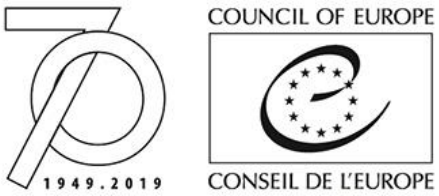

Strasbourg, 20 November 2019 CPT (2019) 69

DRAFT REPORT TO THE ICELANDIC GOVERNMENT ON THE VISIT TO ICELAND CARRIED OUT BY THE EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT (CPT)

FROM 17 TO 24 MAY 2019

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Adopted on 6 November 2019

CONTENTS

EXECUTIVE SUMMARY

The main objective of the fifth periodic visit to Iceland was to review the measures taken by the Icelandic authorities in response to the recommendations made by the Committee after previous visits. In this connection, particular attention was paid to the treatment and conditions of detention of persons in police custody and penitentiary establishments. The delegation also examined the treatment, conditions and legal safeguards offered to psychiatric patients.

Police establishments

The delegation received no allegations – and found no other indications – of ill-treatment of persons deprived of liberty by the police. The Committee concludes that, as during its previous visits, persons in police custody in Iceland run little risk of being ill-treated.

As regards the implementation in practice of the fundamental safeguards against police ill-treatment, namely the right of notification of custody and the rights of access to a lawyer and a doctor, the delegation gained a generally positive impression.

Material conditions of detention in the police establishments visited were found to be adequate for their intended use i.e. periods of detention of a maximum of 24 hours.

Prisons

The CPT's delegation carried out follow-up visits to Akureyri, Kvíabryggja and Litla-Hraun Prisons and visited for the first time Hólmsheiði Prison.

The delegation heard no allegations of ill-treatment of prisoners by staff in any of the prisons visited. On the contrary, many of the inmates spoke positively of the staff (especially in Akureyri and Kvíabryggja) and the delegation observed a generally relaxed atmosphere in the penitentiary establishments visited. Inter-prisoner violence was a problem at Litla-Hraun Prison and was clearly related to the presence of drugs inside the establishment.

Material conditions of detention were, on the whole, of a high standard in all the prisons visited. As regards regime, the Committee recommends that the Icelandic authorities pursue their efforts to develop the availability of work and other organised activities for all inmates, in particular those serving long sentences.

While generally welcoming the adoption of the new Execution of Sentences Act, the Committee expresses its concern about one aspect of the new legislation, essentially motivated by financial and human resources considerations, namely the abolition of the obligation to draw up individual sentence plans for all sentenced prisoners.

Despite the recommendations reiterated by the Committee ever since its very first visit to Iceland (in 1993), in the prisons visited there was still no systematic and (especially) prompt medical screening of newly-arrived inmates, nor were there checks for the presence of injuries and transmissible diseases.

Furthermore, the Committee is seriously concerned by the fact that prisoners in Iceland continue to have extremely limited access to psychiatric care and psychological assistance. The Committee calls upon the Icelandic authorities to take immediate steps to ensure that prisoners with mental health disorders who require in-patient psychiatric treatment are kept and cared for in appropriate facilities.

Drug use continues to be one of the major challenges facing the Icelandic prison system. To address it, the Committee calls upon the Icelandic authorities to devise and implement a comprehensive strategy for the provision of assistance to prisoners with drug-related problems (as part of a wider national drugs strategy) including harm reduction measures.

The Icelandic authorities informed the CPT that the Ministry of Justice had set up a joint working group composed of representatives of the Ministry of Health, the Prison and Probation Administration, Reykjavík University Hospital, the Directorate of Health and the Health Care Institution of South Iceland, the task of which was, by 1 December 2019, to draft an action plan for the provision of health care and for tackling the issue of drugs in prisons.

Psychiatric establishments

The CPT's delegation carried out follow-up visits to the Psychiatric Department of Reykjavik University Hospital (Landspítali), the forensic and secure wards of the Psychiatric Department of Reykjavík University Hospital (the Kleppur campus) and the psychiatric ward at Akureyri Regional Hospital.

No allegations were heard – or any indications found – of any form of ill-treatment by staff in any of the psychiatric establishments visited by the Committee's delegation. On the contrary, most of the patients interviewed spoke highly of the staff, especially the ward-based staff (i.e. the nurses and orderlies).

On the whole, the living conditions in the psychiatric establishments visited could be described as good or even very good. However, the overall range and frequency of therapeutic and rehabilitative activities on offer was rather limited.

The delegation noted that mechanical restraint was never applied and that seclusion or chemical restraint were used only as a last resort in the psychiatric establishments visited.

The CPT is concerned by the fact that uniformed police officers could on occasion still be called upon to help health-care staff control patients with aggressive behaviour. This was despite the fact that – after the 2012 visit – the Committee had recommended the aforementioned practice be stopped immediately in all psychiatric establishments.

Finally, the Committee is concerned that, despite the CPT's long-standing recommendations, the Icelandic authorities have done little to improve the legal safeguards in the context of involuntary hospitalisation; amendments introduced to the Legal Competence Act in 2015 have failed to bring about the necessary changes. Consequently, the Committee cannot but note that most of the related issues identified in the reports on previous visits, some of them dating back 15 years, have still not been addressed, and calls upon the Icelandic authorities to amend the relevant legislation as regards both civil and forensic patients.

I. INTRODUCTION

A. The visit, the report and follow-up

1. In pursuance of Article 7 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as "the Convention"), a delegation of the CPT carried out a visit to Iceland from 17 to 24 May 2019. The visit formed part of the Committee's programme of periodic visits for 2019 and was the CPT's fifth visit to Iceland.[1]

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

- Marzena Ksel, Head of delegation
- Per Granström
- Inga Harutyunyan
- Marie Lukasová
- Vincent Micallef.

They were supported by Borys Wódz (Head of Division) and Dalia Žukauskienė of the CPT's Secretariat, and assisted by:

- Andres Lehtmets, Head of the Centre of Psychiatry, West Tallinn Central Hospital, Estonia (expert)
- Gauti Kristmannsson (interpreter)
- Hilda (Rosa) Richter (interpreter)
- Alda Sigmundsdóttir (interpreter)
- Ólöf Pétursdóttir (interpreter).

3. The list of police, penitentiary and psychiatric establishments visited by the Committee's delegation can be found in Appendix I.

[1] The reports on all previous Committee's visits and related Government responses are available on the CPT's website: https://www.coe.int/en/web/cpt/iceland.

4. The report on the visit was adopted by the CPT at its 100th meeting, held from 4 to 8 November 2019, and transmitted to the Icelandic authorities on 20 November 2019. The various recommendations, comments and requests for information made by the Committee are set out in bold type in the present report. The CPT requests the Icelandic authorities to provide within 6 months a response containing a full account of action taken by them to implement the Committee's recommendations and replies to the comments and requests for information formulated in this report.

B. Consultations held by the delegation and co-operation encountered

5. In the course of the visit, the delegation had consultations with Þórdís Kolbrún R. Gylfadóttir, Minister of Justice,[2] Páll Winkel, Director General of the Prison and Probation Administration (PPA), Helga Björg Ragnarsdóttir, Political Advisor to the Minister of Health, as well as with senior officials from the Ministries of Justice, Health, and the Offices of the National Commissioner of Police and Public Prosecutor.

In addition, talks were held with the NPM team of the Althing Ombudsman's Office. The delegation also met representatives of non-governmental organisations active in areas of concern to the CPT.

A list of the national authorities and non-governmental organisations with which the delegation held consultations is set out in Appendix II.

6. As had been the case during previous visits to Iceland, the delegation received excellent co-operation from both the management and staff in all the establishments visited. In particular, the delegation had rapid access to all premises it wished to visit, was able to meet in private with persons with whom it wanted to speak and was provided with access to all the information it required.

The Committee wishes to express its appreciation of the efficient assistance provided to its delegation before, during and after the visit by the Liaison Officer appointed by the Icelandic authorities, Elísabet Gísladóttir from the Ministry of Justice.

7. That said, the CPT must recall once again that the principle of co-operation between Parties to the Convention and the Committee is not limited to steps taken to facilitate the task of a visiting delegation. It also requires that decisive action be taken to improve the situation in the light of the CPT's recommendations.

In this context, the Committee is very concerned by the fact that little or no action has been taken on a significant number of long-standing recommendations made by the CPT, some of them dating back to the very first visit to Iceland 26 years ago.

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[2] In Iceland the Minister of Justice is, among others, responsible for the police, immigration, public prosecution, the courts and the prison system.

This is *inter alia* the case with tackling the problem of alcohol and drug addiction in prisons,[3] the functioning of prison health care services,[4] the use of means of restraint in psychiatric establishments[5] and the legal safeguards in the context of involuntary psychiatric hospitalisation.[6]

The Committee hopes that the Icelandic authorities will now take decisive steps to implement its recommendations on these subjects, in accordance with the principle of co-operation which lies at the heart of the Convention.

C. Urgent requests made at the end of the visit

8. At the end of the visit, the CPT's delegation met senior Government officials in order to acquaint them with the main facts found during the visit. On this occasion, the delegation made two urgent requests concerning the prison system.

