



Incident management and independent investigations

Addressing risk factors to prevent torture and ill-treatment

“ Where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in detention, strong presumptions of fact will arise in respect of injuries and death occurring during that detention. Indeed, the burden of proof [in such cases] may be regarded as resting on the authorities to provide a satisfactory and convincing explanation.¹ ”

(European Court of Human Rights)

1. Introduction and context

Deaths or serious injuries of persons in custody, disappearances of individuals, and allegations of torture and other forms of ill-treatment by detainees or indications that a detainee might have been subjected to ill-treatment can be summarised as ‘**serious incidents**’ in custody,² which can have a variety of different causes. While this factsheet focuses on prisons, some of the guidance is equally applicable for monitoring bodies in addressing serious incidents in other detention settings, such as police custody and immigration detention facilities.

A prisoner can die from so-called ‘natural causes’ such as illness or old age. There can also be deaths or serious injuries due to suicide or suicide attempts, prison staff violence (including torture), sexual abuse (including rape), inter-prisoner violence, legitimate or excessive use of force by prison staff, self-harm, inadequate medical care, drug overdoses, or sports or work-related accidents. Deaths or serious injuries in custody can therefore occur due to accidents, for which nobody bears any responsibility, or on the other hand they can be due to negligence or lack of care, or they can be directly caused by another person, including prison staff.

All these serious incidents could constitute a violation of one or more of the **most fundamental human rights**, in particular the right to life and the prohibition

of torture and other forms of ill-treatment, as well as the right not to be arbitrarily detained. There is therefore a responsibility on the State to account for any death, injury or disappearance of persons it detains, regardless of how the incident occurred.

International standards consequently require that each serious incident in custody triggers and is followed up by a number of measures, with the aim of clarifying the facts and establishing, where applicable, **State and/or individual responsibility** for the harm suffered, and to prevent as far as possible such incidents in the future.

“ The credibility of the prohibition of torture and other forms of ill-treatment is undermined each time officials responsible for such offences are not held to account for their actions. If the emergence of information indicative of ill-treatment is not followed by a prompt and effective response, those minded to ill-treat persons deprived of their liberty will quickly come to believe – and with very good reason – that they can do so with impunity.³ ”

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

In particular, State authorities are obliged to carry out an **independent, impartial, prompt and effective investigation** into the circumstances and causes of any serious incident; to provide **reparation and redress** to victims and/or their families, including adequate financial compensation and provision of medical care and rehabilitation; and to hold to account individual perpetrators of unlawful killings or serious bodily harm, ill-treatment or disappearances.

The revised UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)⁴ introduce in Rule 71 an explicit obligation of prison directors to report the following incidents to a judicial or other competent authority that is independent of the prison administration and mandated to conduct prompt, impartial and effective investigations into such cases:

- any custodial death, disappearance or serious injury
- any complaint or indication of torture or other cruel, inhuman or degrading treatment or punishment

The UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) include additional guidance on providing support for women who, in the course of a medical screening, are found to have been a victim of violence, including sexual abuse – whether before or during custody⁵ – as well as women who complain of any form of abuse.⁶

State authorities do not only have the responsibility to react adequately after a death, serious injury or similar has happened, but are also under a **positive obligation to prevent** by various measures the occurrence of avoidable death or injury, torture or ill-treatment, and disappearances in custody.⁷ These responsibilities extend to private companies in cases where custodial duties are outsourced by the State.

While torture and enforced disappearances are legally defined in international human rights Conventions,⁸ other forms of cruel, inhuman or degrading treatment or punishment, serious injuries or custodial deaths lack standardised definitions.

Certain groups in detention are more at risk of being subjected to torture, other forms of ill-treatment and/or inter-prisoner violence. These include, among others, women, children, lesbian, gay, bisexual, transgender and intersex (LGBTI) prisoners, members of minority groups or persons with disabilities. In self-governed prisons where prison facilities (or part of them) are under the control of groups of detainees and/or gangs, there are high rates of violence among prisoners (in particular vulnerable persons), leading to serious injuries, ill-treatment and deaths.⁹

This factsheet is intended to give guidance to monitoring bodies in assessing whether the prison authorities have fulfilled all the obligations that arise in cases of serious incidents, i.e. primarily recording and reporting these cases in a timely manner, preserving evidence, and cooperating with the investigation. In addition, the basic elements of an effective investigation are summarised.

2. What are the main standards?

The obligation to carry out effective investigations into the death or serious injuries of persons in State custody, as well as into any allegations or other indications of torture or ill-treatment, is an integral part of the **right to life** and the **prohibition of torture** and other cruel, inhuman or degrading treatment or punishment, as enshrined in international and regional human rights treaties, including the International Covenant on Civil and Political Rights.¹⁰

Moreover, the UN Convention against Torture and other international instruments contain explicit regulations on the responsibility of State parties to **promptly and impartially investigate** any complaint or reasonable grounds for believing that an individual has been subjected to torture¹¹ or to enforced disappearance.¹²

To ensure compliance with the obligation to carry out effective investigations, certain legal and practical **prerequisites** have to be in place. In particular:

- persons in custody, as well as their family members, must have unrestricted access to internal and external independent complaints mechanisms,¹³ as well as to legal advice¹⁴
- prison staff, and in particular medical professionals working in prisons, must be alert to signals of possible ill-treatment¹⁵
- a complaint of torture or disappearance or any death or serious injury in custody must be recorded¹⁶
- detected injuries must be accurately documented and any other evidence preserved¹⁷
- the competent authorities must be notified promptly¹⁸
- safeguards against reprisals must be in place¹⁹

