee's wrists and ankles while he received chemotherapy;

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19. Application No. 28370/05, judgment of 9 July 2012.
20. Application No. 28005/08, judgment of 14 June 2013.
21. Application No. 25336/04, judgment of 7 October 2009.
22. Application No. 50390/99, judgment of 29 April 2003.
23. Application No. 4353/03, judgment of 14 December 2014.
24. Application No. 28005/08, judgment of 14 March 2013.
25. Application No. 49872/11, judgment of 30 April 2013.
26. Application No. 39806/05, judgment of 10 March 2009 (Grand Chamber).
27. Application No. 9870/07, judgment of 24 May 2009 (available in French only).
28. Application No. 43174/10, judgment of 5 February 2013.

– Tarariyeva v. Russia,[29] on account of the detainee being chained to his hospital bed, even while suffering from a severe stomach condition from which he eventually died.

26. The Court has also examined the use of handcuffs on detainees who are being escorted to and from a hospital, finding, for example, in the above-mentioned Mouisel case in which the applicant was kept in chains during transfer, that in light of the applicant's health and his physical weakness, the use of handcuffs was disproportionate to the needs of security.

3.4. Compassionate release for ill detainees

27. Compassionate release for ill detainees encompasses two situations. The first is one in which a detainee seeks temporary release in order to receive medical care from an outside facility when such care is not or cannot be provided by the detention centre; the second occurs when a detainee suffers from a terminal illness and petitions for permanent release in order to die at home.

28. The Committee of Ministers, in its Recommendation No. R (82) 16 on prison leave, recommends first and foremost that member States "grant prison leave to the greatest extent possible on medical … and other social grounds", and that leave be granted "as soon as and as frequently as possible". The Committee of Ministers further indicates that in the event of a refusal, prison services should explain as completely as possible the reasons for refusal and provide a mechanism for review of the refusal.

29. In its Recommendation Rec(2003)22 on conditional release (parole), the Committee of Ministers calls on all member States to implement domestic legislation that allows for some form of conditional release, if they do not have such legislation already. It also establishes the principle that any detainee meeting the minimum criteria to be released should be released, and that it is incumbent upon the relevant authorities to show why a detainee should *not* be released**.**

30. Recommendation Rec(2003)22 also includes various recommendations relating to procedural safeguards. Specifically, it states that "decisions on granting, postponing or revoking conditional release, as well as on imposing or modifying conditions and measures attached to it, should be taken by authorities established by law." It further elaborates that convicted persons applying for conditional release have the right to be heard and present evidence, the right to access their files, and the right to receive a decision in writing that states the underlying reasons for the decision.

31. The Court has established that Article 3 may go as far as requiring the conditional liberation of a prisoner who is seriously ill or disabled, notably where the detainee either can no longer receive adequate treatment while in detention, or his or her condition is so poor that it would be inhuman and degrading to keep him or her in detention. Exemplary cases in which a detainee's condition was no longer deemed compatible with detention, necessitating either temporary or permanent release, include, but are not limited to, the following:

– Tekin Yildiz v. Turkey,[30] due to the continued detention of a detainee suffering complications of a hunger strike;

– Xiros v. Greece,[31] on account of the denial of the applicant's request to receive external treatment for his eyesight problems;

– Gülay Cetin v. Turkey,[32] on account of the authorities' failure to release a detainee suffering from advanced cancer;

– Contrada (no. 2) v. Italy;[33] due to the excessively lengthy detention of a man whose condition was repeatedly found by courts to be incompatible with continued detention.

32. Ad hoc international tribunals, such as the International Criminal Tribunal for the former Yugoslavia (ICTY) and the Nuremberg tribunal, have also engaged in the practice of compassionate release. In the case of the Nuremberg trial, three convicted war criminals were released early for poor health.[34] With respect to the ICTY, Biljana Plavšić, convicted of genocide and other crimes relating to her time served in the collective Presidency of Bosnia and Herzegovina, was released early due to old age and deteriorating health.[35]

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29. Application No. 4353/03, judgment of 14 March 2007.
30. Application No. 22913/04, judgment of 10 February 2006 (available in French only).
31. Application No. 1033/07, judgment of 21 February 2011 (available in French only).
32. Application No. 44084/10, judgment of 5 June 2013 (available in French only).
33. Application No. 7509/08, judgment of 11 May 2014 (available in French only).
34. See the overview compiled by the University of Missouri-Kansas City, "Defendants in the Major War Figures Trial".

3.5. Care of elderly detainees and the potential for early release

33. My fact-finding exercise for the present report extended beyond the fate of critically ill prisoners, to also look at the prospects for release for elderly persons in detention. A report from the World Health Organization (WHO)[36] identifies some of the key challenges to the incarceration of detainees of advanced age, and notes that detainees can be considered geriatric as early as ages 50 to 55. In addition, the report recommends that prison authorities evaluate and adapt detention centres to the unique needs of elderly detainees, review the medication lists to ensure that the medications are appropriate for older detainees, and develop resources to help provide older detainees with palliative care plans or hospice services when necessary.

34. Recommendation No. R (82) 16 of the Committee of Ministers goes further, encouraging member States to grant prison leave on a variety of grounds, specifically mentioning "medical, educational, occupational, family *and other social grounds*" (emphasis added). I believe that advanced age can and should be considered as one of these social grounds.

35. Importantly, the Court does not exclude the possibility that the prolonged detention of an elderly person may amount to inhuman or degrading treatment, in violation of Article 3 of the Convention. It so stated in Papon v. France,[37] although it held that the minimum level of severity necessary to engage Article 3 was not attained in the specific case of the applicant.[38] Another case in which the Court referenced advanced age in the context of a detainee's complaint under Article 3 is Farbtuhs v. Latvia,[39] in which it found a violation on account of the detainee's severe disability and the fact that he was already 84 years old at the time of his sentencing, due to the fact that the crimes in question had been committed nearly six decades earlier.

36. On a more general note, I should like to recall that the CPT's 3rd General Report, as previously mentioned, identifies terminally ill detainees, detainees of advanced age and ill detainees requiring treatment from an outside facility as unfit for continued detention.

3.6. Treatment of other categories of detainees

37. The Assembly recently adopted Resolution 2077 (2015) and Recommendation 2081 (2015) on abuse of pretrial detention in States Parties to the European Convention on Human Rights, based on a report (Doc. 13863) prepared by Mr Pedro Agramunt (Spain, EPP/CD). These texts urge member States to avoid the use of pretrial detention as much as possible, noting multiple negative effects of pretrial detention both on the detainee and society as a whole. I find it worth reiterating that the prohibition of inhuman or degrading treatment (Article 3) applies to all detainees. Pretrial detainees, who are presumed innocent, are thus also entitled to receive adequate medical treatment, including from an outside facility if necessary.

38. Similarly, persons in immigration detention in Contracting Parties are also protected by Article 3. The CPT Standards indicate that "immigration detainees should – in the same way as other categories of persons deprived of their liberty – ... as from the outset of their detention … have access to a lawyer and a doctor". Despite these standards, several cases of inadequate treatment of persons in immigration detention were brought to my attention by the International Federation of Action by Christians for the Abolition of Torture (FIACAT), including the placement of irregular migrants in need of specialised psychological treatment in immigration detention in Luxembourg. In Sweden, a Syrian asylum seeker reportedly died from cancer after five weeks in immigration detention, isolated and without having had access to medicine other than pain killers.[40]

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35. See ICTY, Case No. IT-00-39 & 40/1-ES, "Decision of the President on the Application for Pardon or Commutation of Sentence of Mrs Biljana Plavšić", 14 September 2009.
36. Brie *Williams, Cyrus Ahalt and Robert Greifinger,* "The older prisoner and complex chronic medical care", in World Health Organization (WHO) Regional Office for Europe, *Prisons and Health* (Copenhagen: WHO, May 2014), Chapter 19.
37. Application No. 54210/00, judgment of 7 June 2001.
38. See also Steve Foster, *Human Rights and Civil Liberties,* 2nd edition (Harlow: Pearson Education, 2008), pp. 316-317.
39. Application No. 4672/02, judgment of 6 June 2005 (available in French only).
40. Written contribution of the FIACAT to my report, September 2015 (on file with the Secretariat).

4. Laws, practices, and recurring problems in Council of Europe member States

4.1. Barriers to receiving (outside) medical care for critically ill detainees

39. With respect to the provision of medical care to critically ill detainees, I have found that various member States experience problems relating to the independence of medical staff, the availability of transport options for detainees to outside hospitals, and the restraint of detainees when receiving outside medical care, in apparent non-compliance with the above-cited European standards.