As regards the first urgent request, the Icelandic authorities were asked to take out of service the windowless cell for remand prisoners on court-ordered isolation and to confirm, within one month, that all remand prisoners at Akureyri Prison are accommodated in cells with adequate access to natural light.

As regards the second urgent request, the Icelandic authorities were requested to transmit to the Committee, within three months, a detailed action plan (comprising precise tasks, agencies responsible, deadlines and financial allocations) for the provision of health care and for tackling the issue of drugs in prison.

9. The above-mentioned urgent requests were subsequently confirmed in a letter of 3 June 2019 from the President of the CPT.

By letters of 24 June and 15 August 2019, the Icelandic authorities informed the Committee of the measures taken in response to the delegation's urgent requests. The CPT will consider those measures later in this report.

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3 See paragraph 41 below.
4 See paragraph 43 below.
5 See paragraph 60 below.
6 See paragraph 62 below.

D. National Preventive Mechanism

10. In the report on its last periodic visit to Iceland (carried out in September 2012),[7] the Committee expressed the view that the time had come for Iceland to set up one or several independent monitoring bodies at national level, possessing the relevant powers and the necessary resources to exercise them. In this connection, the CPT noted that Iceland had signed the Optional Protocol to the United Nations Convention against Torture (OPCAT), which provides for the setting up of such a body or bodies (National Preventive Mechanisms), in 2003; however, no progress had been made since then as regards the ratification of the Optional Protocol and setting up of a National Preventive Mechanism (NPM).

The Committee is pleased to note that the Icelandic authorities have finally taken this step (the OPCAT having been ratified in February 2019) and that the NPM (officially referred to as the OPCAT Department) has been set up (following amendments to the Act on the Althing Ombudsman) as part of the Ombudsman's Office with a separate budget.

11. As already mentioned in paragraph 5 above, the delegation met NPM representatives at the outset of the visit.[8] The delegation was informed that the NPM had only just become operational[9] and that work was still ongoing on drafting working procedures and establishing formal co-operation with NGOs and relevant international bodies (especially in other Nordic countries). Despite such an early stage of existence, the NPM had already managed to carry out 3 visits[10] and more visits were planned before the end of 2019, especially to penitentiary establishments and social care establishments for disabled and elderly persons.

The CPT welcomes these developments and hopes that the newly set up NPM will soon be in a position to carry out regular monitoring of all places of deprivation of liberty in Iceland. Indeed, the delegation's findings during the 2019 visit demonstrated that most of the establishments visited by the Committee had not received any external monitoring visits for many years, if at all.[11] **The CPT would like to be provided with information on activities of the Icelandic NPM in 2019 and the first half of 2020.**

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7 See paragraph 10 of document CPT/Inf (2013) 37, https://rm.coe.int/1680696c40.

8 It is also noteworthy as a positive fact that the Icelandic authorities took the initiative of inviting members of the NPM team to attend the final talks in Reykjavik on 24 May 2019.

9 With the full-time staff of three – including the Head who was a forensic psychologist with experience of work in the prison system – and the possibility of using additional staff resources (five to six persons) from the Ombudsman's Office and hiring additional experts (including medical) for particular visits.

10 To Reykjavík Police Headquarters, to forensic and secure wards of the Psychiatric Department of Reykjavík University Hospital (the Kleppur campus) and to Stuðlar Diagnostic and Treatment Centre for Juveniles (visited by the CPT in 1998, see paragraphs 120 to 142 of CPT/Inf (99) 1, https://rm.coe.int/1680696bfd).

11 For example, the management and staff of Stykkishólmur Police Station and Kvíabryggja Prison could not remember any such visit.

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Police establishments

1. Preliminary remarks

12. The legal framework governing the detention of persons by the police in Iceland has remained basically unchanged since the 2012 visit. It is recalled that the maximum period of police custody is 24 hours.[12]

The information gathered during the 2019 visit indicated that this time-limit was duly respected by the police; in practice, the delegation observed that persons detained by the police usually spent no more than a few hours in police custody and that overnight custody was very exceptional and only carried out in the few larger police establishments with permanent presence of custodial staff (e.g. Reykjavík Police Headquarters). In fact, in several police stations visited the last detention in a cell dated back to many months ago.

2. Ill-treatment

13. The delegation received no allegations – and found no other indications – of ill-treatment of persons deprived of their liberty by the police. On the contrary, most of the persons interviewed by the delegation confirmed that they had been treated in a correct manner by police staff.

Consequently, the conclusions reached by the Committee after its previous visits[13] – namely that persons in police custody in Iceland run little risk of being ill-treated – remain fully valid.

14. At the outset of the 2019 visit, the delegation was provided with statistical information about the number of complaints of police misconduct (including ill-treatment) registered by the National Commissioner of Police and the District Prosecutor (who is *inter alia* responsible for the investigation of accusations against the police for alleged criminal offences committed in the course of their work). The number of such complaints was generally not high[14] and only a few of them were related to the treatment of persons in police custody, almost exclusively in the context of apprehension.

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12 The Criminal Procedure Code (CPC) provides for the possibility of exceptionally prolonging police custody in excess of the 24-hour time-limit, in the event of extreme weather conditions and related transportation difficulties.

13 See paragraph 12 of the report on the 1998 visit (CPT/Inf (99) 1, https://rm.coe.int/1680696bfd), paragraph 9 of the report on the 2004 visit (CPT/Inf (2006) 3, https://rm.coe.int/1680696c17) and paragraph 12 of the report on the 2012 visit (CPT/Inf (2013) 37, https://rm.coe.int/1680696c40).

14 20 in 2017, 23 in 2018 and 14 received between 1 January and 1 May 2019.

The District Prosecutor mentioned three cases (the most recent of them dating back to 2016) which had ended with a criminal conviction: a 60-day conditional prison sentence (and dismissal from the police) for a police officer who had punched an apprehended person during arrest; a 30-day conditional prison sentence for another police officer who, after a car chase, had slammed the door of the police car in such a manner that the suspect's leg was broken; and likewise a 30-day conditional sentence for a police officer who had pushed the apprehended suspect violently to the ground which had resulted in a facial injury. Four more cases of alleged excessive use of force upon apprehension were under investigation at the time of the visit.

15. In the context of the above information, **the CPT trusts that the Icelandic authorities will continue their efforts to prevent and combat ill-treatment by police officers. These efforts should include ongoing training activities and a firm message of "zero tolerance" of ill-treatment to all police staff. In particular, continuous attention must be paid to the training for police officers in preventing and minimising violence in the context of an apprehension.**

Further, in order to obtain an updated picture of the situation, **the Committee would like the Icelandic authorities to supply information, in respect of 2019 and the first half of 2020, on:**

- **the number of complaints of ill-treatment made against police officers and the number of criminal/disciplinary proceedings which were instituted as a result;**

- **an account of criminal/disciplinary sanctions imposed following such complaints.**

3. Safeguards against ill-treatment

16. None of the detained persons interviewed by the delegation made any complaints regarding the legal safeguards against police ill-treatment, and the delegation's own observations (based also on the analysis of the available records and other documentation) suggest that persons taken into police custody in Iceland are systematically and rapidly informed, both orally and in writing,[15] of their right to notify someone of their situation, to have access to a lawyer (including *ex officio*) and – if required – an interpreter (free of charge). The exercise of these rights was systematically recorded in the nationwide computerised police database; the custody records seen in the police establishments visited were completed in a proper and diligent way. In short, the situation in this respect could be considered as generally satisfactory.

17. One outstanding issue concerned access to a doctor. Although the delegation had no reason to doubt that persons in police custody were provided with medical assistance whenever needed, the relevant legislation had not been amended despite the CPT's long-standing recommendation that persons in police custody be expressly granted this right in law,[16] and informed of this right.

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15 By means of an information sheet existing in 9 languages (Icelandic, Danish, English, French, German, Lithuanian, Polish, Russian and Spanish).

16 See paragraph 17 of the report on the 2012 visit (CPT/Inf (2013) 37, https://rm.coe.int/1680696c40): "the CPT calls upon the Icelandic authorities to adopt formal provisions regarding the right of persons in police custody to have access to a doctor, including – if they so wish – the right to be examined by a doctor of their own choice (in addition to any medical examination carried out by a doctor called by the police), it being understood that an examination by such a doctor may be carried out at the detained person's own expense."

Further, as concerns notification of custody, the current legislation still allows duty officers or officers in charge of investigation to exceptionally delay such notification, despite the Committee's recommendation that the law be amended so as to ensure that any such delay require the approval of a senior police officer unconnected with the case or a public prosecutor; that said, it should be stressed that the delegation heard absolutely no allegations of delayed notification and it was clear that the police were only making use of this possibility on very rare occasions.

Nevertheless, **the CPT must once again reiterate its aforementioned recommendations concerning the legal framework of access to a doctor and delaying notification of custody**. Their implementation is long overdue (even if the situation in practice does not at present give rise to any particular concern for the Committee).