The investigations into such serious incidents in custody should be carried out by a body that is independent of the authorities that are possibly implicated in the death, injury, ill-treatment or disappearance. Further, the investigations have to be promptly commenced and carried out with expedience, and the authority must possess the necessary competences and resources to carry out an effective investigation and investigate each case thoroughly. Finally, victims have a right to be involved in the investigations.²⁰

Main references

- International Covenant on Civil and Political Rights, Articles 2 (2) and (3), 6 (1), 7, 9 and 10 (1)
- UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Articles 1, 4, 12, 13 and 16
- International Convention for the Protection of All Persons from Enforced Disappearance, Articles 2, 3 and 12
- UN Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions
- UN Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol)
- UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), Rules 7–8, 30–31, 34, 54, 56–57, 68–69, 71–72
- UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), Rules 6–7, 25
- Inter-American Convention to Prevent and Punish Torture, Article 8
- UN Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules), paras. 20–22, 24, 50, 56–57, 75–78
- UN Revised Minnesota Protocol on the Investigation of Potentially Unlawful Death
- Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa (the Luanda Guidelines), part V
- Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas, Principle XXIII
- Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa (the Robben Island Guidelines),²¹ provisions 18–19, 49–50
- Guidelines of the Committee of Ministers of the Council of Europe on eradicating impunity for serious human rights violations
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Combating Impunity, 14th General Report, 2004; and Documenting and Reporting Medical Evidence of Ill-Treatment, 23rd General Report, 2013

3. Types and situations of risk

Deaths in custody

‘Death in custody’ refers (as a minimum)²² to: any death of a person deprived of their liberty, whether in prison, a pre-trial or immigration detention facility, police custody, prison hospital or other place of detention, or during transport to or between such places; a death of a detainee in the course of an attempted escape; any death of a person deprived of their liberty transferred to a civil hospital before dying; or of a person previously deprived of their liberty who was released from custody shortly before dying.²³

The reasons for a death in custody can be manifold, and many deaths may not involve any State or individual responsibility. Nevertheless, **all deaths in custody must be registered and reported** to the competent authorities,²⁴ including deaths that appear to have happened due to natural causes or suicide.²⁵ It is important to identify deaths caused by neglect or omission in order to prevent any concealment of ill-treatment or another crime, to determine if the death could have been avoided, to identify systemic failings, and to prevent comparable situations from emerging in the future.

Every prison system should have a **regulation** in place outlining the necessary steps if an apparent death (where there are no signs of life) is discovered in a prison. These steps could comprise, for instance, the obligation to call emergency services, to stay with the casualty, or to attempt resuscitation until a healthcare professional arrives. Further, the securing of the cell or other place where a casualty was found as a possible crime scene should be regulated to ensure any evidence is preserved, as required by Rule 71 of the Nelson Mandela Rules.

[The Department of Corrective Services of Western Australia has a comprehensive policy directive in place on the procedures to follow in case of a death in custody. This directive includes a checklist intended as a guide to assist prison staff with their duties and required actions in the event of a death in custody.](#)²⁶

An **incident report** should be completed with the input of all staff members involved and an entry should be made in the prisoner file management system (which could be a journal on serious incidents or an electronic database).²⁷ All documentation pertaining to the deceased detainee, including medical files, should be retained and other potential evidence, such as CCTV

footage, must be preserved.²⁸ Depending on the national regulations, the prison management will have to inform relevant bodies within the prison administration of the incident.

In line with Rule 71 of the Mandela Rules, the prison director must also **inform without delay** a ‘judicial or other competent authority that is independent of the prison administration’. The exact authority will vary from country to country, but typically such authorities comprise the criminal police, the office of the prosecutor, investigative judges, the coroner, prison ombudsmen, and/or other independent investigative mechanisms. It is the responsibility of the relevant authority to decide on the next investigative steps. Whenever a person dies in prison (or soon after transfer from prison), an autopsy should be carried out; there may be highly exceptional cases in which, as prescribed by law, an independent authority may decide that an autopsy is not required.²⁹

Prison authorities are obliged to fully **cooperate** with the investigation, by, inter alia, providing all the names of prisoners and staff members who might have witnessed the events that led to the death of the individual or who might hold other pertinent information.³⁰

Clear rules should also be in place on informing the **next of kin** of the death of their relative,³¹ as well as on the return of the body upon completion of the investigation.³²

In Panama, the Ministry of Government has put in place a Protocol regarding deaths in custody. This Protocol outlines processes for notifying penitentiary and judicial authorities as well as family members. The Protocol also defines the procedures for initiating administrative and criminal investigations into any death in custody.³³

While an independent external investigation of any death in custody is indispensable, an **internal investigation** by prison authorities into any death in custody should also take place. The aim of an internal investigation is to establish whether structural or individual shortcomings have led to an avoidable death, and to learn important lessons which should be implemented to prevent future deaths.³⁴

The task of external independent investigation bodies is two-fold. Firstly, to determine any **individual responsibility** for the death of the person concerned, including through omission or negligence. Secondly, investigations of deaths in custody should establish whether there is wider-reaching **State responsibility**. The State has a duty of care vis-à-vis those it holds in custody, which includes the provision of adequate medical care and personal security.³⁵ Deaths in prison directly or indirectly caused by inadequate staffing levels, lack of medical care or necessary medical equipment, absence of suicide prevention programmes, etc., may be attributable to the State.³⁶

Following a recommendation by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the Director General of the Irish Prison Service improved the structures and methods of dealing with all deaths in custody. In addition to an investigation by An Garda Síochána [the police], the Coroner's investigation and inquest and an independent investigation by the Inspector of Prisons, every death in custody, including those arising from natural causes and suicide, was made the subject of an internal review and assessment of the circumstances of the death, to determine accountability and any lessons learned, both in the prison concerned and across the prison system generally.³⁷

➔ What could monitoring bodies check?