4.1.1. Lack of independence of medical staff

40. European standards require that medical staff in detention centres be professionally independent in order to make medical diagnoses and administer care, with the health of the detainee as the foremost consideration. Still, in many cases, I find that medical professionals within detention centres are still far too dependent on the prison administration. According to the replies to my questionnaire, in Austria, terminally ill detainees are assessed by two independent doctors as well as a "control" examination by the chief of the medical service; this appears to be a good practice. By contrast, in Bosnia and Herzegovina, it is only the medical services of each penal institution that decide on the need for external medical care.

41. Independent medical professionals enjoy improved patient trust and have more freedom to diagnose solely on the basis of the condition of the detainee, as opposed to also having to take into account the resources and preferences of the detention centre itself. Member States should strive for greater independence of medical professionals who work in detention centres. Reports have noted that one way to improve independence of health-care providers in detention centres is to shift the responsibility for prison health from prison officials to the health ministry – an option that some countries (amongst them France, Luxembourg, Norway, Turkey and the United Kingdom) have pursued.[41] Although this is not the only way to achieve professional independence, I would encourage more member States to consider making this transition.

4.1.2. Delays in ensuring access to medical care

42. I also share the concern expressed by the Council of Europe Commissioner for Human Rights in a number of reports following visits to various member States – including, but not limited to, Azerbaijan (2010), Belgium (2008) and France (2008) – which highlight the issue of cancellation or delay of outside medical appointments, due either to a lack of available transport from the detention centre to the hospital facility, or to too restrictive a policy of granting such treatment on the part of the prison administration.[42] I also raised this issue during my fact-finding missions, and I cannot but stress the importance of ill prisoners and detainees being transferred to outside doctors or medical facilities without delay. The procedure for requesting and organising such transfers should be flexible and avoid undue bureaucracy, while guaranteeing a non-discriminatory approach and preventing arbitrary decisions to delay or deny a transfer.

4.1.3. Use of restraints on detainees in medical settings

43. Another persistent problem I have observed in respect of various member States is the continuous and unnecessary or disproportionate use of restraints on detainees, even when the circumstances are such that the possibility of escape or harm to others is all but impossible. Even in member States in which a risk assessment is undertaken to determine the appropriate level of restraint, prison staff sometimes only complete the risk assessment once, before the initial transfer of the detainee, rather than continuously reassessing the situation as the condition of the detainee changes.

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41. See International Centre for Prison Studies, King's College London, "Prison Health and Public Health: The integration of Prison Health Services", Report from a conference organised by the Department of Health and the International Centre for Prison Studies (London, 2 April 2004).

42. As to the latter, the FIACAT noted, in its written submission, that the problem in France was often not one of availability of specialised services, but the authorities' rigid attitude regarding granting access thereto.

44. I endorse the guidance given on this matter by the Prisons and Probation Ombudsman for England and Wales, which indicated, in a 2013 report on "End of Life Care", that the "level of restraints used on prisoners must at all times be proportionate to the perceived security risks and be balanced by consideration of care and decency for the prisoner". Nevertheless, it is worrisome that the principle of proportionality appears to be (sometimes blatantly) ignored in practice, as in the following examples:

– a 67-year-old inmate suffering from terminal cancer died while chained to a prison guard;[43]

– an inmate remained chained during a four-day medically induced coma, during which time no new risk assessment was undertaken;[44]

– a female detainee was forced to remain chained to a female guard while undergoing an invasive gynaecological examination;[45]

– a 65-year-old detainee had to cancel and reschedule a heart procedure because the six accompanying guards refused to remove his cuffs for the procedure;[46]

– a 22-year-old detainee on life support remained chained to a prison guard until after his life support machine was turned off.[47]

45. It is important to note, however, that the United Kingdom is not the only country that can be criticised for excessive restraint of its detainees, as evidenced by the judgments of the European Court of Human Rights mentioned above (at paragraph 25) with respect to France and Russia. In the same vein, the French "Contrôleur Général des Lieux de Privation de Liberté" criticised the fact that detainees were often handcuffed not only during transfer to a hospital, but also during medical consultations and sometimes even during surgery.[48] The FIACAT reports that prisoners in Luxembourg are regularly handcuffed to their beds, even when they are placed in dedicated secure hospital rooms.[49] I suspect and fear that more member States also engage in the practice of excessively restraining their detainees as they receive medical assistance.

4.1.4. Deliberate withholding of medical care

46. One of the most striking problems is the intentional prevention, by the government or other relevant authorities, of the provision of necessary medical care. Just recently, in September 2015, Vladimir Kondrulin died of prostate cancer at a tuberculosis hospital under the Federal Penal Service Department for the Chelyabinsk Region in Russia. He could have legally qualified for compassionate release, but his petition was denied; and Mr Kondrulin was not transferred to a specialised hospital.[50] Similarly, a recent CPT report (document CPT/Inf(2015)27) on the visit of a CPT delegation to the Caribbean part of the Kingdom of the Netherlands noted that, "[i]n 2013, a 36-year old woman prisoner died from cardiomyopathy after having waited for several hours before the doctor came to see her" (paragraph 171).

47. These cases are all the more concerning when assistance is denied to alleged political prisoners. Specific examples include the detention of Leyla and Arif Yunus in Azerbaijan, both of whom suffer from serious conditions and have continuously been denied treatment,[51] and the case of Yulia Tymoshenko,[52] who was denied critical medical treatment until a Rule 39 intervention by the European Court of Human Rights.

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43. Prisons and Probation Ombudsman for England and Wales, "Learning lessons bulletin, Fatal accidents investigations 2", February 2013.
44. Ibid.
45. *The Guardian,* "Dying in chains, why do we treat sick prisoners like this?", 9 November 2013.
46. Ibid.
47. Ibid.
48. Contrôleur Général des Lieux de Privation de Liberté (France), "Avis du 16 juin 2015 relatif a la prise en charge des personnes détentues au sein des établissements de santé" (available in French only).
49. Written contribution of the FIACAT to my report, September 2015 (on file with the Secretariat). See also the latest CPT report on Luxembourg, CPT/Inf(2015)30 (available in French only), p. 24.
50. Russian Legal Information Agency (RAPSI), "Terminally ill Russian inmate dies despite ECHR efforts" (9 September 2015). See also RAPSI, "ECHR asks Russia to provide medical assistance to terminally ill inmate" (1 September 2015).
51. Leyla Yunus reportedly suffers from diabetes and requires a special diet, while her husband suffers from heart and blood pressure conditions. Reports claim that they have repeatedly been denied treatment. See International Federation for Human Rights (FIDH), "Concerns over the deterioration of the health of Leyla Yunus, Arif Yunusov and Anar Mammadli while in arbitrary detention", 13 February 2015. I note that Arif Yunus has recently been released on humanitarian ground and I welcome this, as has Assembly President Anne Brasseur. When so doing, she rightly stressed the need to release more persons, especially those whose health condition is a matter of serious concern, www.assembly.coe.int/nw/xml/News/News-View-EN.asp?newsid=5873&lang=2&cat=15.
52. See the Court's judgment of 30 April 2013, Application No. 49872/11.

48. Probably the best-known, if not to say notorious, case in this category is that of Sergei Magnitsky, whose death in pretrial detention after the denial of essential treatment for pancreatitis caused an international outcry and led to the adoption of Resolution 1966 (2014) and Recommendation 2031 (2014) on refusing impunity for the killers of Sergei Magnitsky, on the basis of a report (Doc. 13356 and addendum) I had prepared on behalf of the Assembly. Despite his clearly diagnosed condition necessitating surgery, Mr Magnitsky was transferred to a prison that lacked the requisite facilities. His case is currently pending before the European Court of Human Rights.[53]

49. Lastly, the case of Aleksanyan v. Russia[54] concerned the treatment of former Executive Vice President of Yukos oil company and lawyer for Mikhail Khodorkovsky and Platon Lebedev, Vasily Aleksanyan. Notwithstanding a serious deterioration in the health of Mr Aleksanyan, who suffered from AIDS and had developed tuberculosis as well as liver cancer with metastasis in the lymph nodes, he was not transferred to a specialised clinic to receive antiretroviral treatment and chemotherapy. On the contrary, his pretrial detention was even extended, in apparent disregard of two interim measures indicated by the Strasbourg Court, by means of which the authorities were ordered "to secure immediately, by appropriate means, the in-patient treatment of the applicant in a hospital specialised in the treatment of Aids and concomitant diseases" (paragraph 76 of the judgment). Mr Aleksanyan was only released on bail (on a bond of the equivalent of 2 million euros) after the Court found an Article 3 violation on account of the lack of proper medical assistance in the remand prison and held that his pretrial detention should be discontinued; he died some two and a half years later.