18. Following an amendment to Section 35 of the Police Act, a new Police Monitoring Committee (PMC) was set up in 2017. Composed of three members (the Chair appointed by the Minister of Justice, the second member nominated by the Bar Association and the third nominated by the Icelandic Human Rights Center), supported by administrative staff and possessing its own budget, it is an independent body authorised to receive complaints,[17] analyse them and forward them to competent organs (usually the National Police Commissioner or the District Prosecutor). The PMC also receives copies of all complaints of police misconduct registered by the police and prosecution authorities, as well as information of any cases of death or injury in police custody. It does not carry out visits to police establishments, but it performs a supervisory/quality check function in respect of all disciplinary and criminal cases concerning alleged police misconduct, and the relevant agencies are required to keep the PMC informed of the progress and the outcome of these procedures. The PMC may then issue an advisory opinion regarding the procedure and its outcome, addressed to the relevant bodies for consideration and reaction.

The CPT welcomes the setting up (and the activity so far) of the PMC which has indeed the potential to improve the quality of police complaints procedures, further reduce the risk of impunity and, more generally, contribute to a better police work (especially as concerns the treatment of persons in police custody). **The Committee would welcome receiving an update of the work of the PMC in the second half of 2019 and the first half of 2020, including any PMC's comments on systemic and/or substantive issues regarding the matters falling within the CPT's mandate.**

[17] According to information received by the CPT from the Chairman of the PMC after the visit (by a letter dated 14 June 2019), 32 complaints of police misconduct (including ill-treatment) had been received directly by the PMC between 2017 and the first half of 2019; the PMC transmitted 22 of them to the District Prosecutor and 6 to the National Police Commissioner (the remaining 4 complaints being still analysed by the PMC). One of the cases had resulted in prosecution, the rest having been dismissed for lack of evidence or closed for lack of sufficient interest in prosecuting the alleged offence; in 7 cases the PMC appealed the decision to close the case to the Director of Public Prosecutions who upheld the decision of the District Prosecutor in 5 cases (appeal proceedings in respect of the 2 remaining cases were still ongoing at the time of the visit).

4. Conditions of detention

19. As had been the case during the previous visits to Iceland, the delegation found conditions of detention in the police establishments visited to be adequate for their intended use i.e. periods of detention of a maximum of 24 hours.[18]

The cells were of a fully satisfactory size (e.g. 8 m² for single and 15 m² for double occupancy), suitably equipped (a bed or a sleeping platform with a washable mattress, a blanket and a pillow, sometimes a small table and a chair or stool, call system), clean and in a good state of repair. Not all the cells had access to natural light[19] but all were well ventilated and had adequate artificial lighting. Persons in police custody had ready access to decent toilets, washing and shower facilities, and arrangements were in place to offer food to anyone who would have to stay in the cell for more than a few hours (which was rare in practice, as already mentioned).

To sum up, conditions of detention in police establishments do not call for any particular comment or recommendation by the Committee.

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[18] As already mentioned in paragraph 12 above, cells in most police establishments visited were used very rarely and in most cases for periods not exceeding a few hours (never overnight, except at Reykjavík Police Headquarters).

[19] The cells at Akureyri, Búðardalur, Kópavogur, Selfoss and Stykkishólmur Police Stations did not have such access.

B. Prisons

1. Preliminary remarks

20. The CPT's delegation carried out follow-up visits to Akureyri, Kvíabryggja and Litla-Hraun Prisons and visited for the first time Hólmsheiði Prison.

Akureyri Prison, a closed-type low security establishment, was last visited by the Committee in 2012.[20] At the time of the 2019 visit, the prison had the official capacity of 10 (down from 15 in 2012) and was accommodating seven adult male sentenced prisoners with remaining sentences of one year or less.

Kvíabryggja Prison, an open-type penitentiary establishment,[21] was previously visited by the CPT in 2004.[22] With the official capacity of 23 (as compared to 14 during the 2004 visit),[23] the establishment was accommodating 21 adult sentenced prisoners including one female.[24] Most of the prisoners had been transferred there from a closed prison for the last period (up to 2 years) of their sentence.

Litla-Hraun Prison, Iceland's main and biggest penitentiary establishment (and the only one officially classified as a closed-type high security prison) had been visited on each of the Committee's previous visits.[25] At the time of the 2019 visit, it had the capacity of 87 and was accommodating 68 male adult prisoners including 15 on remand.

Hólmsheiði Prison, a closed-type establishment with medium security located in the outskirts of Reykjavík, was opened in 2016. A cross-shaped modulable structure (allowing to adapt the size of units to current needs) with the official capacity of 56, it was accommodating at the time of the 2019 visit 44 prisoners including 11 women (in a separate unit) and 16 male prisoners on remand.

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20 See paragraph 49 of CPT/Inf (2013) 37 (https://rm.coe.int/1680696c40) and the general description in paragraphs 68 to 72 of the report on the 1998 visit (CPT/Inf (99) 1, https://rm.coe.int/1680696bfd).

21 The prison had no secure perimeter and inmates could move freely within the extensive territory during the day (the main detention block was locked between 11 p.m. and 7 a.m. but prisoners' cells were never locked by staff – only prisoners could lock them from inside but naturally staff could unlock them if necessary).

22 See paragraph 42 of CPT/Inf (2006) 3, https://rm.coe.int/1680696c17.

23 The additional capacity had been created by converting into cells some of the space originally foreseen (during the 2001 extension) to contain staff offices, rooms for activities and visits; see also paragraph 28 below.

24 The delegation was told that Kvíabryggja Prison had started receiving female prisoners in 2011 and that there could on occasion be up to 5 female inmates there. See also paragraph 28 below.

25 See e.g. paragraph 45 of the report on the 2012 visit (CPT/Inf (2013) 37), https://rm.coe.int/1680696c40.

21. The long-awaited[26] opening of a new prison in Reykjavík (i.e. *Hólmsheiði Prison*) had been a major positive development since the CPT's 2012 visit. It had made it possible to finally close the old prisons in the centre of Reykjavík (on Skólavörðustígur street)[27] and in Kópavogur,[28] both of which had been too small to provide any space for association and activities.

The opening of the new establishment had also enabled putting a stop to the practice – criticised by the CPT in the past[29] – of sending remand prisoners from the Reykjavík area to *Litla-Hraun Prison*, far away from their homes and from the seats of competent investigating, prosecution and court authorities. Further, the new prison had a proper dedicated unit for female prisoners, which had not been the case in the old Kópavogur Prison.

The Committee will comment further in this report on the material conditions and activities at *Hólmsheiði Prison*;[30] however, already at this stage the CPT wishes to welcome this development.

22. Another major development since the 2012 visit had been the adoption, in 2016, of the new Execution of Sentences Act which *inter alia* clarified the objectives of imprisonment and the tasks of the Prison and Probation Administration (PPA), enlarged the catalogue and degree of recourse to alternatives to imprisonment (bail, community service, electronic surveillance, probation) and further facilitated early release. One of the objectives of these changes was to address the long-standing[31] problem of persons awaiting at home the start of their sentence; in fact, due to budgetary restrictions (see paragraph 24 below), the waiting list had actually become longer since the 2012 visit (from some 400 persons to approximately 500 at the time of the 2019 visit).[32]

23. While generally welcoming the adoption of the new Execution of Sentences Act, the Committee must express its concern about one aspect of the new legislation, essentially motivated (as the delegation was told) by financial and human resources considerations, namely the abolition of the obligation to draw up individual sentence plans for all sentenced prisoners. In the new Act, such plans had become optional, only if the PPA considered their adoption to be suitable and practicable in each particular case (and, in practice, only a small proportion of sentenced inmates has such a plan).[33] It is noteworthy that the absence of individual sentence plans was resented by several of the prisoners interviewed by the delegation and was also pointed out as problematic by NGO representatives with whom the delegation met.

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26 The necessity of opening a new establishment for remand prisoners from Reykjavík area was acknowledged by the Icelandic authorities during the CPT's very first visit to Iceland in 1993, see paragraph 52 of document CPT/Inf (94) 8 (https://rm.coe.int/1680696bda).

27 See the Committee's views on Skólavörðustígur Prison in paragraph 46 of the report on the 2012 visit (CPT/Inf (2013) 37), https://rm.coe.int/1680696c40.

28 See paragraphs 47 and 48 of the report on the 2012 visit (CPT/Inf (2013) 37), https://rm.coe.int/1680696c40.

29 See *inter alia* paragraph 31 of the report on the 2012 visit (CPT/Inf (2013) 37), https://rm.coe.int/1680696c40.

30 See paragraphs 28 and 30 below.

31 See e.g. paragraph 32 of the report on the 2012 visit (CPT/Inf (2013) 37), https://rm.coe.int/1680696c40.

32 Representatives of the PPA estimated that approximately half of these persons would eventually have their imprisonment sentence replaced with community service, and from the remaining half a significant proportion would never go to prison because the waiting time was longer than the sentence.

33 I.e. some of the sentenced prisoners accommodated at Hólmsheiði Prison.

The CPT recommends that the Icelandic authorities amend the Execution of Sentences Act and restore the obligation to draw up individual sentence plans for all sentenced prisoners; as a first priority, such plans should be developed for prisoners serving long sentences. The current absence of such plans makes it more difficult to offer individually tailored purposeful activities to prisoners[34] and to prepare the inmates for their eventual return to the community at large.[35]

Once the aforementioned amendment is adopted, **particular attention will have to be paid to involving (to the extent possible) prisoners in the drafting and reviewing the sentence plans, so as to secure their commitment to the implementation of the plans and to their social rehabilitation.**

24. At the outset of the 2019 visit, the delegation was informed by senior officials from the Ministry of Justice and from the PPA that the Icelandic prison system was operating below its full official capacity (85% of the available capacity was being used) due to budgetary constraints.[36] The main consequence of these constraints – apart from the longer waiting list – was that the PPA was not in a position to fill all the available staff posts in prisons.[37] The delegation was also told that the lack of proper funding had obliged the PPA to suspend the activity of the prison staff training centre for the past 5 years, but that it had recently been reactivated and that the first 20 new recruits were expected to graduate before the end of 2019.