- Have all cases of death in custody been recorded within individual prison file management systems and also centrally?
- Is a regulation in place, compliant with international standards, guiding the prison staff regarding their duties and required actions in case of a death in custody? Are the prison administration and staff aware of and trained on the regulation?
- Has the prison administration reported without delay all cases of death in custody to the relevant internal and external authorities?
- Has an independent authority undertaken an investigation into every death in custody in line with international standards?
- Has the prison administration secured evidence and cooperated with the investigative authorities?
- Have the next of kin of the deceased person been adequately informed, without delay, in every case where there is a death in custody?
- Is an internal procedure in place to identify lessons learned after every death?
- Have lessons learned been translated into reforms to address the shortcomings identified?
- Are measures in place to prevent avoidable deaths, such as a comprehensive suicide prevention programme?
- Is statistical data on death in custody used to identify possible structural deficiencies leading to a higher risk of death in custody? Is such data disaggregated to allow for analysis of discrimination for specific categories of prisoners?

In April 2016, a 38-year-old inmate of Milwaukee County Jail, Wisconsin, died of dehydration because water to his cell was shut off for seven days as a punishment. Prosecutors not only charged the two officers who were said to be directly responsible, but also the former director of the facility for failing to preserve a surveillance video and lying to the police; if convicted, she could face more than four years in prison.³⁸

Serious injuries in custody

International instruments do not conclusively define the types of injuries that can be regarded as constituting 'serious injuries'. National norms on 'serious bodily harm' or similar provisions³⁹ can provide guidance for decisions on which injuries fall into this category. Typically, the loss of limbs, fractures, injuries to inner organs and crushes, burns or severe cuts that require hospitalisation are regarded as being serious. Additionally, injuries sustained through rape and other sexual violence can be considered to constitute serious injuries.⁴⁰

Prison staff are obliged to administer **first aid** and organise urgent medical care for the injured person, e.g. by calling an ambulance. At all times, including at night time and during weekends, an adequate number of staff trained in administering first aid should be present in the detention facility.⁴¹

If a serious injury is detected, similar **recording and reporting obligations** apply as outlined above in cases of death; any evidence must be secured and witnesses to the event identified and protected. Serious injuries could be indicative of ill-treatment or of a criminal act by another prisoner or non-State party (e.g. a service provider in prison) and must therefore trigger a prompt and independent investigation. As with deaths in prison, the occurrence of serious injuries should be scrutinised with a view to preventing them in the future.

→ What could monitoring bodies check?

- Are there guarantees that a sufficient number of staff members trained in first aid are present on the premises at all times?
- Have all persons who suffered a serious injury in prison received urgent medical care?
- Have all cases of serious injuries in custody been registered within individual prisons and in a centralised manner?
- Is a regulation in place guiding the prison staff regarding their duties and required actions in case of a serious injury in custody? Are the prison administration and staff aware of and trained on the regulation?
- Has the prison administration reported without delay all cases of serious injuries in custody to the relevant internal and external authorities?

- Has an independent authority undertaken an investigation into every serious injury in custody in line with international standards?
- Has the prison administration secured evidence and cooperated with the investigative authorities?
- Is an internal procedure in place to identify lessons learned after every serious injury?
- Have lessons learned been translated into reforms to address the shortcomings identified?
- Are measures in place to prevent avoidable injuries?
- Is statistical data on serious injury in custody used to identify possible structural deficiencies leading to a higher risk of injuries in custody?

Indications of torture and other ill-treatment

Certain physical injuries, such as marks and bruises that do not necessarily qualify as 'serious' injuries, could nevertheless be **indicative of torture or ill-treatment** and should be documented and reported to the relevant investigative authorities, even in the absence of an official complaint. For instance, bruising to the soles of the feet or so-called 'tram-line' bruises (i.e. parallel linear bruises) may constitute typical signs of torture, as they may be the result of beatings with a baton or similarly shaped object (or 'falanga').⁴² Also, non-physical symptoms, such as significant changes in the demeanour or complete withdrawal of a detainee,⁴³ should be scrutinised with a view to establishing the cause of the behavioural changes.

In order to detect possible indications of torture or ill-treatment and violence by other prisoners, it is necessary that all prison staff are sensitised and adequately trained.

Similarly, **prison healthcare staff**, including psychologists and social workers, should be trained to detect ill-treatment in prison and in the use of the Istanbul Protocol. Prison healthcare services can also play an important role in reducing ill-treatment and torture by the police. Any person transferred to a prison or pre-trial detention facility should be seen by a qualified medical professional within the shortest possible time (i.e. within 24 hours) after admission.⁴⁴ This **initial medical screening** should include a full visual examination of the body of the person. It is vital that these examinations take place in full compliance with medical confidentiality, without the presence of non-medical staff;⁴⁵ moreover, women prisoners should be entitled to request that they be examined by women healthcare staff, and if this is not possible there must be a woman present.⁴⁶

Additionally, detainees should be routinely presented to a member of the medical staff **after incidents of inter-prisoner violence**, including, in particular, indications of sexual abuse, **or any use of force** by staff.⁴⁷ Such a practice is not only important for the early detection of ill-treatment, but also to provide timely

psychological support for victims. In particular, victims of gender-based violence and sexual abuse are likely to experience extreme and prolonged psychological damage, which can be exacerbated by concerns over a possible pregnancy or sexually transmitted disease.