50. Needless to say that these (political) cases are only the tip of the iceberg. More generally, I have to admit that I was struck by the fact that the recommendations and clear guidance emanating from the above-referenced, numerous documents adopted by the Committee of Ministers, the Parliamentary Assembly and the CPT that seek to set a minimum standard of treatment for detainees often appear to go unheeded. Worse still, by the time a detainee is able to seek redress before a domestic court or the European Court of Human Rights, they have often already been subjected to damage that cannot be undone. The Assembly must therefore call on all member States to provide necessary medical treatment to all detainees.

4.1.5. Overcoming the identified barriers to medical care

51. In light of the foregoing, I find it of the utmost importance to recall the Committee of Ministers' Recommendation Rec(2000)22 on improving the implementation of the European rules on community sanctions and measures, as well as the Assembly Resolution 1938 (2013) and Recommendation 2018 (2013) on promoting alternatives to imprisonment[55] by utilising community sanctions and other alternative measures instead of detention wherever possible. Sending less people to prison not only relieves the pressure on overburdened prison staff, but also lessens the risk of a violation of the rights of an ill detainee. Besides, adopting a more lenient approach to compassionate release will also contribute to reducing prison overcrowding, which, in turn, will foster detention conditions conducive to good health. Before considering the type of medical treatment needed by a detainee, governments should therefore first consider whether the person should be detained at all.

52. The case law of the Court makes it very clear that critically ill detainees must receive adequate medical care and be restrained no more than necessary. Domestic law should allow for access to outside hospital assistance whenever an independent medical professional determines that such access is in the best interest of the detainee's health. Domestic law should also ensure, and be implemented in such a way, that the standard should be no restraint at all, unless a case-by-case risk assessment demands it. Domestic law should mandate a constant re-evaluation of a detainee's medical condition in order to determine if and when restraints are no longer needed.

53. Finally, governments must never deliberately deny detainees medical treatment. Such clear, intentional violations of Article 3 are totally unacceptable.

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53. See Magnitskiy and Zharikova v. Russia, Applications Nos. 32631/09 and 53799/12, communicated to the Russian Government on 28 November 2014.
54. Application No. 46468/06, judgment of 22 December 2008.
55. See also the report, Doc. 13174 (rapporteur: Ms Nataša Vučković, Serbia, SOC).

4.2. General care and conditions for elderly detainees

54. Europe's prison population is aging. By way of example, I should like to note that, in my own country, Switzerland, the number of prisoners above the age of 59 increased by 11% between 1990 and 2012; the number of over 70 year olds has increased by 425% in the last 20 years.[56] With this aging trend come a number of challenges, including, for example, the question as to how to deal with detainees suffering from certain age-related diseases. I draw again from an example from Switzerland, where the oldest prisoner in the country, aged 90 at the time, had seen his request for interruption of his sentence denied despite the fact that he suffered from terminal cancer and advanced dementia.[57] When it comes to advanced stages of dementia, I consider continued detention to be entirely unjustified, for the person concerned will most likely no longer understand the purpose of his or her punishment.

55. More generally, many Council of Europe member States do not have detention centres equipped to handle the unique needs of an aging detainee population. In some countries, prisons are located in old buildings with narrow hallways and staircases, without elevators.[58] It appears that, in States in which the prison population is small – and the geriatric prison population even smaller – there is little incentive for meaningful change.[59] But these inmates are entitled to the same rights, and appropriate medical care under CPT standards and Article 3 of the Convention. Elderly detainees suffer unnecessarily in conditions that are not well adapted to their needs. Therefore, member States should modernise their detention facilities in order to accommodate this population (for example wider hallways, wheelchair accessibility and accessible pharmacies and infirmaries).

56. On a positive note, some member States have started to enter into discussions about ways to improve the quality of life for older detainees.[60] In Portugal, sentences depriving people of their freedom, when applied to those over 65, "must respect their specific needs and state of health and autonomy, guaranteeing the help needed for everyday activities and providing accommodation, conditions, security, activities and programmes that are especially suitable". Other States have similar provisions. Detainees of advanced age in Austria are "sheltered either in a semi-open regime or in a special medical department within the prison system", depending on nursing needs. The Republic of Moldova allows for convicted men who have reached the age of 65 and convicted women who have reached the age of 60 to request their placement in institutions for the disabled or elderly; however, no information was given on the standards of these institutions.

57. End-of-life and palliative care plans are actively used for detainees in some member States. The existence and appropriate use of these plans is crucial to the protection of the basic dignity of aging inmates. In the United Kingdom, the Prisons and Probation Ombudsman for England and Wales issued a report that examined the inadequacies and deficiencies of end-of-life care programmes that were used in the cases of detainees who had died in recent years. The report offers case studies of successful and unsuccessful instances and uses of palliative care for dying detainees, and highlights the importance of an effective palliative care programme, failing the (preferable) compassionate release of elderly detainees. End-of-life and palliative care plans allow individuals to receive high quality end-of-life care. Close co-operation with specialised palliative care centres as well as hospices is to be encouraged.

4.3. Standards and processes for compassionate release

58. In many member States, some form of compassionate release is available to detainees. Yet, domestic laws vary: the decision is sometimes made by the Minister of Justice, or the equivalent government minister, after the detainee receives a serious or terminal diagnosis and submits a petition for release (as is the case in Ireland and the United Kingdom, for instance). In other member States (such as France), the decision is referred to a normal parole board, or a regular court of law that adjudicates parole requests. A case raising

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56. Schweizerische Eidgenossenschaft, Bundesamt für Statistik, figures as at 28 August 2013; as cited in Nicolas Quenoz, "Mourir en prison: entre punition supplémentaire et 'choix' contraint", 3 *Revue international de criminology et de police technique et scientifique* 373, 2014.
57. Ibid.
58. See Contrôleur Général des Lieux de Privation de Liberté (France), Rapport d'activité 2012, pp. 240-241; as well as *The Telegraph*, "Should we help our OAPs? (Old Age Prisoners)" (11 June 2013); *The Economist*, "In it for life" (2 March 2013).
59. Ibid.
60. See Ken Howse/Centre for Policy on Ageing and Prison Reform Trust, "Growing Old in Prison. A scoping study on older prisoners" (London: Prison Reform Trust, 2003); as well as swissinfo.ch, "More prisoners face old age behind bars" (2 February 2009).

concerns of a risk of political bias and a lack of independence from the executive is that of Turkey, which I will examine more closely below. In Turkey, the decision to suspend a sentence on grounds of illness or disability is taken by the prosecutor's office.

59. The procedures and the criteria for adjudicating an application for temporary or permanent compassionate release can vary. The vast majority of States allow for applications from both the prisoner and the prison authority. The Slovak Republic, however, appears only to allow applications from the director of the detention facility, raising questions of independence and individual access to compassionate release.

60. Most systems appear to apply similarly to both pretrial detainees and detainees serving a sentence. Both the Czech Republic and Finland, for example, gave evidence in their questionnaire responses of systems to postpone imprisonment in the face of medical evidence. However, in the Slovak Republic, release on compassionate grounds is not possible for a pretrial detainee. This gives rise to concerns in light of Mr Agramunt's above-mentioned report on the abuse of pretrial detention in member States. Compassionate release should not be denied to those awaiting trial.

4.3.1. Temporary or permanent release from (remand) prison

61. Grounds for compassionate release vary between States. Some provide closed lists of qualifying illnesses while others take broader assessments. The Ministry of Health, Labour and Social Affairs of Georgia, for example, has adopted a list of severe and terminal illnesses that are grounds for release. Greece similarly states in law the severe illnesses that qualify for release. Israel, whose parliament has observer status with the Parliamentary Assembly, requires that the stay in prison endanger the prisoner's life substantially and that the medical condition leaves the prisoner requiring artificial respiration measures, permanent unconsciousness or advanced dementia requiring continuous supervision 24 hours a day, or cancer, or the transplant of a vital organ.

62. I am of the view that more individual-focused approaches are preferable. Poland allows for temporary release for treatment if the illness threatens the prisoner's life or if continuing imprisonment will lead to a deterioration of the prisoner's health – an assessment made on a case-by-case basis. Finland, on the other hand, assesses whether treatment would be particularly difficult in prison, which attaches more importance to the institutional ability to cope with the prisoner than to the prisoner's own situation.

63. The Spanish Constitutional Court has limited compassionate release on probation to "serious and incurable illness, the progression of which would be unfavourably affected by remaining in prison, entailing a deterioration in the patient's health and thus shortening his or her life, even where there is no imminent risk of death". While Germany's Code of Criminal Procedure limits compassionate release to those cases where imprisonment would cause a threat to the detainee's life, the Higher Regional Court of Hamburg ruled in 2006 that the respect of human dignity required release for a terminally ill detainee who posed only a very limited danger to society, even though imprisonment itself did not pose a risk to the prisoner's life and treatment in the hospital of the penal institution was possible.