Considering the crucial role of duly trained prison staff, present in sufficient numbers and representing the appropriate range of specialities,[38] in providing a safe environment for prisoners[39] and enabling their social rehabilitation, **the Committee recommends that increased efforts be made by the Icelandic authorities to secure the necessary financial and human resources for the prison system. Reference is also made to the recommendation in paragraph 31 below.**

2. Ill-treatment and inter-prisoner violence

25. The delegation heard no allegations of ill-treatment of prisoners by staff in any of the prisons visited. On the contrary, many of the inmates spoke positively of the staff (especially in *Akureyri* and *Kvíabryggja*) and the delegation observed a generally relaxed atmosphere in the penitentiary establishments visited, although the level of staff-inmate interaction was generally not very high (especially in closed-type prisons).[40]

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34 See also paragraph 30 below.

35 See also Rules 103.1 to 103.8 of the European Prison Rules, https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae.

36 See also paragraph 22 above. The delegation was told that budget cuts had affected all the public administration and that the PPA would have to reduce its budget by 2% in 2020 and a further 2% in 2021.

37 The total number of prison staff posts was 107.5 full-time equivalents, and the total actual number of staff was slightly under 100 (not all of them full-time).

38 Which was hardly the case at the time of the 2019 visit, e.g. the whole prison service employed only 3 social workers (one of whom was mostly working at Litla-Hraun Prison) and there were almost no work instructors. See also the comments and recommendations in paragraphs 31, 40 and 43 below.

39 See also paragraph 26 below.

40 Custodial staffing levels were generally satisfactory (e.g. there were up to 30 custodial staff present on a day shift during week days at Litla-Hraun Prison, though less on weekends – 11 officers) but the delegation gained the impression that staff spent most of their shift in their offices and in the CCTV control room, rather than inside prisoner accommodation units (admittedly though, they did several daily rounds and came to the units to

26. Likewise, the delegation heard no allegations – and observed no other indications – of inter-prisoner violence at *Akureyri, Hólmsheiði and Kvíabryggja Prisons*.

However, inter-prisoner violence was a problem at *Litla-Hraun Prison* (as was acknowledged by the prison's Director and staff[41]) and it was clearly related to the presence of drugs inside the establishment.[42] Although the management and staff did attempt to react to violent incidents (by separating prisoners concerned[43] and by applying disciplinary sanctions[44]), it was clear that the root of the problem (i.e. the prevalence of drugs) was not adequately addressed. The CPT will comment on this issue later in this report.[45]

27. The Director of the PPA informed the delegation that he had issued, in November 2013, instructions to prison staff on how to deal with incidents of inter-prisoner violence. The instructions made *inter alia* clear that custodial staff had to intervene at the slightest indication of a possible conflict, separate the conflicting parties and alert the health-care staff immediately; the instructions also clarified reporting obligations of the custodial staff concerned (reports had to be sent to the Director, the PPA and the police[46] whenever injuries had been sustained by any of the inmates, irrespective of whether the injured prisoner wished to press charges or not) and stressed the staff's duty to describe each incident in a detailed manner[47] in the dedicated electronic database.

The delegation gained the impression that the aforementioned instructions were duly applied in practice; that said, **the Committee trusts that staff at Litla-Hraun Prison in particular will continue to be vigilant and make use of all means at their disposal to combat and prevent inter-prisoner violence and intimidation. Achieving this objective will require improving the training of custodial staff in dynamic security.**[48] See also the recommendation in paragraph 42 below.

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escort inmates to outdoor exercise, to the gym, to the workshops and classrooms, as well as to give them prescribed medication, see paragraph 35 below).

41 And as could be seen upon examination of the (detailed and well-documented) incident reports at Litla-Hraun Prison, with an incident involving physical violence between inmates recorded approximately every month.

42 Many of the conflicts were reportedly due to unpaid drug debts.

43 In this context, it is noteworthy that an inmate was placed in the disciplinary isolation cell (in House 1 of the prison) at the time of the visit, upon his own request and reportedly in relation to an unpaid drug debt. The delegation was told that this was only a temporary solution (for a few days maximum) and that the PPA would most likely transfer him to another establishment, after he would have been seen by one of the PPA psychologists.

44 See paragraph 46 below.

45 See paragraph 41 below.

46 Police officers in Selfoss (the nearest town) told the delegation that they had been called to Litla-Hraun Prison on 6 occasions between 1 January and 19 May 2019.

47 Who, where, when, any visible injuries, witness statements, action taken by staff with precise time of each step, etc.

48 Dynamic security is the development by staff of positive relationships with prisoners based on firmness and fairness, in combination with an understanding of their personal situation and any risk posed by individual prisoners (see Rule 51 of the European Prison Rules, https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae, and paragraph 18.a of the Recommendation Rec (2003) 23 of the Committee of Ministers of the Council of Europe to member states on the management by prison administrations of life sentence and other long-term prisoners, https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805dec7a). Dynamic security also implies an adequate offer of constructive activities, see paragraph 30 below.

3. Conditions of detention

28. Material conditions of detention were, on the whole, of a high standard in all the prisons visited. Cells (exclusively single-occupancy) were of a good size (9 to 12 m² of actual living space), generally well-lit and ventilated, suitably equipped (as a minimum a bed with full bedding, a wardrobe, a desk, a chair, shelves and call system[49]), clean and in most cases in a very good state of repair. Many cells were equipped with fully-screened sanitary annexes, and all prisoners had ready access to a toilet and to high-standard communal washing and shower facilities. As for the food, it was invariably excellent and plentiful (and most prisoners could cook their own meals).

There were only a few exceptions to this generally very satisfactory picture: some of the sea-side last-floor cells in House 3 at *Litla-Hraun Prison* were beginning to suffer from water ingress in the outer walls and under the roof. Further, some of the cells at *Hólmsheiði Prison* (in the women's unit and in the security unit[50]) had frosted glass windows, apparently to ensure privacy. While the objective was obviously legitimate, the result was that inmates accommodated in these cells (especially female prisoners, who spent longer periods in them) had no outside view.

At *Kvíabryggja Prison*, there was no entirely safe accommodation for female inmates – especially as regards communal showers[51] – and the main accommodation building (the common areas, not the cells) was so cramped that there was no proper office space for the staff and no room for visits. The prison's Director showed to the delegation plans to extend the establishment by adding a new wing to the main accommodation building, which would *inter alia* contain a small (4 cells) unit for women, a classroom, a dedicated room for visits and staff offices; he had already submitted these plans to the PPA for consideration.

The CPT recommends that steps be taken to address the above-mentioned shortcomings at Litla-Hraun, Hólmsheiði and Kvíabryggja Prisons. Regarding the latter establishment, the Committee would like to be provided with more detailed information on the proposed extension. On a more general issue, the Icelandic authorities should reflect upon the manner to provide safe(r) accommodation to women serving their sentence in an open prison.[52]

29. The delegation was very concerned to learn from the management and staff that remand prisoners on court-ordered isolation at *Akureyri Prison*[53] would (despite the CPT's recommendation in the report on the 2012 visit[54]) continue to be accommodated in a windowless cell, for periods of up to 14 days.

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49 As well as, usually, numerous personal items and various audio-visual electronic equipment.

50 Security cells were rarely used and if so, only for a short time.

51 Although the sole female prisoner at the time of the visit made it expressly and insistently clear to the delegation that she did not feel threatened in any way by the fact of sharing communal accommodation areas with male inmates. She added that she could lock her cell from the inside if she wanted (as was the case with all the other prisoners, see paragraph 20 above).

52 The only dedicated female unit, at Hólmsheiði Prison, was of a closed type.

53 There were no such prisoners at the time of the visit to the establishment (only Hólmsheiði Prison had a few of them) and, in general, the number of such prisoners had greatly diminished since the 2012 visit and court-imposed isolation for remand prisoners was now exceptional and rare in practice, which is to be welcomed (see also paragraph 47 below).

54 See paragraph 49 of CPT/Inf (2013) 37, https://rm.coe.int/1680696c40.

As already mentioned in paragraph 8 above, at the end of the visit the delegation stated that this state of affairs was unacceptable and requested the Icelandic authorities to confirm, within one month, that the above-mentioned cell has been taken out of service and that all remand prisoners in *Akureyri* are accommodated in cells with adequate access to natural light. In their letter of 24 June 2019, the Icelandic authorities informed the Committee that this had already been done. The CPT welcomes this positive reaction to its delegation's urgent request.