Indications of ill-treatment should be **accurately documented**, with a detailed description of injuries, in line with the Istanbul Protocol.⁴⁸ Medical staff should use body charts to indicate the exact location of any injury or mark, and should additionally take photographs of the injuries, if possible. Any statement made by the person as to the origins of the injuries should be noted down, and the medical professional carrying out the examination should indicate whether these explanations could be consistent with the objective medical findings.⁴⁹ It is also good practice for prison healthcare staff to keep a dedicated register of traumatic lesions, often referred to as a 'trauma register', which can, inter alia, help to provide an overview of the prevalence of inter-prisoner violence.

Commonly, prison healthcare services in Europe keep some kind of register on traumatic lesions of prisoners. For example, in 2012, Greece introduced specific registers for injuries and incidents of ill-treatment in all prisons.⁵⁰

If staff reasonably believe that injuries or other signs are indicative of torture or ill-treatment, they should automatically **report** their findings to the competent medical, administrative or judicial authority,⁵¹ regardless of an official complaint or allegation.⁵² However, in respect to women prisoners who have been subjected to sexual abuse or other forms of violence before or during detention, the Bangkok Rules make an important exception to the automatic reporting requirement, thereby recognising that in some circumstances women may not wish to take legal action against the perpetrator(s).⁵³

Healthcare professionals working in prisons should be specifically trained in order to gain the necessary competence in the documentation and interpretation of injuries, as well as to ensure full knowledge of the reporting obligation and procedure.⁵⁴

➔ What could monitoring bodies check?

- Are comprehensive medical screenings, including for signs of ill-treatment, undertaken by a medical professional within 24 hours of the arrival of all prisoners?
- Are persons who have been involved in inter-prisoner violence, or who have experienced the use of force by prison staff, routinely presented to a member of the medical staff? Are measures subsequently taken to prevent future incidents?

- Are medical examinations conducted in line with international standards – including maintaining full confidentiality and, in the case of female prisoners, by female healthcare staff?
- Is a regulation in place outlining the precepts of documenting and reporting injuries?
- Is a trauma register in place?
- Have physical injuries of detainees been accurately documented?
- Do healthcare professionals working in prisons have body charts and photo cameras at their disposal for the proper documentation of ill-treatment/injuries?
- Are medical professionals working in prison specifically trained in documenting injuries and in the procedures to follow in case of an injury indicative of ill-treatment?
- Have detected injuries that are indicative of ill-treatment been promptly reported to the relevant authorities, if necessary with the consent of the alleged victim?

Allegations of ill-treatment

A **functioning complaints system** is an important prerequisite for effective investigations into allegations of ill-treatment. Upon arrival at a detention facility, prisoners should be informed of the various existing avenues of complaint and the procedures to approach these bodies.⁵⁵ A variety of mechanisms should be in place to receive prisoners' requests and complaints about any aspect of their treatment and the conditions of their detention.

Persons in custody should be enabled to personally approach the director of the facility or their representatives on a regular basis, as well as to complain to the higher prison authorities and ministry responsible for the prison system.⁵⁶ Additionally, they should have unrestricted access to independent external bodies, such as national human rights or ombudsman institutions, National Preventive Mechanisms, judicial authorities and others.⁵⁷

The Imprisonment Code of Georgia stipulates that all prisoners can request the provision of items necessary for filing a complaint, as well as support for matters such as identifying the correct addressee or access to interpreters, free of charge. In 2015, Georgia's Ombudsperson reported that 90 per cent of prisoners had access to envelopes, paper, pens and a complaints box.⁵⁸

In order to **prevent possible reprisals** against persons who make a complaint or allege ill-treatment, the confidentiality of complaints against prison staff should be safeguarded.⁵⁹ This could be achieved by means of personal meetings between prisoners and the director, or between prisoners and higher prison authorities or prison inspectors and monitors; sealed complaints boxes that can only be opened by the director or external complaints bodies; and the possibility of uncensored correspondence with certain institutions.

Any internal complaint that reaches the director or higher administration of a prison should be recorded and followed up. Priority should be given to any complaint alleging torture or ill-treatment.⁶⁰ Denunciations of criminal behaviour, such as acts of torture or other forms of more severe ill-treatment,⁶¹ should be forwarded without delay to the authorities responsible for criminal investigations, such as the criminal police, the prosecutor's office or a judicial authority, and, depending on the national system, to other independent bodies. Even if the alleged ill-treatment falls below the threshold of criminal behaviour, such as in cases of insulting or disrespectful behaviour by prison staff that could amount to degrading treatment, an investigation by an authority independent of the prison should be triggered.⁶²

→ What could monitoring bodies check?

- Can prisoners directly and personally approach the director of the facility or their representatives?
- Do prisoners have access to the higher prison administration, as well as to independent external authorities?
- Are prisoners informed, both upon admission and routinely after, of the available internal and external avenues of complaint, and the procedures to lodge a complaint?
- Do prisoners have access to items necessary for lodging a complaint?
- Is the confidentiality of complaints safeguarded?
- Are all internal complaints recorded and responded to?
- Are all internal complaints containing allegations of torture or ill-treatment promptly forwarded to an independent investigative authority?