64. In the Netherlands, amnesty is assessed on the grounds of whether it has become apparent that the implementation or continuance of imprisonment no longer reasonably serves the intended purpose. France, likewise, allows for release if the prisoner's terminal illness is incompatible with the continuance of detention. This is arguably the most progressive system in all member States, as it acknowledges the unnecessary nature of incarcerating the critically ill, regardless as to whether or not incarceration would be actively detrimental to their health. I fully endorse this approach.

65. Acknowledging the inherent dignity of the prisoner, even in cases where further imprisonment may not imminently lead to death, is commendable. Assessing the effect of continued incarceration on the prisoner as an individual rather than against a "closed list" of sufficiently serious illnesses better reflects their fundamental rights.

66. Against this backdrop, I am concerned to note that in Croatia compassionate release is limited to a temporary release of 12 months, after which the prisoner must continue serving his or her sentence, in complete disregard of the rights of the individual. Further, in Montenegro, compassionate release is granted only to prisoners over 50 suffering from severe illness. I am troubled that no such compassionate release is open to younger prisoners.

67. Connected to these issues is the assessment of the prisoner's threat to public security. Lithuania will take into account the "gravity of the committed criminal act, the personality of the convicted person, the nature of the illness [and] also [the] conduct of the convicted person". When considering conditional release on health

grounds, Israel will consider "the prisoner's family conditions and the victim and his family conditions"; and while Portugal allows for a wide range of reasons for compassionate leave, this is allowed only when there are no serious considerations relating to prevention or social peace and order.

68. I do not contest that questions of public security are always to be considered, but member States always ought to guarantee the human dignity of the prisoner, in particular when they are terminally ill or facing short-term fatal prognoses. There is an undeniable potential for abuse, especially in the case of political prisoners, if compassionate release can be denied on – often vague – grounds of public order. I would add to this that there are less restrictive alternatives to continued detention to prevent reoffending, such as (telephonic) reporting requirements and even electronic monitoring.

69. A limited number of States retain systems of pardon.[61] Regrettably, no information was provided by member States as to how many pardons are granted on such grounds. It would be useful if States were to keep statistics on this, and make them publicly available. While Cyprus *de jure* only allows for a Presidential pardon to obtain compassionate release, it acknowledges that, in practice, there is a legal process for requesting suspension or commutation of the prisoner's sentence before the Attorney General and that this process is appealable. I am more concerned that, in Hungary, Presidential pardon constitutes the only way to obtain early release from prison; there is no codified, legal mechanism for compassionate release. As no reasons are given for the pardons, there is no way of assessing even the existence of compassionate release. I believe that compassionate release of critically ill prisoners must not be left to political discretion.

70. Several countries provided numbers both for petitions for early release received and those granted or rejected:

– in 2012, France received 296 applications for suspension of sentence. 253 were accepted; 33 were rejected.[62] Figures were not provided for the number of prisoners permanently released on compassionate grounds;

– in 2013, Lithuania received 14 applications for compassionate release, four of which were granted. In 2014, it received 17 applications and granted 9;

– the Slovak Republic produces detailed statistics, a good practice I would invite other countries to follow. In 2014, 63 applications were made for discontinuation or remission of the execution of a prison sentence. Six were related to a short-term fatal prognosis, and all of these applications were approved. 34 applications were made relating to severe illness requiring treatment outside the place of detention, 32% of which were approved. A further 19 prisoners were released on grounds of terminal illness. Four prisoners died pending the examination of their application. The average duration of the decision-making process is six days;

– Estonia also provided statistics over a five-year period. Of a prisoner population of around 3 200, around five critically ill detainees were released each year. This number has in fact grown, from only two releases in 2010 to four in the first six months of 2015 alone. In every year except 2011, all applications were approved. Many of the prisoners released still had long periods of their sentence remaining, and the ages of those released ranged from 26 to 70. In the same time period, there were two detainees receiving treatment outside the place of detention.

71. There is no statistical information on the number of prisoners who died in prison after the rejection of their application for release. What is clear, however, is that sometimes States face problems in actually releasing people deemed unfit to remain in detention, for example when detainees engage in hunger strikes to the point of developing complications, including the Wernicke-Korsakoff syndrome.[63] Still, determinations by medical officials that a person is not fit to remain in detention are not always heeded by the decision-making authorities, and critically ill detainees sometimes remain in detention for months after a determination that they are medically unfit to remain detained.[64]

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61. Cyprus, Hungary, Poland, the Republic of Moldova, Romania, Switzerland and Turkey.
62. It is unclear why there are 10 applications unaccounted for.
63. Tekin Yildiz v. Turkey (see note 30), in which a detainee developed Wernicke-Korsakoff syndrome and remained in detention despite his state of health having consistently been found to be incompatible with detention, in violation of Article 3.
64. *The Guardian*, "Dying asylum seeker on hunger strike must stay in custody, says high court" (19 November 2013).

72. In this connection, Georgia states that the duration of its decision-making process is 14 days, but this has been recognised by the State as too long and is now subject to review. Cyprus described the average duration of its decision-making process as "the soonest possible", and asserted that no prisoner eligible for compassionate release had died pending the examination of the application. In the Slovak Republic, many decisions took as little as one or two days, but two cases took as long as 15 days.

73. Additionally, many processes for release require some form of medical evidence from one of more doctors, though the doctors or hospitals supplying this medical evidence are not always independent. For example, in Turkey, the Forensic Medicine Institute (Adli Tıp Kurumu Başkanlığı) makes medical recommendations as to which detainees are suffering from illnesses that give them eligibility for compassionate release. Not only is the Forensic Medicine Institute an organisation subject to bureaucratic delays, but it is also closely linked to the Ministry of Justice and therefore is not an independent medical authority, as recommended by international standards and the Council of Europe.

74. Another cause for concern is the lack, in some member States, of an opportunity for judicial review of a decision not to release a detainee. Romania and Croatia both allow for appeals within three days of the original decision,[65] and Albania provides for a possibility to file an appeal within five days; but no (judicial) review is foreseen in Spain, for example. Appeals in Lithuania are conducted through the ordinary Lithuanian courts procedure. Lithuania has, however, also had over 20 violations of Article 6 found against it by the European Court of Human Rights on grounds of unreasonable delay of proceedings. States should therefore ensure that compassionate release applications and appeals are heard as swiftly as possible.

75. I fear that the absence of an appeal may cause the deciding authority to "err on the side of caution", by turning down the request, since the decision to release a detainee is final and binding. The possibility for judicial review of a decision not to release an ill or elderly detainee is crucial and should be provided by all member States.

4.3.2. Release of elderly detainees

76. With respect to elderly detainees, no Council of Europe member State currently has established an upper age limit for detention. Nor do any member States specifically have early release legislation based solely on the advanced age of a detainee, although age does appear to be among the factors considered in applications for compassionate release,[66] as confirmed by the replies to the questionnaire:

– Romania allows for parole for convicts from the age of 60 as long as they are serving their sentence in an open or semi-open regime and the court is convinced the convicted person can be rehabilitated;

– Spain allows for probation for prisoners over the age of 70;

– Georgia, which allows for release of men over 70 and women over 65 if half of their sentence has been served, released 43 prisoners on grounds of old age between 28 December 2012 and 6 July 2015;[67]

– one man, aged 74, was released in Cyprus on grounds of advanced age;

– those over 70 can be released in Greece provided they have served two fifths of their penalty and subject to certain conditions. Furthermore, any day a person over 65 spends in prison counts as two days of their sentence – a sensible approach that deserves to be imitated.

77. Nevertheless, the number of elderly detainees continues to grow, in part because of convictions for crimes committed decades past. For example, the recent conviction of a former SS guard, who was sentenced to four years in prison at age 94, appears to have encouraged prosecutors to continue bringing cases regardless of the potential defendant's age.[68] Although the 94-year-old may not serve his sentence, it being subject to a forthcoming decision from medical officials and the prosecutor, the sentencing judge acknowledged that he would probably not outlive his sentence anyway.[69]

65. Romania also allows for appeal against the Parole Commission, with similar time-limits.
66. Recall Farbtuhs v. Latvia, cited above (see note 40), in which the detainee's age was taken into account.
67. The age limit in place in Georgia was not given in the questionnaire response.
68. *The Guardian*, "Accountant of Auschwitz' jailed for the murder of 300 000 Jews" (15 July 2015).
69. Ibid.