30. As for activities, the delegation observed efforts made in all the establishments visited to provide a varied programme to the inmates. That said, there was relatively little on offer at *Hólmsheiði Prison*[55] and the work and education facilities at *Litla-Hraun Prison* remained under-utilised.[56]

The offer was also quite limited at *Akureyri Prison*, with some distance learning courses and a few work positions (cleaning, assembling barbecues, work in the municipal gardening enterprise). By contrast, all inmates worked at *Kvíabryggja Prison*[57] (except one, who was close to retirement age and did not wish to work)[58] and a few inmates followed distance learning courses on the secondary school level.

31. **The CPT recommends that the Icelandic authorities pursue their efforts to develop the offer of work and other organised activities for all inmates, in particular those serving long sentences. Reference is made here to the recommendation in paragraph 23 above.**

The Committee is also of the view that tailored programmes of therapeutic and rehabilitative activities should be offered to prisoners with mental disorders[59] and learning disabilities.[60]

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55 Which, in particular, did not provide prisoners with any permanent classes and any vocational training; only some distance learning was available but many interviewed prisoners told the delegation that they had been told upon admission that it was too late for them to enrol because the school year had already started.

56 35 prisoners had a job (cleaning, making vehicle registration plates, repairing and washing cars, manufacturing wooden and metal items, recycling old computers, etc.) and 27 attended school; however, 19 of the prisoners concerned worked and studied simultaneously. There were also occasional vocational training courses (for welders and car mechanics). Prisoners were paid for both working and attending education classes (they could earn, according to the statements of the inmates interviewed by the delegation, anything between the equivalent of 200 and 700 EUR per month).

57 Mainly on the prison's own sheep farm and in car repairs and carpentry workshops. Some inmates also worked in the kitchen, cleaned the common areas and a few were even allowed to run (legally) their own online accounting or IT business after the regular working hours.

58 The Director of Kvíabryggja Prison told the delegation that although theoretically sentenced prisoners were obliged to work in Iceland, he had no intention to sanction the inmate's refusal to work.

59 See paragraph 39 below. As regards the (numerous) inmates with an addiction problem, see paragraph 26 above and paragraph 41 below.

60 There were *inter alia* some prisoners with a learning disability in House 3 at Litla-Hraun Prison and one at Kvíabryggja Prison.

All this (as well as the generalised implementation of individual sentence plans)[61] will require better trained custodial staff[62] but also recruiting more social workers,[63] teachers and work instructors, as well as more input from prison psychologists and addiction specialists.[64] **The CPT recommends that steps be taken in the light of the above remarks.**

32. The bulk of the prisoners in the establishments visited were entitled to generous out-of-cell time[65] and had access to well-appointed common areas,[66] indoor gyms[67] and outdoor exercise yards (for at least one hour – for inmates in security and disciplinary units – and for up to 4.5 hours per day for the rest of the prisoners)[68] with some sports equipment. That said, despite the Committee's earlier recommendations, the exercise yards in *Litla-Hraun* and *Akureyri* had not been fitted with shelters against inclement weather. **The CPT calls upon the Icelandic authorities to remedy these deficiencies.**

At *Akureyri Prison*, the delegation was concerned to note that despite the Committee's earlier recommendation, remand prisoners on court-ordered isolation would still only be allowed outdoor exercise either before 8 a.m. or after 10 p.m. (when cell doors were locked in the general detention area). This is not acceptable. **The CPT calls upon the Icelandic authorities to enable remand prisoners at Akureyri Prison to take their outdoor exercise during the day time.**

33. The situation with respect to activities was less favourable as regards inmates accommodated on the ground level of House 4 at *Litla-Hraun Prison*, several of them reportedly being sex offenders.

For quite obvious reasons, some of these inmates were afraid to associate with the rest of the prisoner population, which resulted in them being unable to attend workshops, classes[69] and to take their daily outdoor exercise (as there was no separate secure exercise area for them).[70] The management and staff tried to alleviate the negative consequences of this situation by being more present in the unit and by offering those inmates some compensation e.g. longer time in the gym (under appropriate supervision, preventing contact with other categories of prisoners); however, the fact remained that some of the inmates concerned only left their unit to go to the visiting area or to see the doctor. **The Committee recommends that more efforts be made to offer some activities (in a secure environment) to these prisoners.**

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61 See paragraph 23 above.

62 Able and willing to engage with prisoners inside accommodation areas to a larger extent than it is presently the case, see also paragraph 25 above.

63 At the time of the visit there were only three social workers in the whole prison system, and they shared their presence and activity between the 5 prisons in Iceland.

64 See paragraphs 40 and 42 below.

65 They were free to move inside their units between 7 – 8 a.m. and 10 – 11 p.m.

66 With sitting areas, tables, kitchenettes, TV sets, DVD players, computers and computer games, audio equipment, board games, books and magazines.

67 During 1.5 to 2 hours per day.

68 As already mentioned (see paragraph 20 above), inmates at Kvíabryggja could move within the whole territory of the prison.

69 Only one of the ten prisoners concerned had a job and one more attended school.

70 According to the staff, six out of ten prisoners refused to take their daily outdoor exercise.

At the end of the visit to *Litla-Hraun Prison*, the Director told the delegation that he had decided to allow the aforementioned prisoners to use the exercise yard by themselves (without the presence of other inmates) for one hour each day. The CPT welcomes this initiative which can be considered as a first step forward; however, **the prisoners concerned (and, more generally, any other prisoners who might have a reason to fear their fellow inmates) should ideally have the same entitlement to daily outdoor exercise as all the others, under conditions which guarantee their safety. This may well require constructing a separate, secure outdoor exercise yard for them.**

4. Health care

34. As regards health-care staff resources, *Akureyri Prison*[71] continued to receive a weekly visit by a doctor (a GP)[72] but, unlike in 2012, there was no visiting nurse. In case of a medical emergency an ambulance was called.

Just as during the 2004 visit,[73] *Kvíabryggja Prison*[74] did not possess its own health-care service and relied in case of need on the nearby (7 km away) health-care centre in Grundarfjörður. This arrangement continued, it seemed, to operate generally adequately and the delegation did not hear any complaints from inmates about their access to the GP.

At *Litla-Hraun Prison*[75] primary health care was provided by a team of three GPs and two nurses from the Health Care Institution of South Iceland (Heilbrigisstofnun Suðurlands) located in Selfoss (the nearest town, 11 km away).[76] The GP's were present in the prison 6 times per month.[77]

One of the nurses (who had undergone training in psychiatric nursing) worked at *Litla-Hraun Prison* 4 times per week, the other one came twice per week. All in all, the health-care staff coverage amounted to 8 hours per day from Monday to Friday (i.e. there was no coverage at night and on weekends).

Hólmsheiði Prison[78] was attended by a GP twice per week,[79] by a nurse 3 – 4 times per week (for 6 to 8 hours at a time) and by another nurse once per week. Doctors were also on call every working day from 8 a.m. to 5 p.m. and one of the nurses could be called in any time (the other one on weekdays only).

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71 Capacity 10, population at the time of the visit: 7.

72 As had been the case during the 2012 visit, see paragraph 52 of CPT/Inf (2013) 37, https://rm.coe.int/1680696c40.

73 See paragraph 47 of CPT/Inf (2006) 3, https://rm.coe.int/1680696c17.

74 Capacity 23, population at the time of the visit: 21.

75 Capacity 87, population at the time of the visit: 68.

76 By comparison, in 2012 the establishment (which back then had the population of 73) was visited by a GP on two days per week and by a nurse on four days per week; so, the coverage by doctors had worsened and that of nurses had improved. See paragraph 52 of CPT/Inf (2013) 37, https://rm.coe.int/1680696c40.

77 Twice during the 1st and the 3rd week of the month, and once during the 2nd and the 4th week, reportedly (according to one of the doctors interviewed by the delegation) "for as many hours as needed"; they were also available on call outside of these periods. In case of emergency an ambulance from Selfoss could be called; it apparently took some 10 minutes for the ambulance team to arrive.

78 Capacity 56, population at the time of the visit: 44.

79 There was a team of doctors employed by a private GP practice in Reykjavík, with which the PPA had signed a contract following a tender procedure.

35. In the light of the above, **the Committee reiterates its recommendation that the Icelandic authorities strive to increase the time of presence of a doctor at Litla-Hraun Prison.**

As regards nursing staff, **establishments accommodating remand prisoners (especially Hólmsheiði Prison and Litla-Hraun Prison)[80] should, in the CPT's view, have a 24-hour health-care staff availability. As a minimum, steps must be taken to ensure that a person competent to provide first aid is always present in those establishments, including at night and on weekends; preferably, this person should be a qualified nurse.**

As for *Akureyri and Kvíabryggja Prisons*, the Committee remains of the view that they would benefit from daily visits by a qualified nurse, who could respond to the prisoners' needs for basic care and, where necessary, refer cases to a doctor. Furthermore, the nurse in question could receive prisoners' requests for consultations and administer prescribed medicines, tasks currently performed – in all the prisons visited – by medically untrained prison officers (which also raises the medical confidentiality issue).[81] **The CPT recommends that efforts be made to arrange such daily visits in the two aforementioned establishments.** More generally, **the practice of distributing medication by medically untrained custodial staff should be discontinued in all Icelandic prisons as soon as possible.**

36. As had been criticised by the Committee in the past,[82] access to dental care remained restricted for prisoners because they were expected to pay for such treatments,[83] at least partially.[84] Several inmates interviewed by the delegation complained about this.