Disappearances

An enforced disappearance is a crime under international law,⁶³ which typically **combines a number of serious human rights violations**, such as arbitrary arrest and detention and the torture and/or killing of the victim. Additionally, it has been acknowledged that the disappearance of a person causes severe anguish to family members, which may constitute a human rights violation in itself.⁶⁴

'Enforced disappearance' is considered to be the arrest, detention, abduction or any other form of deprivation of liberty by agents of the State or by persons or groups of persons acting with the authorisation, support or acquiescence of the State, followed by a refusal to acknowledge the deprivation of liberty or by concealment of the fate or whereabouts of the disappeared person, which place such a person outside the protection of the law. (Article 2 CED).

Not every person who goes missing is necessarily a victim of an enforced disappearance; however, it is upon the State to account for every person that the authorities have taken into custody,⁶⁵ and to provide an explanation with regard to their whereabouts. Therefore, if there are allegations or other serious grounds to believe that a person has disappeared, an independent investigation into their fate has to be carried out.⁶⁶

There are specific **measures to prevent** the disappearance of persons who are in State custody. In particular, persons deprived of liberty should only be held in officially recognised places of detention and should have regular access to the outside world (such as family visits, communication with legal representatives, phone calls, correspondence, etc.). So-called 'incommunicado detention', during which a detained person is denied any contact with family members, lawyers and other persons outside the prison, should be abolished or kept to an absolute minimum, with strict safeguards in place.⁶⁷

Record-keeping is another key measure to prevent disappearances. Prison and other authorities responsible for custody should compile and maintain up-to-date official records (electronic databases or registers) of persons deprived of liberty.

The International Convention for the Protection of All Persons from Enforced Disappearance and the Nelson Mandela Rules outline that prisoner files should, inter alia, include:

- precise information on the identity of the person
- the date, time and place of arrest and the arresting authority that deprived the person of liberty
- the grounds for the deprivation of liberty
- the date and time of admission to the place of deprivation of liberty
- the date and time of release or transfer to another place of detention, the destination and the authority responsible for the transfer⁶⁸

→ What could monitoring bodies check?

- Have prison authorities documented and reported every case of disappearance to an independent investigation authority?
- Have independent investigations been carried out into the whereabouts of disappeared persons?
- Are persons held only in officially recognised places of detention?
- Do all detainees have regular contact with the outside world, with conditions that comply with international standards?
- Is 'incommunicado detention' abolished in law and practice? If not, are safeguards in place to prevent serious human rights violations during incommunicado detention?
- Do places of detention keep official records with the required comprehensive information on all persons deprived of liberty?

Effective investigations

The effectiveness of an investigation into a death or serious injury in custody, or a disappearance or complaint of torture or ill-treatment, depends on whether a number of elements are met.

The main criteria for assessing the effectiveness of an investigation are:

- Independence and impartiality
- Promptness and expedience
- Thoroughness and competences
- Victim involvement and public scrutiny

The investigating body must be **institutionally independent** from the authority implicated in the facts under investigation.⁶⁹ Moreover, all decision makers within the investigation must be **procedurally and personally independent** from individuals implicated in the facts being investigated, including experts assigned to particular investigative steps (e.g. forensic doctors). The element of impartiality implies that investigators must objectively assess all the evidence before them, not apply double standards when it comes to witness statements (e.g. by lending more credibility to prison staff than to other witnesses, such as prisoners), and make a genuine attempt to clarify contradicting evidence.⁷⁰

Due to the fact that medical evidence of ill-treatment, including sexual abuse and rape, often disappears after a short time, it is important that the investigations commence **promptly**. Similarly, the reliability of witnesses' memories deteriorates over time, and perpetrators can more easily fabricate a story if there is a gap between the incident and the investigation. Delays of several days have been found to be inconsistent with the requirement of promptness.⁷¹ Any legal proceedings against alleged perpetrators and/or regarding reparation claims must be reasonably **expedient**.⁷²

The investigating body must possess the full range of investigatory **competences**, such as the power to order an autopsy and the power to identify alleged perpetrators and to oblige them to appear and testify. As to the **thoroughness** of an investigation, instruments such as the Istanbul Protocol and the Minnesota Protocol give detailed guidelines on how to properly conduct an investigation into a death or a case of ill-treatment or disappearance.

Finally, alleged **victims** and their families should be **involved** in investigative procedures to the extent necessary to safeguard their legitimate interests. They should be entitled to request specific steps to be taken and be regularly informed as to the progress of investigations and all relevant decisions made.⁷³ In general, investigations should be conducted in a transparent manner and allow for **public scrutiny**.⁷⁴

→ What could monitoring bodies check?

- Are investigations into serious incidents in custody carried out independently, impartially, promptly, expediently, and thoroughly?
- Are the victims and/or their families involved in the investigations?
- Is the general public adequately informed of the findings of investigations?
- Are the findings of investigations fed back to the prison system with a view to identifying systematic shortcomings?

Protection against reprisals

When serious incidents occur in custody – whatever the circumstances – victims and their families, as well as witnesses to the events, have to be protected against any form of reprisal or intimidation.⁷⁵

The Nelson Mandela Rules refer to the protection of potential victims and witnesses in Rule 34, stipulating that, upon detecting signs of torture or ill-treatment of a detainee, proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm. Rule 57(2) requires that complainants must not be exposed to any risk of retaliation, intimidation or other negative consequences as a result of having submitted a request or complaint; and Rule 71(3) requires that in cases of death or serious injury in custody, or allegations or other indications of torture or ill-treatment or disappearance, steps are to be taken immediately to ensure that all potentially implicated persons have no contact with the witnesses, the victim or the victim's family.