4.3.3. Assessment and recommendations

78. Only 12 States provided any form of statistical information on the treatment of critically ill detainees,[70] with the Slovak Republic alone able to provide all of the requested information. A crucial first step would therefore be a requirement upon member States to keep such statistics in a regulated and uniform manner. In order to assess policy in this area, the numbers of successful and failed applications, the number of deaths during the application process, and the comparison of these figures over time and between member States are needed.

79. Tied to this recommendation is a need for greater terminological clarity when discussing cases of critically ill detainees. It is clear from the wide variety of responses that Europe currently lacks a unified assessment and treatment of its critically ill prisoners. Much information was provided on wider parole systems which, while sometimes relevant, often did not consider the unique position of critically ill prisoners. These prisoners face specific human rights challenges which require treatment separate from normal parole considerations. Member States' policies must be clear as to whether they allow for permanent release or only permanent treatment within health-care institutions, inside or outside the prison system. States often interchangeably use the phrases "interruption", "suspension", "temporary release", and "termination of the sentence". In any event, however, what is of paramount importance is that treatment and release not be subject to arbitrary limitations.

80. Regarding pretrial, immigration, asylum and other kinds of detention outside of the standard prison system, human rights must apply equally to all detained persons. Member States must not only ensure that their systems of compassionate leave cover all detainees within their jurisdiction, but also ensure proper collation of data on such detainees in order to thoroughly assess their treatment.

81. Notwithstanding that the lack of statistics makes it difficult to draw general conclusions, I find that many laws and practices regarding temporary or permanent release are too restrictive and that applications for release take far too long to decide.

82. Compassionate release processes that require testimony or reports from doctors must ensure that those doctors are independent of the prison system. Under no circumstances should they be government officials or employees of a government institution. Only independent or private doctors should be allowed to make recommendations as to the medical condition of a detainee with respect to the potential for compassionate release.

83. Whenever a detainee's condition is deemed incompatible with continued detention, he or she should immediately be granted a temporary release from detention and be allowed to receive medical treatment at an outside facility. For detainees with terminal conditions, compassionate release should always be available. Advanced age should remain part of the criteria when deciding an application for compassionate release.

84. Lastly, there is also a need for clarification of the appeals process in member States. Appeals by terminally ill detainees must be given priority and due attention. The deaths of prisoners awaiting the outcome of their applications is unacceptable. Applications for compassionate release should always be adjudicated by a court of law and the decision to grant or deny compassionate release should never rest in the hands of one government official. All decisions should be subject to judicial review.

5. Summaries of fact-finding visits

85. With the committee's authorisation, I visited three countries – Montenegro, Romania and Turkey – with a view to exploring in more detail the situation of critically ill and elderly detainees. As mentioned above, the selection of countries was partly predetermined by the focus of the motion at the origin of my rapporteur mandate (in the case of Turkey), and partly made on the basis of information contained in CPT reports hinting at the prevalence of certain problems or shortcomings in relation to the matters at stake (in the cases of Montenegro and Romania). I should like to reiterate, however, that problems are not exclusive to these

70. Cyprus, the Czech Republic, Estonia, Finland, France, Georgia, Iceland, Italy, Lithuania, Portugal, the Slovak Republic and Turkey. Bosnia and Herzegovina had promised further data, and statistics were unavailable in Montenegro due to such compassionate release laws only recently coming into force. Other States were able to provide wider data of all prisoners on leave (Poland), parole figures (Romania), or overall Presidential pardons (Hungary), but the specific reasons for release were not indicated. Croatia was able to make a limited inference of the existence of compassionate release from figures on the number of prisoners who had died during the interruption of serving a prison sentence.

countries, as the replies to the questionnaire show. I should also like to take this opportunity to thank all three national delegations and their respective secretariats for the excellent co-operation in the planning and realisation of my fact-finding missions and for their hospitality.

5.1. Romania

86. On 25 May 2015, I undertook a fact-finding visit to Romania, where I held meetings with the Head of the National Administration of Penitentiaries and representatives of the Ministry of Justice, the Office of the People's Advocate and non-governmental organisations (NGOs). I also met with members of the Committee for the Investigation of Abuses, Corrupt Practices, and for Petitions and of the Committee for Human Rights, Cults, and National Minorities Issues of the Chamber of Deputies of the Parliament of Romania.

87. The right to medical assistance, treatment and health care for persons deprived of their liberty is set out in Article 71 of Law No. 254/2013 on the enforcement of sentences and of measures involving deprivation of liberty ordered by the judicial bodies during criminal proceedings, which was designed to bring the legislation into compliance with the standards set out in the European Prison Rules and the United Nations Standard Minimum Rules for the Treatment of Prisoners. Details are regulated in the Common Ministry of Health/ Ministry of Justice Order No. 429/2012 on granting medical assistance to persons deprived of liberty placed in the custody of the National Administration of Penitentiaries.

88. Nonetheless, both civil society representatives and MPs I met in Bucharest pointed to local and regional disparities and prevailing shortcomings in the implementation of the right to health care. There continues to be a shortage of medical staff in the penitentiaries. Of particular concern is the lack of adequate psychological treatment: there are apparently only three psychiatric wards in Romania, and co-operation between prisons and civil hospitals needs to be reinforced.

89. The inadequacy of mental health care appears to be a broader problem, as reflected in the types of complaints filed with the People's Advocate (Ombudsman). In its 2008 judgment in the case of Petrea v. Romania,[71] the European Court of Human Rights held that the lack of medical treatment for the applicant's mental disorder, together with inadequate conditions of his detention, amounted to a violation of Article 3 of the Convention. The CPT continues to denounce the poor material conditions of detention, especially as regards overcrowding.[72] Based on my visit, I consider that there is political will to improve the conditions of detention, including health care. But this matter must be given priority, in line with the recommendations of the CPT.

90. Civil society organisations point to the reluctance of prison managers to agree to the transfer of inmates to civilian hospitals better equipped to provide specialised treatment. This seems to be corroborated by statistics, which show that, in 2014, 97% (2013: 95%) of all hospital admissions of detainees were admissions to prison hospitals. It is unlikely that there was no greater need for treatment outside the prison system, especially since one of my official interlocutors told me that prison doctors were overburdened, and that "sometimes it is impossible to provide the medical services that the prisoners really need access to".

91. My NGO interlocutors in Bucharest further noted that medical professionals were reluctant to work in prison hospitals. At the same time, if a prisoner requests to be examined by a particular physician from outside the prison system, he or she must pay a fee. The Romanian authorities ought to create incentives for well-trained medical staff to work in prison hospitals, including by creating better working conditions (*inter alia* as regards working hours and equipment) and employment benefits (such as adequate pay and the guarantee of long-term employment).

92. Another worrisome issue concerns the quality and quantity of food provided to persons deprived of their liberty in Romania. I was shocked to learn that the average daily spending on nutrition per detainee and per day is less than one euro. Such a low daily allowance is entirely insufficient, as officials in Bucharest admitted – especially in respect of persons with special dietary requirements due to illness.[73] The authorities must ensure without delay the allocation of sufficient resources to guarantee a healthy food supply. In the medium

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71. Application No. 4792/03, judgment of 29 April 2008.

72. See the latest CPT reports (document CPT/Inf(2015)31 on the CPT's visit in 2014, and document CPT/Inf(2011)31 on the visit in 2010, both available in French only). See also Remus Tudor v. Romania (Application No. 19779/11, judgment of 15 April 2014), Brânduşe v. Romania (Application No. 6586/03, judgment of 7 April 2009, available in French only), and Iacov Stanciu v. Romania (Application No. 35972/05, judgment of 24 July 2012). In this latter case, the Court noted that there were 80 similar applications against Romania concerning detention conditions pending before the Court, and that this case reflected a common problem in Romanian prisons.

term, as I have pointed out in Bucharest, it might be advisable for Romania to introduce a system where detainees can grow their own food. Not only would this save the penitentiary services a considerable amount of money; it would also foster resocialisation.

93. In 2009, the European Court of Human Rights held that there had been a violation of Article 2 (right to life) of the Convention in respect of the Romanian authorities' obligation to protect the life of Mr Traian Gagiu by administering necessary medical treatment. Although Mr Gagiu had been suffering from a number of serious diseases, he had been placed in a cell until the day before he died, instead of receiving the treatment prescribed by surgeons and specialists.[74]

94. In 2014, 122 deaths in prisons were recorded (the average prison population during this period being 31 847[75]), 87% of which were due to medical causes – mainly cardiovascular diseases, neoplasia (cancer), digestive diseases and respiratory diseases. The officials I met in Bucharest agreed with me that nobody should die in prison.