In the CPT's view,[85] the provision of health care in prisons must be the State's responsibility and, given their specific health-care needs, prisoners should enjoy at least the same standards of health care as those available in the community, and should have access to necessary health-care services (examinations, treatments and medication) free of charge.

The CPT calls upon the Icelandic authorities to ensure that all prisoners have access to adequate dental treatment, including those without the means to pay for such treatment.

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80 Akureyri Prison did accommodate remand prisoners occasionally, but never for a long period.

81 Medication prescribed by doctors was packed by nurses (those working in the establishments concerned or those from local health-care centres) into plastic boxes for each prisoner for one week (labelled with the name of the prisoner and names and dosages of medication) and was stored in the custodial staff's duty rooms; it was thus possible for custodial staff to obtain information about inmates' medical conditions. It is also noteworthy that – at least at Hólmsheiði Prison – some inmates claimed that custodial officers had occasionally made mistakes regarding the type, dosage and/or frequency of medication they were supposed to give to prisoners.

82 See e.g. paragraph 50 of the report on the 2004 visit (CPT/Inf (2006) 3, https://rm.coe.int/1680696c17).

83 One of interviewed prisoners told the delegation that 2 visits to a dentist had recently cost him 85.000 ISK (approximately 620 EUR), which reportedly corresponded to his entire monthly salary for work.

84 It was reportedly possible to request partial *ex post* reimbursement from the relevant local (municipal) social care services, but the procedure was cumbersome and slow, and not every interviewed prisoner knew about it.

85 As well as in the view of the United Nations, see Rule 24 (1) of the UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), adopted by the UN General Assembly on 29 September 2015, https://undocs.org/A/RES/70/175.

37. Despite the recommendations reiterated by the Committee ever since its very first visit to Iceland (in 1993),[86] there was still no systematic and (especially) prompt medical screening of newly-arrived inmates,[87] including the checking for the presence of injuries and transmissible diseases,[88] in the prisons visited.[89]

The CPT has stressed in the past that the aforementioned situation is unacceptable. Systematic medical screening of newly-arrived prisoners is essential, particularly to reduce the risk of suicides and prevent the spread of transmissible diseases, and for recording injuries in good time. Save for exceptional circumstances, the medical screening of prisoners should be carried out on the day of admission, especially as regards those entering the prison system. **The Committee once again calls upon the Icelandic authorities to take the necessary measures to ensure that all prisoners are examined by a doctor, or by a qualified nurse reporting to a doctor, within 24 hours of their admission. The procedure should also include systematic TB screening and voluntary testing for HIV and hepatitis B and C.**

Further, **the CPT reiterates its recommendation that specific instructions[90] be issued to ensure that, whenever prison health-care staff observe injuries on an inmate's body which are consistent with allegations of ill-treatment made by the prisoner (or which, even in the absence of allegations, are indicative of ill-treatment), such injuries are duly recorded by the health-care staff and the record is immediately and systematically brought to the attention of the relevant prosecutor, regardless of the wishes of the person concerned. The health-care staff should advise the prisoner concerned that the writing of such a report falls within the framework of a system for preventing ill-treatment, that this report automatically has to be forwarded to a clearly specified independent investigating body and that such forwarding does not substitute for the lodging of a complaint in proper form.[91]**

The Committee also reiterates its recommendation that a centralised system for recording injuries be introduced (e.g. a specific register kept by the prison health-care service) to better monitor the situation, detect incidents and identify potential risks in order to prevent inter-prisoner violence.

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86 See paragraph 103 of CPT/Inf (94) 8, https://rm.coe.int/1680696bda.

87 Some inmates at Litla-Hraun alleged it had taken up to 12 days after their arrival before they had first seen a doctor, and a few claimed they had only seen one after they had requested it. At Hólmsheiði Prison – a primarily remand prison and a point of entry to the prison system for many inmates – there were reportedly frequent delays of up to 3 days before the initial medical screening.

88 The delegation was told at the outset of the visit that there used to be a programme (run by staff from the National Hospital in Reykjavik) under which newly-arrived inmates at Hólmsheiði and Litla-Hraun Prisons had been offered screening for HIV and Hepatitis B and C, but the programme had ended during the recession period and presently there was no such screening (and also no treatment) at any of the prisons.

89 And there was no screening at all at Kvíabryggja Prison.

90 The Committee understands that the existing instructions on this subject issued by the PPA Director General (see paragraph 27 above) do not apply to health-care staff.

91 Reference is also made here to more detailed standards contained in the substantive section of the CPT's 23rd General Report ("Documenting and reporting medical evidence of ill-treatment"), in particular in paragraphs 73 to 82 (document CPT/Inf (2013) 29, https://rm.coe.int/1680696a9b).

38. As regards medical documentation, the delegation noted that the (exclusively) computerised records in the prisons visited were generally well kept and that the confidentiality of the data contained in them was respected. That said, there was still no uniform system for the keeping of such documentation, and no efficient procedure for the exchange of medical information between prisons (especially between *Hólmsheiði* and *Litla-Hraun Prisons*).[92] This posed a problem if/when an inmate needed to be transferred to another penitentiary establishment.

The CPT recommends that the Icelandic authorities establish systems to facilitate the sharing of medical records amongst the relevant medical services for the benefit of the overall care of prisoners. Consideration should be given to merging the information into one unified electronic system, to ensure swift and easy access to relevant medical information for prison health-care staff and to enable adequate continuity and equivalence of care for inmates, both to and from the outside community.

39. The Committee is seriously concerned by the fact that prisoners in Iceland continue to have extremely limited access to psychiatric care and psychological assistance.

The situation at *Litla-Hraun Prison* had even further deteriorated, as there were no more visits by a psychiatrist to the establishment,[93] despite the presence of inmates suffering from psychiatric problems.[94] The situation was likewise unacceptable in the other prisons visited, which were never visited by a psychiatrist. The Director of *Hólmsheiði* and *Litla-Hraun Prisons* (and GPs working there) acknowledged that the mental state of several inmates was such that they should have been transferred to an appropriate health-care facility. However, such transfers remained virtually impossible to arrange.

As for psychological assistance, the PPA employed three psychologists[95] who visited *Litla-Hraun and Hólmsheiði Prisons* once – twice per week; however, visits to the other two prisons were very rare (e.g. twice per year in *Kvíabryggja*) and the PPA offered instead to inmates the possibility to have consultations with psychologists using Voice over Internet Protocol (VoIP).[96] It is also noteworthy that the PPA psychologists performed both risk assessment and therapeutic functions.

40. In the light of the above, **the CPT reiterates its long-standing recommendation that the provision of psychiatric care be significantly improved in all the prisons visited. The Committee also calls upon the Icelandic authorities to take immediate steps to ensure that mentally ill prisoners who require in-patient psychiatric treatment are kept and cared for in appropriate facilities.**

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92 This was apparently due to the fact that (as already mentioned in paragraph 34 above) health-care staff working at Hólmsheiði Prison was not part of the public health-care system but belonged to a private company that had won the tender to provide health-care services to prisoners there.

93 Since 2013. Until the end of 2012 Litla-Hraun Prison had been visited by a psychiatrist twice a month, see paragraph 57 of CPT/Inf (2013) 37, https://rm.coe.int/1680696c40.

94 At least 10% of inmates according to the PPA representatives whom the delegation met at the outset of the visit.

95 The delegation was informed by the PPA officials that a fourth psychologist had just been recruited and was expected to start working as from 1 June 2019.

96 One prisoner at Kvíabryggja Prison had obtained the authorisation to have such consultations with his private psychologist, at his own cost (10.000 ISK, approximately 75 EUR, for each 30-minute session).

Further, **the CPT recommends that the Icelandic authorities develop the role of prison psychologists, especially as regards therapeutic clinical work with various categories of inmates. In this context, efforts are needed to recruit, in due course, clinically trained psychologists who should form part of the health-care team and whose work should avoid combining two different roles i.e. risk assessment and therapeutic clinical work.**

41. The problem of alcohol and drug addiction continues to be one of the major challenges facing the Icelandic prison system.[97]

Representatives of the PPA met by the delegation at the outset of the visit estimated that 70 to 80% of inmates at *Litla-Hraun Prison* had an addiction problem. Some limited access to drug substitution (Suboxone, a combination medication that includes buprenorphine and naloxone) was provided in the establishment[98] but starting the treatment required a rather long and cumbersome procedure[99] and the delegation heard some complaints from inmates that they had to go through withdrawal without any medication alleviating the symptoms because it had taken too long to process the request.

As previously,[100] there was also a "drug free" unit at *Litla-Hraun Prison* (with 11 places and nine inmates at the time of the visit) where prisoners could follow (upon their personal written application and after signing a "contract"[101] with the administration) a dedicated drug treatment programme[102] which, upon successful completion, could result in their transfer to an open prison or to an outside drug treatment facility (Vogur).[103]

More was on offer for inmates with alcohol addiction: AA meetings were held every day at *Litla-Hraun Prison* (attended by 2 to 12 prisoners every time), twice a week at *Hólmsheiði Prison* and occasionally at *Akureyri and Kvíabryggja Prisons*.