Rule 25 of the Bangkok Rules stipulates that women who report abuse shall be provided immediate protection, and that protection measures shall take into account specifically the risks of retaliation.

Victim and witness protection measures could include a transfer of the person in question to another place of detention if necessary.⁷⁶ There should also be rules on mandatory investigations of indications of reprisals, a procedural obligation to scrutinise the motives behind a withdrawal of a complaint, and in the case of staff, removal from direct contact with detainees and consideration of a leave of absence or suspension of alleged perpetrators while the investigation is taking place. Segregation of the victim for protection should be only used as a measure of last resort and should be for the shortest time possible.⁷⁷

→ What could monitoring bodies check?

- Are legal regulations in place to protect victims and witnesses against reprisals and intimidation?
- Have detainees who were victims or witnesses of serious incidents de facto been protected against reprisals and intimidation?
- Have protective measures involving segregation of the victim been used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review?

4. What can monitoring bodies do?

Unless explicitly mandated to do so, monitoring bodies are usually not directly involved in the investigations of serious incidents. Nevertheless, they can play a vital role regarding many different aspects of the management and investigation of serious incidents in custody.

Monitoring bodies can influence the legal framework in place that regulates the institutional setup of independent investigative bodies, as well as the procedures for investigations into serious incidents. Moreover, they can ensure that the prison system has procedures in place for the management of and response to serious incidents.

Through preventive monitoring, National Preventive Mechanisms in particular can assess individual cases to identify systemic issues leading to serious incidents in a given prison or wider prison system. They can scrutinise actions taken by prison administration and staff in the immediate aftermath of a serious incident, as well as at a later period, including during any investigation. Furthermore, monitoring bodies should check whether adequate preventive measures and policies are in place and sufficiently known about by prison staff. Monitoring bodies can follow the investigations conducted and assess whether prison administrations cooperated in line with international standards and whether the elements for an effective investigation were met.

Monitoring bodies should regularly assess the implementation of recommendations made by any investigatory body. Many bodies, including National Preventive Mechanisms, monitor different detention settings and therefore can identify cross-cutting lessons or good practices which can be replicated.

Monitoring bodies can contribute to the protection of victims and witnesses in detention against reprisals by assessing policies and practices in place for this. They can also conduct regular and confidential follow-up visits to prisoners at risk.

Finally, monitoring bodies should be part of assessments on the lessons learned in cases of serious incidents in custody. Certainly, it is one of the main tasks of any monitoring body to make recommendations on structural changes to the prison system, which aim at preventing disappearances, torture or ill-treatment and avoiding deaths or serious injuries.