95. This underscores the importance of creating opportunities for the (temporary or definitive) release of persons from detention. Aside from the Constitution enshrining, in Article 100(1), the possibility for a presidential pardon (based on a decree signed by both the Head of State and the Head of Government), Romanian law (Articles 590-594 of the Penal Procedure Code) allows for an interruption of a prison sentence where the convicted person is unable to be treated within the National Administration of Penitentiaries' health network. This possibility depends on the competent court not considering the prisoner to pose a threat to society. In deciding on petitions for interruption of a prisoner's sentence, the court will take into account the seriousness of the crime committed.

96. It is commendable that the National Administration of Penitentiaries was able to provide statistics on releases on grounds of interruption of serving a prison sentence. Unfortunately, however, no information was given on the ratio of requests granted and rejected. But some conclusions may still be drawn. Strikingly, the statistics show that, while the number of medico-legal examinations of prisoners performed increased from 256 in 2010 to 357 in 2014, the number of proposals of medico-legal commissions[76] to grant an interruption of sentence decreased continuously and sharply during the same period – from 59 to only three. While these statistics relate exclusively to illnesses in the final stage (e.g. cancer) and "very serious illnesses" (such as chronic kidney failure of a person on dialysis or illnesses that require open heart surgery), and other categories of persons are entitled to submit a petition for suspension of their sentence, this trend is worrying and cannot be explained (solely) by improvements in the treatment possibilities within Romania's penitentiary system. This trend is mirrored in the statistics on requests actually granted. Between February 2009 and 31 April 2015, 727 releases on grounds of interruption of a sentence took place, with a declining trend. A total of 51 people died during the period of the interruption of their sentence, and 21 were released or pardoned. Moreover, most of these releases were due to pregnancy or childcare. In the first quarter of 2015, only four people had their sentence interrupted for medical reasons.

97. In conclusion, I recognise that there are some good intentions on the part of the government representatives and parliamentarians whom I met in Bucharest to fully respect the dignity and rights of persons in detention. But efforts to address the shortcomings in the provision of timely and high quality medical care within the country's prisons must be redoubled – including by combating overcrowding, increasing the number of medical staff in prisons, further strengthening co-operation between prisons and public hospitals, and ensuring that detainees suffering from mental illness be transferred to specialised hospitals. Aside from this, a more lenient approach to granting interruption of sentences for medical reasons should be adopted.

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73. The World Health Organization (WHO) highlights that: "Adequate nutrition should be considered one of prisoners' basic human rights, especially as many have poor health. Healthy, nutritious meals will enable them to take their medication properly and prevent the development of life-threatening infections such as HIV/AIDS and tuberculosis. Also, vulnerable population groups in prisons – such as pregnant and breastfeeding women, substance users, teenagers and elderly people – have specific dietary requirements." See information available from the website of the WHO's Regional Office for Europe: www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/activities/nutrition.

74. Gagiu v. Romania, Application No. 63258/00, judgment of 24 February 2009 (available in French only).

75. This figure stood at 28 487 at 22 September 2015, www.prisonstudies.org/country/romania.

76. For oncological diseases in terminal phases, the members of the commission are: a coroner, a doctor appointed by the National Administration of Penitentiaries and a health-care network physician.

5.2. Montenegro

98. On 26 May 2015, I undertook a fact-finding visit to Montenegro. I engaged in a number of official visits which included meetings with the following: the Director of the Institute for the Execution of Criminal Sanctions, the Director General of the Directorate for the Execution of Criminal Sanctions in the Ministry of Justice, and the Ombudsman. I also met with representatives from various NGOs and with the Montenegrin delegation to the Parliamentary Assembly.

99. With an overall prison population of around 1 500, there are, according to figures provided by the Institute for the Execution of Criminal Sanctions, around 80 to 90 convicted prisoners who are considered "seriously ill". About 70 prisoners were known to have psychological problems. At the time of my visit, two pretrial detainees were receiving treatment in hospital, which was burdensome for the authorities, for they needed to ensure adequate security measures. Courts should always have due regard to a person's health when deciding whether or not to remand them in custody. In cases of illness or disease, the widest possible use should be made of alternatives to pretrial detention. Similarly, I encourage Montenegro to continue its important efforts to reinforce its probation service and to increase the use of alternative sanctions for minor offences.[77]

100. I was also informed that, between July 2012 and May 2015, four prisoners had died; one in prison and three in medical institutions.[78] It should be noted that all my interlocutors in Podgorica agreed that nobody should die in prison. Relatedly, a representative of the Montenegrin NGO Human Rights Action (Akcije za ljudska prava) noted that Montenegrin society at large felt empathy with seriously ill persons in detention and was generally in favour of their release to die at home.

101. In Podgorica, I was told that the Montenegrin health service currently employed 23 medical workers, including three general practitioners and one dentist. Specialist medical doctors were commissioned to make regular visits to the prisons, one to three times a week, and therapies were co-ordinated with public hospitals, especially those in Podgorica and in Bijelo Polje. NGOs describe the staffing as still insufficient, despite improvements in recent years. In particular, they observe that nursing staff continue to be required to work very long shifts and a significant amount of overtime, as had been criticised by the CPT.[79] It is advisable that Montenegro create incentives for doctors and other medical staff to work in prison conditions, including through adequate remuneration and training. I received assurances from the Director General of the Directorate for the Execution of Criminal Sanctions within the Ministry of Justice that it was envisaged to create better opportunities for medical staff working in the country's prisons to advance their careers, and to provide for the opportunity for detainees to be taken not only to public hospitals, but also to private medical institutions; these appear to be important steps towards ensuring prompt and adequate health care to persons in detention.

102. A particular concern relates to the provision of psychological and psychiatric care for detainees with mental illnesses. Only one psychiatrist visits the prison health-care centres approximately once a week – a situation denounced by the CPT in its report on its 2013 visit. More frequent consultations with psychiatrists must urgently be ensured, and detainees suffering from severe mental illness should be transferred to an adequately resourced hospital.

103. Interestingly, officials and civil society representatives alike noted that the doctor-patient ratio (i.e. the number of doctors per *x* patients) in Montenegro was higher within the State's penitentiary system than within society as a whole. Occasionally, a detainee's medical condition was only detected during the initial screening upon admission. The Ombudsman's office had received a total of 73 complaints from prisoners and detainees in the past year, 15 of which related to health and medical care, and mostly to delays in transfers to hospitals. According to this office, the waiting time to see a physician, and even more so to get an appointment for surgery, chemotherapy or other specialised care, was too long both for detainees and ordinary citizens. Montenegro should therefore strive to further improve its health system in general.

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77. See also the recommendations of the Civil Alliance (Gradanska alijansa), "Report about the Situation of Alternative Sanctions in Montenegro", Podgorica, April 2015, p. 25; and the assessment made by the European Commission in its "Montenegro Progress Report" of October 2014, at p. 44.

78. One of these instances was a spontaneous death by cardiac arrest, as confirmed by a forensic report.

79. See Report to the Government of Montenegro on the visit to Montenegro carried out by the CPT from 13 to 20 February 2013, CPT/Inf(2014)16 of 22 May 2014, paragraph 57.

104. When it comes to compassionate release, Article 53 of the Law on the Execution of Criminal Sanctions (Law No. 40/2011) allows for the suspension of a prison sentence of a detainee for the purposes of obtaining treatment outside the place of detention, subject to the person's return to the place of deprivation of liberty, his or her state of health permitting. The decision on such requests is taken by the Ministry of Justice, and can be appealed to the administrative court.

105. In 2014, a total of 20 prison sentences were suspended for the purpose of receiving treatment at a hospital or even at home.[80] My official interlocutors explained that the factors taken into account when assessing prisoners' eligibility for interruption of their sentence include the length of the sentence, the time served, the prisoners' state of health and medical history, the treatment needed and treatment possibilities in prison, and the prisoners' age. There do not appear to exist any problems in the practical application of the relevant provisions in Montenegro.

106. Yet, according to the questionnaire response, the expenses of the expert medical opinion supporting a petition for suspension of a sentence must be borne by the prisoner. Further, if the prisoner is treated in a health-care institution not covered by the national Health Insurance Fund, he or she must not only cover the cost of medical treatment, but also the costs of transport and security. I am also concerned at the assumption, expressed by NGO representatives, that elderly prisoners hospitalised following a heart attack preferred to return to prison only a few days after their admission to the hospital, rather than request a suspension of their sentence to recover fully. The reason for this appears to be that the time they would spend at the hospital while their sentence was interrupted would not be counted towards the time spent in prison. These factors may wrongly incite prisoners not to seek treatment or apply for a suspension of their sentence.