42. Despite the above, the delegation's overall impression was that there was still no comprehensive multi-disciplinary strategy to deal with drugs in prison, and that the main means applied in practice were disciplinary sanctions[104] at *Litla-Hraun Prison* and sending prisoners back to closed prisons from *Kvíabryggja*,[105] in case of a positive drug test.[106]

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97 Impacting also the general atmosphere in prisons and related to the phenomenon of inter-prisoner violence at Litla-Hraun Prison (see paragraph 26 above).

98 Ten inmates were on Suboxone at the time of the visit (and one prisoner at Hólmsheiði Prison).

99 Reportedly, only one medical specialist, working at the National University Hospital in Reykjavík, was authorised to prescribe Suboxone (prescriptions were apparently usually sent to the prison by e-mail) upon official written request by the prison doctor.

100 See paragraph 58 of the report on the 2012 visit (CPT/Inf (2013) 37, https://rm.coe.int/1680696c40).

101 In which prisoners concerned undertook to stay off drugs (and consented to regular drug testing) and to follow the programme.

102 Consisting, among others, of individual and group therapy (provided by one of the PPA psychologists and a drug counsellor), lectures, meditation sessions and AA meetings.

103 Although the facility reportedly only had 1 – 2 vacant places per year, and there was a long waiting list.

104 See paragraph 46 below.

105 According to the Director of Kvíabryggja Prison, two to eight inmates were sent back to a closed prison every year for this reason.

106 It is noteworthy that the urine drug tests available in prisons (so called UScreen drug test cups) were capable of detecting different "classical" drugs (marihuana, cannabis, cocaine, opiates 300, opiates 2000, phencyclidine, oxycodone, tricyclic antidepressants, ecstasy, amphetamine, methamphetamine, barbiturates, benzodiazepine, methadone, buprenorphine, etc.) but not the new synthetic drugs (synthetic cannabinoids) and in particular the so-called "Spice" which was, according to interviewed prisoners, management and staff, becoming

In particular, the PPA did not initiate any harm reduction measures, leaving this area entirely to the Icelandic Red Cross and NGOs.

In this context, the CPT must reiterate its view that the management of prisoners with drug dependence must be varied – eliminating the supply of drugs into prisons, dealing with drug abuse through identifying and engaging drug users, providing them with treatment options and ensuring that there is appropriate through care, developing standards, monitoring and research on drug issues, and the provision of staff training and development – and linked to a proper national prevention policy. This policy should also highlight the risks of HIV or hepatitis B/C infection through drug use and address methods of transmission and means of protection. It goes without saying that the multi-disciplinary task of drawing up, implementing and monitoring the programmes concerned must be performed by prison staff in close co-operation with health-care personnel and other (psycho-socio-educational) staff involved.

The Committee calls upon the Icelandic authorities to devise and implement a comprehensive strategy for the provision of assistance to prisoners with drug-related problems (as part of a wider national drugs strategy) including harm reduction measures, in the light of the above remarks. Reference is also made to paragraphs 43 and 44 below.

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43. Iceland has been among those of the States-Parties to the Convention which had decided (many years ago) that the provision of health care to prisoners should be under the entire responsibility of the Ministry of Health. While this was in principle a positive decision (as it should have better guaranteed the respect of professional independence of health-care staff and of the general principle of equivalence of health care in prison with that in the wider community), the Committee has – from its very first visit to Iceland in 1993[107] – pointed out several persistent and serious shortcomings of prison health-care services, including those referred to (again) in paragraphs 37, 39, and 41 above (as regards medical screening including recording of injuries, psychiatric care and psychological assistance, and tackling drug and alcohol addiction in prisons).

In the CPT's view, the persistence of this highly unsatisfactory state of affairs is at least partly due to the fact that the specificity of health-care needs of the prisoner population is not duly recognised by the Icelandic authorities, in particular by the Ministries of Justice and Health. The organisation of prison health-care services, their interaction with outside clinics and hospitals (especially psychiatric) and the job descriptions and training of health care professionals working with prisoners do not sufficiently reflect this specificity. Furthermore, the absence of a clear structure and chain of responsibility, specific to the health-care service provision in prisons, and a lack of an effective quality control by the Ministry of Health has a negative impact on the quality of care.

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increasingly "popular" among inmates. The only law enforcement agency equipped to detect "Spice" was the Icelandic Customs Service (the delegation spoke with customs officers at Keflavik International Airport) which had at its disposal a spectrophotometer that could scan more than 450 suspected controlled substances in a single, definitive test.

107 See e.g. paragraphs 93 to 113 of CPT/Inf (94) 8, https://rm.coe.int/1680696bda.

44. In the light of the above-mentioned findings, the delegation has – at the end of the visit[108] – requested the Icelandic authorities to transmit to the Committee, within 3 months, a detailed action plan (comprising precise tasks, agencies responsible, deadlines and financial allocations) for the provision of health care and for tackling the issue of drugs in prison. The delegation stressed that this would require putting in place genuine co-ordination, at both the senior and the operational levels, between the Ministries of Justice and Health, and developing specific protocols for the provision of primary and specialist health care in prisons, reflecting particular health-care needs of the prisoner population.

In their letter of 15 August 2019, the Icelandic authorities informed the CPT that the Ministry of Justice had set up a joint working group composed of representatives of the Ministry of Health, the PPA, Reykjavík University Hospital, the Directorate of Health and the Health Care Institution of South Iceland, the task of which was to draft an action plan by 1 December 2019. **The Committee requests to be provided with the full text of the above-mentioned action plan in the Icelandic authorities' response to this report.**

5. Other issues

45. Overall, the rules concerning prisoners' contact with the outside world have remained the same as on the CPT's 2012 visit.

Inmates, both those on remand and those already sentenced, were entitled to receive *visits* twice per week for up to 2 hours, usually in open conditions.[109] Further, the managements of the prisons visited frequently granted additional visits to prisoners. Visits took place in well-equipped and pleasantly decorated facilities (except at Kvíabryggja Prison where there were no dedicated visiting premises, see paragraph 28 above).

In all the prisons visited, inmates could make *telephone* calls every day for at least 15 minutes. At Kvíabryggja Prison inmates could have their own mobile phones (without a camera and without Internet) or could rent a mobile from the establishment.

Further, there were no restrictions on incoming and outgoing *correspondence.* In addition, inmates whose families lived abroad (or in Iceland but a long distance from the prison) had the possibility to communicate with their relatives using Voice over Internet Protocol (VoIP). Some prisoners also had access to e-mail (if justified by their work, e.g. those who ran their companies from Kvíabryggja Prison).

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108 See paragraph 8 above.

109 Visits in closed facilities (through glass partition, without physical contact) were exceptionally practiced in closed-type prisons and were as a rule imposed by prison Directors for a short period of time, as disciplinary sanction for a violation of the house rules in the context of a visit (in general, attempted drug smuggling or a positive drug test where the circumstances suggested that the inmate had obtained the drugs during a visit). In those rare cases where remand prisoners were subjected to court-ordered isolation (there were five such inmates at the time of the 2019 visit, all accommodated at Hólmsheiði Prison), their visits would also take place in closed facilities.

46. Disciplinary sanctions were generally not applied in an excessive manner in the prisons visited, and disciplinary isolation of up to 15 days[110] was imposed only exceptionally.[111]

That said, although in practice inmates were rarely sent to disciplinary isolation for longer than a few days, the Committee is of the view that, given its potentially very damaging effects, the maximum period of disciplinary isolation should be no more than 14 days for a given offence, and preferably lower.[112] **The CPT recommends that Section 74 of the Execution of Sentences Act be amended accordingly.**

The Committee has no concerns as regards the disciplinary procedure, which continued to offer the necessary safeguards to prisoners.[113] Also the material conditions and the regime[114] in disciplinary isolation do not call for any particular comment.[115]

47. The delegation was informed at the outset of the visit that recourse to court-ordered isolation of remand prisoners for investigative purposes had much diminished and was now rare, generally applied for a short period of time (up to two weeks) and hardly ever full.[116]

As for isolation on security grounds,[117] the only issue of concern worth mentioning here is the presence – in the dedicated cell at *Hólmsheiði Prison*[118] – of metal rings connected to the floor and surrounding the area for the location of the mattress. Though the delegation had absolutely no reason to doubt the veracity of explanations provided by the staff (that the rings had been fitted during the construction of the prison due to a planning mistake and that they had never been used), **the CPT recommends that the aforementioned rings be removed.**

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110 Pursuant to Section 74 of the Execution of Sentences Act.

111 The most frequent disciplinary sanctions were as follows: reprimand, temporary ban on non-standard items, temporary ban on additional activities (other than outdoor exercise), temporary reduction in salary and temporary imposition of closed visits. As already mentioned in paragraph 45 above, the last-mentioned sanction was often related to attempted drug smuggling during a visit or a justified suspicion that drugs consumed by the inmate had been introduced to the prison during a visit.

112 See also paragraph 56 of the CPT's 21st General Report (CPT/Inf (2011) 28, https://www.coe.int/en/web/cpt/annual-reports).

113 In particular, prisoners were systematically offered the possibility to attend an oral hearing and to present their explanations prior to the decision, and were given a document with the reasoned decision and information on the avenues of complaint available. They were also offered legal assistance.