Endnotes

1. European Court of Human Rights (ECtHR), *Salman vs. Turkey*, Application no. 21986/93, judgment of 27 June 2000, para. 100.
2. Other serious incidents in custody, which are not covered by this factsheet, are for example prison riots, the taking of hostages, escapes or mass hunger strikes.
3. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 14th General Report, 2004, CPT/Inf(2004)28, para. 25.
4. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), UN General Assembly Resolution 70/175, 8 January 2016.
5. United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), UN General Assembly Resolution 65/229, 21 December 2010, Rule 7.
6. Rule 25, the Bangkok Rules.
7. United Nations Human Rights Committee General Comments no. 20, A/44/40, 10 March 1992, para. 8; and no. 31, CCPR/C/21/Rev.1/Add. 13, 26 May 2004, paras. 7 and 17; United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), Arts. 2 (1) and 16; International Convention for the Protection of All Persons from Enforced Disappearance (CED), Arts. 22 and 23; Inter-American Court of Human Rights, *Velásquez Rodríguez vs. Honduras*, Inter-Am. Ct. H.R. (Ser. C) No. 4 (1988), judgment of July 29, 1988, paras. 166–175.
8. Article 1, CAT; and Article 2, CED.
9. Henrique Apolinario, 'In Brazil, prison riots and killings expose the structural failures of mass incarceration', *PRI Blog*, 28 March 2018, www.penalreform.org/blog/prison-rioting-and-deaths-in-brazil/.
10. Arts. 3 and 5 Universal Declaration of Human Rights (UDHR), Arts. 6 and 7 International Covenant on Civil and Political Rights (CCPR), Arts. 4 and 5 African Charter on Human and Peoples' Rights (AfCHPR), Arts. 4 and 5 American Convention on Human Rights (ACHR), and Arts. 2 and 3 European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR).
11. Articles 12 and 13, CAT.
12. Article 12, CED.
13. Rule 56, the Nelson Mandela Rules.
14. Rule 61, the Nelson Mandela Rules; United Nations Rules for the Protection of Juveniles Deprived of their Liberty, General Assembly resolution 45/113, 14 December 1990 (the Havana Rules), para. 78.
15. Rules 30 (b) and 34, the Nelson Mandela Rules; Rule 6 (e), the Bangkok Rules; the Havana Rules, para. 50; CPT, Documenting and Reporting Medical Evidence of Ill-Treatment, 23rd General Report, 2013, CPT/Inf(2013)29, para. 82.
16. Rules 7 and 8, the Nelson Mandela Rules.
17. Office of the United Nations High Commissioner for Human Rights, Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Istanbul Protocol), HR/P/PT/8/Rev.1, 2004; Rule 34, the Nelson Mandela Rules.
18. Rule 71, the Nelson Mandela Rules.
19. Rule 57 (2), the Nelson Mandela Rules.
20. Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, UN General Assembly Resolution 55/89, 4 December 2000; Guidelines of the Committee of Ministers of the Council of Europe on eradicating impunity for serious human rights violations, 30 March 2011.
21. Resolution on the Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa (the Robben Island Guidelines), 32nd Session, Banjul, The Gambia, October 2002.
22. It is possible to conceive that, in addition to detainees, deaths of prison staff members or visitors in prisons constitute a 'death in custody'.
23. Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, General Assembly resolution 43/173, 9 December 1988, Principle 34; the Havana Rules, para. 57; compare also the mandate of the UK Prisons and Probations Ombudsman, who can also investigate the death of someone who has recently been released from custody.
24. Rules 8 and 71, the Nelson Mandela Rules.
25. Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016) – The Revised United Nations Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions, paras. 2 and 17.
26. Government of Western Australia, Department of Corrective Services, Policy Directive no. 30, Death of a Prisoner – Procedures, www.correctiveservices.wa.gov.au/files/prisons/adult-custodial-rules/policy-directives/pd-30-procedures.pdf.
27. Rule 8(f), the Nelson Mandela Rules.
28. Rule 71, the Nelson Mandela Rules.
29. Recommendation of the CPT to various Member States, including to 'the Former Yugoslav Republic of Macedonia', Report on the CPT's visit from 6 to 9 December 2016, CPT/Inf (2017) 30, para. 42.
30. Rule 71, the Nelson Mandela Rules.
31. Rule 69, the Nelson Mandela Rules and the Havana Rules (para. 56) place the obligation to inform a deceased prisoner's family on the prison director. It is critical that family of a deceased prisoner do not learn of the death through unofficial sources, such as other prisoners or the media.
32. Rule 72, the Nelson Mandela Rules; the Havana Rules, para. 57.
33. Available in Spanish: Ministerio de Gobierno, Dirección General del Sistema Penitenciario, 'Protocolo de Actuación en Caso de Muerte de Personas Privadas de Libertad', www.sistemapenitenciario.gob.pa/sites/default/files/img-204012732-0001.pdf.
34. CPT, Report to the Government of Ireland on the visit to Ireland carried out from 16 to 26 September 2014, CPT/Inf (2015) 38, para. 30.
35. Rules 1 and 24, the Nelson Mandela Rules.
36. In numerous judgments, the ECtHR has held that the right to life obliges States not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction, and in particular vulnerable individuals, such as persons in custody. Such positive obligations may arise, inter alia, in situations of risk to the lives of detainees from other individuals (see e.g. *Paul and Audrey Edwards vs. the United Kingdom*, Application no. 46477/99, judgment of 14 March 2002); in cases of suicide in detention (see e.g. *Keller vs. Russia*, Application no. 26824/04, judgment of 17 October 2013); lack of medical care (see e.g. *Centre for Legal Resources on behalf of Valentin Câmpeanu vs. Romania*, Application no. 47848/08, (GC) judgment of 17 July 2014); or generally inhuman living conditions which lead to the death of inmates (see e.g. *Nencheva and Others vs. Bulgaria*, Application no. 48609/06, judgment of 18 June 2013).
37. Response of the Government of Ireland to the CPT's visit report, CPT/Inf (2015) 39, September 2015, p18.
38. The Washington Post, "'Profound dehydration': Milwaukee County sheriff's officers charged in death of inmate denied water for a week', 13 February 2018, www.washingtonpost.com/news/morning-mix/wp/2018/02/13/profound-dehydration-milwaukee-county-sheriffs-officers-charged-in-death-of-inmate-denied-water-for-a-week/?utm_term=.3cee85699ab5.
39. E.g. European Commission, Directorate General for Transport, Serious Injuries, September 2015.
40. International Committee of the Red Cross (ICRC), Aide-Memoire of 3 December 1992.
41. CPT, Health Care Services in Prisons, 3rd General Report, 1993, CPT/Inf(93)12, para. 35.
42. Istanbul Protocol, paras. 149 and 203 et seq.
43. *Ibid.*, Chapter VI.
44. Rule 30, the Nelson Mandela Rules; Rule 6, the Bangkok Rules; Havana Rules, para. 50. See also CPT, Documenting and Reporting Medical Evidence of Ill-Treatment, para. 73.
45. Rule 31, the Nelson Mandela Rules; Rule 11, the Bangkok Rules; CPT, Health Care Services in Prison, para. 51.
46. Rule 10 (2), the Bangkok Rules.
47. CPT, Imprisonment, 2nd General Report, 1992, CPT/Inf(92)3, para. 53; CPT, Documenting and Reporting Medical Evidence of Ill-Treatment, para. 73.
48. Istanbul Protocol, HR/P/PT/8/Rev.1, 2004.
49. Istanbul Protocol, para. 83; Annex III of the Istanbul Protocol contains model body charts.
50. CPT, Report to the Greek Government on the visit to Greece carried out from 4 to 16 April 2013, CPT/Inf (2014) 26, para. 126.
51. Rule 34, the Nelson Mandela Rules.
52. Rule 34, the Nelson Mandela Rules. According to CPT standards, an indication of ill-treatment should be automatically reported, *regardless of the wishes of the detainee*. See CPT, Documenting and Reporting Medical Evidence of Ill-Treatment, para. 77.
53. According to Rule 7 (1) of the Bangkok Rules, whether a referral of the case for investigation is made depends on the informed consent of the woman prisoner concerned.
54. CPT, Documenting and Reporting Medical Evidence of Ill-Treatment, para. 82.
55. Rule 54, the Nelson Mandela Rules; the Havana Rules, para. 24.
56. Rule 56, the Nelson Mandela Rules; the Havana Rules, paras. 75 and 76.
57. CPT, Imprisonment, para. 54.
58. Public Defender (Ombudsman) of Georgia, Special Report on Requests/Complaints Mechanism in Penitentiary System of Georgia, 9 November 2015.