107. Against this background, I was all the more pleased to learn that, following my fact-finding visit to Montenegro, the parliament had adopted, on 26 June 2015, the Law on Enforcement of Sentences of Imprisonment, Fines and Security Measures. At the initiative of the members of the Montenegrin Delegation to the Assembly, with whom I had held a constructive exchange of views, the initial draft law was amended to introduce a provision (contained in Article 36 of the new law, dealing with Interruption of Sentence Enforcement) which allows, "exceptionally … and … with previously obtained medical report and opinion of the competent medical council, for interruption of sentence enforcement for an indefinite period of time to prisoner[s] over 50 years of age suffering from a life-threatening acute illness or deteriorating chronic disease" (unofficial English translation).

5.3. Turkey

108. Finally, I visited Turkey and held discussions in Ankara on 17 and 18 September 2015. It was precisely the situation of ill prisoners in Turkey that had prompted Mr Nazmi Gür and other members of the Assembly to table their motion for a resolution. And indeed, I should like to point out from the outset that the situation in Turkey worried me more than that in the other countries I visited.

109. Prior to my fact-finding mission, I obtained information from NGO sources, including copies of the medical and legal files of a number of ill prisoners. In Ankara, I held consultations with, *inter alia*, representatives of the Ministries of Justice and Health, the Ombudsman's Institution, the National Human Rights Institution, the Public Prosecutor's Office and NGOs. Moreover, the President of the Institute of Forensic Medicine provided a written reply to a number of questions I had sent him.

110. My visit also took me to Sincan F-type prison, a high security prison outside Ankara, where I had the opportunity to speak with the prison management as well as with two seriously ill prisoners. Much to my regret, however, I was not permitted to talk to Messrs Kaytan and Alkiş in private, nor was I able to see their cells; the prison administration instead showed me what they referred to as a "typical cell". I am therefore not in a position to comment on the adequacy of MM. Kaytan and Alkiş's accommodation.

111. Both men suffer from severe health problems, as was evident from their medical files as well as their respective oral accounts: they have been imprisoned already for 13 and 22 years, respectively. Suffice it to note here that, following open heart surgery in 2004, the Forensic Medicine Institute found that Mr Alkiş should be temporarily released to recover outside of prison; this recommendation was not followed by the Public Prosecutor and Mr Alkiş remained in prison. The cases of MM. Kaytan and Alkiş raise particular concern because, as individuals serving aggravated life sentences, they are not eligible for (conditional) release, despite their deteriorating health conditions. As a result, they both face dying in prison. This appears to be in clear contradiction to the case law of the European Court of Human Rights, according to which there

80. Figures provided by the Institute for the Execution of Criminal Sanctions during my visit.

must always be a prospect for release.[81] But their cases are only the tip of the iceberg. I received information, from several interlocutors, about other worrisome cases, but addressing them in detail would go beyond the scope of this chapter of my report.

112. Moreover, one day before my visit to Sincan prison, I learnt that Mr Vedad Dağ, who had been diagnosed with traumatic paraplegia, was allegedly being held there in pretrial detention, handcuffed to his bed. I requested to see him too, but this was denied on the grounds that I had not asked to speak to him prior to my visit, and that Mr Dağ was receiving palliative care at the prison hospital. The latter was confirmed by my interlocutors from the Ministry of Health, who noted that his mother was taking care of him in prison. The public prosecutor asserted that the prosecutor's office had recommended Mr Dağ's release, and that he expected that the court before which his case was pending would issue a favourable decision shortly. However, I understand that the court has decided not to follow this recommendation. Mr Dağ continues to be detained at Sincan prison hospital, despite a report by Numune Hospital stating that his condition required a six-month suspension of his stay in detention.[82] Although I was unable to see for myself how Mr Dağ was being treated, I am deeply troubled by his case. I urge the Turkish authorities to take all necessary steps to ensure that he receives appropriate care, and to secure his release without further delay.

113. At the time of my visit, the overall prison population in Turkey stood at 172 247. I received varying figures as regards the number of prisoners who are severely ill; while the parliamentary research division provided the figure of 809, the NGO Human Rights Association spoke of 721 as of May 2015.

114. Within the Turkish penitentiary system, medical care is normally provided by general practitioners and specialists at the place of detention. These doctors are appointed to work in the prison by the Ministry of Health. Five prisons across the country have a prison hospital. For emergency cases, co-operation is foreseen between the place of detention and university hospitals.

115. Prior and during my information visit, I was confronted with allegations of breaches of medical confidentiality, notably due to the presence of custodial staff during medical examinations.[83] This problem is well-documented by the CPT with regard to a number of countries, including Turkey.[84] The vague assertions by officials from the General Directorate of Prisons and Detention Houses that prisoners' "privacy rights [were] respected", while necessary "security measures [were] taken", and that doctors were able to see their patients in private if they so wished, did not convince me that these shortcomings are being addressed in a satisfactory manner. I can only repeat the CPT's position that "[a]ll medical examinations … must be conducted out of the hearing of law enforcement officials and, unless the doctor concerned requests otherwise in a particular case, out of the sight of such officials".

116. It is also a cause of concern that prisoners and detainees appear too often, if not routinely, to be handcuffed during medical examinations at hospitals. This was confirmed by both by my interlocutors at the National Human Rights Institution and NGO representatives. Ms Ayse Doğan, a former prisoner and detainee whom I met in Ankara, told me that she had at times refused treatment, because her hands would have been handcuffed behind her back, making it impossible for her to undress and be properly examined. I appreciate that the Director General of Prisons and Detention Houses agreed that treatment in handcuffs was against human dignity. Now every effort must be made to move from words to deeds.

117. Another problem brought to my attention concerns the transfer of detainees to outside hospital facilities. This task falls within the remit of the Gendarmerie. I received accounts claiming that there continue to be instances of ill-treatment at the hands of gendarmes during transfer to hospitals.[85] Kurdish political prisoners seem to be particularly prone to such abuse.[86] Ms Doğan credibly described having been left waiting in a Gendarmerie vehicle for hours, without food or water. I saw one of these vehicles myself, and I can imagine how exhausting it must be for an ill person to be kept for hours in such a poorly ventilated confined space. During my meeting with officials from the Ministry of Health, I was informed that the Ministry of Justice was

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81. See Vinter and Others v. United Kingdom, Applications Nos. 66069/09, 130/10 and 3896/10, judgment of 9 July 2013 (Grand Chamber); and, more generally, Trabelsi v Belgium, Application No. 140/10, judgment of 4 September 2014.
82. Information as at 19 October 2015. Apparently, the report issued by Numune Hospital has been sent to the Institute of Forensic Medicine for assessment.
83. See Human Rights Foundation of Turkey (HRFT), "Treatment and Rehabilitation Centres Report 2014", Ankara, May 2015, p. 45.
84. See Report to the Turkish Government on the visit to Turkey carried out by the CPT from 9 to 21 June 2013, CPT/Inf(2005)6, paragraphs 101-102.
85. See also Amnesty International's recent Urgent Action, "Protect Men from Further Ill-Treatment", 28 August 2015 (UA 187/15; Index: EUR 44/2328/2015 Turkey).
86. This may not come as a surprise, given that the Gendarmerie is a party to the Turkey-PKK conflict which has erupted anew this summer, following the breakdown of the peace process.

planning to set up a new unit which would replace the Gendarmerie as the entity responsible for the external security of prisons. This appears to be a welcome step. My position on the matter is clear: transfers to hospitals must always take place in conditions respecting the detainees' dignity, and the Gendarmerie should not be involved in such transfers. I also base this argument on credible accounts of delays in taking prisoners to hospital, due, at times, to a shortage of vehicles, but apparently also to deliberate obstruction by gendarmes. If gendarmes fail to take detainees to the hospital on time, the patients miss their appointments, which then have to be rescheduled. This causes potentially harmful interruptions or delays in treatment, and unjustifiably extends the suffering of detainees requiring medical care.

118. The problem of delays seems to also exist in the context of early release from prison on health grounds. Article 16(2) of the Law No. 5275 on the Execution of Sentences and Security Measures provides that the execution of a prison sentence may be suspended for persons who are "unable to maintain their life in a penal institution due to a severe illness or disability".

119. Unfortunately, the statistics I received from the parliamentary research division, the Institute of Forensic Medicine and the Ministry of Justice differed. According to the most comprehensive set of data (provided by the Ministry of Justice), between the entry into force of the latest amendment to Article 16 of Law No. 5275 on 31 January 2013 and the date of my visit, a total of 5 814 applications for suspension of sentence had been filed. 1 423 applications were currently pending, of which 1 068 petitioners were awaiting to be taken to the hospital to receive a medical report, and 345 were awaiting the final assessment by the Institute of Forensic Medicine. 691 persons were released (on other grounds) before a decision on their requests had been taken. Of the 3 700 decisions taken, 512 requests (or 14%) were granted, and 3 188 (86%) were denied.