59. Rule 57 (2), the Nelson Mandela Rules; Rule 25 (1), the Bangkok Rules.
60. Rule 57 (3), the Nelson Mandela Rules.
61. In many national legal systems, torture and sometimes also other forms of cruel, inhuman or degrading treatment constitute a crime; the UN Convention against Torture (Art. 4) stipulates that State Parties ensure that all acts of torture as defined in the Convention are offences under criminal law. However, even if this is not the case, other criminal law provisions, such as abuse of power, serious bodily harm or rape, will be applicable in case of allegations of torture.
62. Rules 57 (3) and 71, the Nelson Mandela Rules.
63. Preamble of the CED.
64. Art. 1 of the Declaration on the Protection of All Persons from Enforced Disappearance, United Nations General Assembly Resolution 47/133, 18 December 1992.
65. Note that in accordance with Art. 3 CED, acts of disappearance committed by private individuals or groups shall be officially investigated by the State authorities.
66. Art. 12 CED.
67. Various United Nations human rights mechanisms, such as the Human Rights Committee, the Committee against Torture, and special procedures of the Human Rights Council have called for the abolition of incommunicado detention. The former United Nations Commission on Human Rights has repeatedly reaffirmed that 'prolonged incommunicado detention may facilitate the perpetration of torture and can in itself constitute a form of cruel, inhuman or degrading treatment or even torture'. Despite this, many countries retain the legal possibility to hold persons, particularly terrorism suspects, incommunicado for a certain amount of days.
68. Rules 6 and 7, the Nelson Mandela Rules; the Havana Rules, para. 21; Art. 17 CED.
69. In the case of *Mikashvili v. Georgia*, Application no. 18996/06, judgment of 9 October 2012, para. 87, the ECtHR held 'all the investigative measures were conducted by the Investigation Department of the Ministry of Justice, the very same Ministry which was in charge of the prison system. Their findings were then simply endorsed by a prosecutor. [...] This institutional connection between the investigators and those implicated in the incident raises legitimate doubts as to the independence of the investigation conducted'.
70. In the case of *Dvalishvili vs. Georgia*, Application no. 19634/07, judgment of 18 December 2012, para. 50, the ECtHR noted, 'the authorities accepted the credibility of the police officers' testimonies without giving any convincing reasons for doing so, despite the fact that those officers' statements might have been subjective and aimed at evading criminal liability for the purported ill-treatment of the applicant'.
71. ECtHR, *Pădureț vs. Moldova*, Application no. 33134/03, judgment of 5 January 2010, para. 63.
72. ECtHR, *Buzilo vs. Moldova*, Application no. 52643/07, judgment of 21 February 2012, paras. 31 and 32.
73. Istanbul Protocol, para. 116; Guidelines of the Committee of Ministers of the Council of Europe on eradicating impunity for serious human rights violations, VII.
74. Minnesota Protocol, paras. 32 and 33.
75. Art. 13 CAT; Art. 12 (4) CED; Istanbul Protocol, para. 112; Minnesota Protocol, paras. 86 and 87; Guidelines of the Committee of Ministers of the Council of Europe on eradicating impunity for serious human rights violations, VII (6).
76. Note, however, that a transfer to another establishment could be seriously detrimental for the prisoner concerned, in particular when moved far from his/her family. In such a case, a transfer should be used as a protection measure only if no other measures are available.
77. Rule 45, the Nelson Mandela Rules.

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We promote alternatives to prison that support the rehabilitation of offenders, and promote the right of detainees to fair and humane treatment. We campaign for the prevention of torture and the abolition of the death penalty, and we work to ensure just and appropriate responses to children and women who come into contact with the law.

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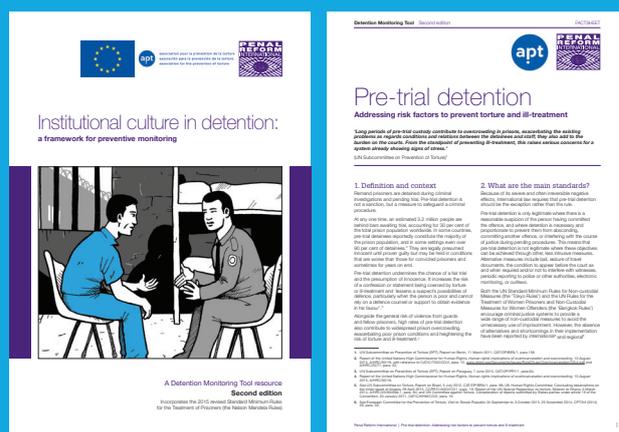
Penal Reform International
1 Ardleigh Road
London N1 4HS
United Kingdom

+44 (0) 207 923 0946
www.penalreform.org
Twitter: @PenalReformInt
Facebook: @penalreforminternational

DETENTION MONITORING TOOL

This Factsheet is part of **Penal Reform International** and the **Association for the Prevention of Torture's Detention Monitoring Tool**, which aims to provide analysis and practical guidance to help monitoring bodies, including National Preventive Mechanisms, to fulfil their preventive mandate as effectively as possible when visiting police facilities or prisons. All resources in the tool are also available online at www.penalreform.org and www.aprt.ch.

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Association for the Prevention of Torture
PO Box 137
CH-1211 Geneva 19
Switzerland

+41 (22) 919 21 70
www.aprt.ch
Twitter: @aprt_geneva