120. On a more positive note, I learnt that the prison administration and Ministry of Justice can initiate the proceeding for suspension on health grounds *ex officio*. I can only encourage them to make wide use of this power. But pursuant to Article 16(3) of Law No. 5275, the decision on a request for suspension of a sentence is made by the Office of the Public Prosecutor. This, in my view, is problematic. Although an appeal may be filed with the office of the judge in charge of the execution of sentences, there may be a potential conflict of interest where the prosecutor who decides on petitions for early release forms part of the same hierarchy that asked for the imposition of a prison sentence at the trial stage.

121. The prosecutor's decision is largely based on a report issued by the Institute of Forensic Medicine or by the health committee of a fully equipped hospital designated by the Ministry of Justice and approved by the Institute of Forensic Medicine. Here again, there is potential for political bias and a lack of independence from the executive.

122. First, I am not convinced of the explanations given by my interlocutors as to the necessity of "monopolising" the forensic expertise at the Institute of Forensic Medicine in Istanbul.[87] The latter clearly plays a crucial role in the decision-making process: a Forensic Expertise Board evaluates all medical files in light of the questions asked by the public prosecutor, and comes up with an explicit conclusion as to the prisoner's eligibility for suspension of his or her sentence for the purposes of Article 16 of Law No. 5275. What makes this key role problematic is that the Institute of Forensic Medicine is an official organ of the Ministry of Justice. While my interlocutors stressed that the Institute's affiliation with the ministry was purely administrative, the Head of the Institute indicated that "the President, Vice-Presidents, the head and members of the Forensic Expertise Boards are appointed by … decree … signed by [the] Justice Minister, [the] Prime Minister and the President. The appointments of the Forensic Medicine Specialists and other technical personnel are done by the Ministry". This casts serious doubt on the Institute's independence.

123. Moreover, the process foreseen by law apparently leads to significant delays in the processing of requests for temporary release. Although the Institute of Forensic Medicine states that prisoners' case files are "handled immediately and the prisoner is accepted for an examination without appointment", it transpires from the case files that I have been able to examine that months may pass between the filing of a petition and the decision. When a prisoner needs to be examined in person at the Institute of Forensic Medicine, he or she will usually be taken to the Metris R-type prison in Istanbul. There, s/he may wait for weeks or months to be seen, because the Institute might request that additional medical files be provided. The resulting exchange of letters between the Institute, the Prosecutor General and the local hospital that drew up the initial report unnecessarily prolongs the process.

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87. The Head of the Institute noted that clinically trained physicians tended to lack the forensic expertise to assess whether a person's condition fell within the ambit of the relevant legal provisions. At the Ministry of Justice, I was told that local hospitals may be influenced by "criminal organisations" and therefore more inclined to request hospitalisation or a suspension of sentence.

124. NGO representatives also criticise the legislation as being predominantly security-oriented, rather than focused on compassionate considerations. The law provides that prisoners may only be released for illness or disability if they do not pose a security risk. Importantly, the relevant provision was amended in June 2014. Article 16 of the Law No. 5275 used to read as follows:

> *"the execution of sentences of prisoners who are unable to maintain their life in a penal institution due to a severe illness or disability and who do not pose a severe and substantial threat to public security shall be suspended until they recover."*

125. In its current version, the law stipulates that the sentences of these prisoners should be suspended unless they pose "*a severe and specific [or concrete] threat to public security*" (unofficial English translation; emphases added). Regrettably, however, whilst this formulation at first glance seems to be an improvement capable of reducing the risk of arbitrariness, it appears to have little practical impact on the prosecutors' decision making.

126. What struck me most was the poor reasoning in some of the prosecutors' decisions, sometimes against favourable reports from the Institute of Forensic Medicine. Some claims that the person, if released, would pose a threat to public security were not substantiated at all. In other cases, reference was made to a presumed risk that the person, even though not posing a threat him- or herself, could be used as a "tool for propaganda" if released. I would argue that such a line of argument makes it *de facto* impossible for any prisoner having been convicted on account of affiliation with the PKK to ever be released on health grounds. Turkey should abandon this discriminatory criterion and release all prisoners who are eligible for release on medical grounds, whilst imposing whatever conditions may be needed to avoid reoffending.

5.4. Conclusions of my fact-finding missions

127. The magnitude of the challenges to detainees' effective enjoyment of their health rights varies across the three countries I visited. At the same time, as anticipated, some of my findings from my country visits enable more general lessons to be learned, as well as recommendations to be addressed to several, if not all, Council of Europe member States.

128. In all three countries that I visited, further improvements are needed to ensure compliance with the United Nations Standard Minimum Rules for the Treatment of Prisoners, which require that "where hospital facilities are provided in an institution, their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitably trained officers". I also wish to draw attention to the Council of Europe's manual for health-care workers and other prison staff with responsibility for prisoners' well-being,[88] which contains good practices, highlights important ethical standards, and proposes responses to ethical dilemmas related to access to a doctor, equivalence of care, patients' consent and confidentiality, preventive health care, and professional independence and competence. Moreover, I believe that all three countries, and probably most other Council of Europe member States, would do well to reinforce the co-operation between prison medical services and outside hospitals. This would also bring national practice better into line with paragraph 40(1) of the European Prison Rules, which sets out that "[m]edical services in prison shall be organised in close relation with the general health administration of the community or nation".

129. I was pleased to learn that all three countries that I visited, alongside other Council of Europe member States, provide for a temporary stay of prison sentences to obtain medical treatment. Where the time spent in an outside hospital is not counted to the detainee's served time, States should seek ways to ensure that the law does not dissuade persons in detention from seeking the treatment they need. Delays in access to medical examinations, treatment and hospital transfers must be avoided.

6. Conclusion

130. Widespread reports of human rights abuses in detention centres have drawn attention to the problems and lack of solutions faced by particularly vulnerable factions of society: critically ill and elderly detainees. Doing nothing will only lead to continued abuses and some detainees may continue to find themselves at the mercy of a domestic prison system that does not account for their medical needs and does not allow any realistic possibility for early release. It is the duty of the Council of Europe to ensure that all its member States comply with the most basic of human rights protections. The Council of Europe must seize this opportunity to

88. Andres Lehtmets and Jörg Pont, "Prison health care and medical ethics. A manual for health-care workers and other prison staff with responsibility for prisoners' well-being" (Strasbourg: Council of Europe, November 2014).

draw attention to the fact that even though the CPT and the Committee of Ministers have issued various recommendations concerning a detainee's access to medical care and early release procedures, these rights are still not being adequately met in many cases.

131. The detainee population is aging, as is the general population. Member States must recognise the aging trend of their detainee populations, and examine and modify current accommodations to make their detention as comfortable as possible. They should also examine their domestic laws to ensure that they contain adequate remedies, such as broad provisions for early release. Better conditions for ill and elderly detainees are necessary from both a legal and a humanitarian standpoint.

132. No human being should perish in detention, but trends in Europe show that more people die behind bars now than have in past years.[89] The Council of Europe must ask of its member States that laws and policies be examined in order to make changes that will allow for every human being to die with dignity, not chained to a bed while in detention. The Assembly must ask all Council of Europe member States to address this dire situation urgently and effectively.

89. The most recent report of the Council of Europe Annual Penal Statistics indicates that from 2010 to 2012, the mortality rate in prisons rose from 25 deaths per 10 000 inmates to 28 deaths per 10 000 inmates.

Appendix – Questionnaire sent to national delegations via the European Centre for Parliamentary Research and Documentation (ECPRD) on 30 April 2015

1. What are the legal eligibility criteria for the (temporary) release, on compassionate grounds, of:

    1.1. terminally ill detainees (i.e. detainees who are the subject of a short-term fatal prognosis);

    1.2. detainees suffering from a severe illness requiring treatment outside of the place of detention;

    1.3. detainees of advanced age?

2. Which authorities decide on releases, on compassionate grounds, of persons belonging to the above categories, and following which procedures?

3. Is there a possibility of judicial review?

4. Please provide the most up-to-date statistics – if possible broken down by age, gender and ethnic origin – relating to:

    4.1. the percentage of requests for compassionate release granted in respect of:

        4.1.1. terminally ill detainees (i.e. detainees who are the subject of a short-term fatal prognosis);

        4.1.2. detainees suffering from a severe illness requiring treatment outside of the place of detention;

        4.1.3. detainees of advanced age;

    4.2. the illness and life expectancy of terminally ill detainees released on medical grounds;

    4.3. the remaining length of the sentence of those found eligible for compassionate release, the type of offence(s) for which they had been found guilty, as well as the time served prior to release;

    4.4. the average duration of the decision-making process;

    4.5. the number of persons eligible for compassionate (medical) release on grounds of terminal illness or advanced age who died pending the examination of their application for release.