114 In particular, prisoners in disciplinary isolation had access to daily outdoor exercise (at least one hour) and reading matter, and could receive visits (in closed-type facilities) and make telephone calls.

115 It is noteworthy that disciplinary isolation cells only existed at Litla-Hraun and Hólmsheiði Prisons.

116 (Closed) visits and phone calls (to selected numbers) were usually permitted to prisoners concerned.

117 Based on Sections 75 (temporary placement for up to 24 hours) and 76 (if necessary to prevent violence, contain violent resistance or prevent an inmate from injuring him/herself or others, for as long as "compatible with the aim of the measure") of the Execution of Sentences Act. E.g. at Hólmsheiði Prison there had been 13 placements pursuant to Sections 75 and 76 between April 2018 and April 2019, lasting from a few hours to 5 days.

118 Which otherwise offered adequate conditions: it measured some 18 m², was well-lit and ventilated, clean and equipped with a washable mattress and a floor-level toilet, as well as a call system and CCTV.

48. As had been observed in the past,[119] prisoners could send complaints to a range of bodies including the prison's Director,[120] the Director General of the PPA, the Minister of Justice and the Althing Ombudsman.[121] Information on these bodies (including their contact details) was posted in a visible manner, in at least Icelandic and English, in the common areas of prisoner accommodation units.

That said, the delegation noted that internal complaints (unlike the external ones) could not be made in a confidential manner (e.g. in a sealed envelope). **The Committee recommends that steps be taken to remedy this *lacuna* (by providing complaint forms and envelopes that prisoners could place in a locked complaints box, located in each accommodation unit, to be opened only by specially designated persons).**

Furthermore, the CPT's delegation was told by management and staff in the prisons visited that their respective establishments had never (or only very rarely) received internal inspections, be it from the Ministry of Justice or the PPA. Considering the importance of effective internal oversight in ensuring adequate treatment of prisoners, **the CPT would welcome the Icelandic authorities' comments on this subject.**

As regards monitoring, reference is made to the comments in paragraph 11 above.

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119 See e.g. paragraph 65 of the report on the 2012 visit (CPT/Inf (2013) 37, https://rm.coe.int/1680696c40).

120 The procedure for internal complaints was set out in an order issued by the Director General of the PPA on 26 June 2017. The prisoner handed out his/her written complaint (or made it verbally, in which case the complaint had to be recorded) to the duty head of shift who had to inform the Director without delay. The prisoner was then invited to present his/her complaint orally to the Director, who could invite the incriminated staff member to comment (in which case the inmate had to be given the opportunity to comment further). The prisoner had to be informed (in a written and reasoned manner) of the Director's decision and of the possibility of further appeal. If the complaint concerned the Director, it had to be entered in a dedicated electronic register and transmitted without delay to the PPA.

121 They could also contact the prisoner's union (Afstaða) which *inter alia* offered free legal assistance to inmates. Information on this possibility was clearly visible in prisoner accommodation areas. It is interesting to note in this context that Afstaða representatives met the PPA Director General on a regular (monthly) basis to discuss various issues of inmates' concern.

C. Psychiatric establishments

1. Preliminary remarks

49. The CPT's delegation carried out follow-up visits to the Psychiatric Department of Reykjavik University Hospital (Landspítali),[122] the forensic and secure wards of the Psychiatric Department of Reykjavík University Hospital (the Kleppur campus)[123] and the psychiatric ward at Akureyri Regional Hospital.[124]

The catchment area of the Psychiatric Department of Reykjavik University Hospital extended across almost the whole country, except for the northern Akureyri region, served by the psychiatric ward at Akureyri Regional Hospital. Patients at the Psychiatric Department were accommodated on three units – psychiatric intensive care unit (10 beds), acute general psychiatry unit (31 beds), and acute dual diagnosis (addiction) unit (15 beds); the total capacity of the Psychiatric Department was 56 beds. At the time of the visit, the ward was accommodating 61 adult patients – 29 male and 32 female;[125] 13 of them were involuntary.

The forensic ward in Kleppur had an official capacity of 9 beds, and on the day of the CPT's visit was accommodating two adult male forensic patients (one since 2017 and another since late 2015).[126]

The secure ward in Kleppur had 8 beds and was operating at its full capacity on the day of the delegation's visit. All patients (adult males) had been involuntarily admitted and were deprived of their legal competence.[127] The average stay on the secure ward was 4 months.[128]

The psychiatric ward at Akureyri Regional Hospital served a population of around 40,000 inhabitants and had 10 beds. At the time of the visit, the ward was accommodating seven patients, five of them women. None of the patients were involuntary; however, according to the head psychiatrist, there were five or six involuntary patients every year on average.

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122 Visited by the CPT in 2004, see paragraphs 66 and following of the report on the visit (CPT/Inf (2006) 3), https://rm.coe.int/1680696c17.

123 Visited by the CPT in 2012, see paragraphs 68 and following of the report on the visit (CPT/Inf (2013) 37), https://rm.coe.int/1680696c40.

124 Visited by the CPT in 1998, see paragraphs 102 and following of the report on the visit (CPT/Inf (99) 1), https://rm.coe.int/1680696bfd, and in 2012, see paragraphs 68 and following of the report on the visit (CPT/Inf (2013) 37), https://rm.coe.int/1680696c40.

125 Additional beds were used in the acute general psychiatry unit and acute dual diagnosis unit. The psychiatrist informed the delegation that in 2018 the average occupancy was 104%.

126 One more patient was already in the process of leaving the institution; he had been given social housing but would still sometimes come and spend a night in the ward.

127 Usually these were persons suffering from schizophrenia with a long history of drug abuse and violence.

128 It is important to note, however, that the average term of deprivation of legal competence was 2 years, which meant that if a patient's condition worsened after being discharged while he/she was still deprived of his/her legal competence, he/she would be hospitalised again on the secure ward in Kleppur without any additional decisions being taken by the District Commissioner or the court.

50. The delegation was informed in the Kleppur campus that there was one patient on the forensic ward and two patients on the secure ward who did not need to be hospitalised any longer but who were not discharged because of a lack of social housing in the community. In the Committee's view, for persons to remain *de facto* deprived of their liberty as a result of the absence of appropriate community facilities is a highly questionable state of affairs. **The CPT invites the Icelandic authorities to increase their efforts in developing psychiatric care in the community.**[129]

51. It should be stressed that no allegations were heard – or any indications found – of any form of ill-treatment by staff in any of the psychiatric establishments visited by the Committee's delegation. On the contrary, most of the patients interviewed spoke highly of the staff, especially the ward-based staff (i.e. the nurses and orderlies).

Further, inter-patient violence did not appear to be a major problem and whenever such incidents occurred, staff intervened promptly and adequately. The CPT welcomes this.

2. Patients' living conditions

52. The living conditions in the psychiatric establishments visited by the delegation could be described as good or even very good on the whole. Patients were accommodated in spacious rooms (9 to 15 m² for single use;[130] 14 to 16 m² for double occupancy), with adequate access to natural light, artificial lighting and ventilation; the rooms were suitably equipped.[131] Patients' clothing was individualised – patients were allowed to wear their own clothes which they could wash themselves using washing machines on the wards.

The rooms were not locked (including at night)[132] and patients had unrestricted access to day rooms and other communal facilities (e.g. dining and smoking areas) which were pleasantly furnished, comfortable, and offered a warm atmosphere.[133]

53. However, in every establishment visited, there were some shortcomings regarding the patients' access to a daily outdoor exercise.

Despite the Committee's recommendation following the 2012 visit, there was still no specific assigned outdoor area for patients on the psychiatric ward of Akureyri Hospital which meant that involuntary patients had no access to a daily outdoor exercise.[134]

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129 This should also be seen in the context of the State's obligations stemming from the UN Convention on the Rights of Persons with Disabilities, ratified by Iceland in 2016.

130 All patient rooms in the psychiatric intensive care unit at the Psychiatric Department of Reykjavik University Hospital and on both wards of Kleppur campus were single occupancy.

131 Beds with full bedding, tables, chairs, lockers, shelves, television sets, call bells, etc.

132 Patients had keys to their rooms.

133 The day area on the psychiatric ward at Akureyri Regional Hospital was especially cosy and welcoming.

134 Voluntary patients were free to walk within the entire territory of the hospital.

The outdoor area for involuntary patients at the Psychiatric Department of Reykjavik University Hospital[135] was not properly equipped (there were no means of rest or any shelter against inclement weather and no paths for patients to walk, just a lawn and a small tiled strip in the corner) and it was difficult to access (patients needed to be accompanied by the staff to navigate the hospital corridors leading to the outdoor area).

Furthermore, none of the secure areas[136] in any of the establishments visited was equipped with an outdoor yard and, as the delegation learned, there were cases when a patient could spend days, and sometimes weeks, in the secure area without having access to a daily outdoor exercise.[137]

In the CPT's view, all patients should benefit from unrestricted daily access to the open air, unless there are clear medical contraindications. **The Committee reiterates its recommendation that the Icelandic authorities provide the psychiatric ward at Akureyri Regional Hospital with a designated secure outdoor area for involuntary patients.** Further, **the CPT recommends that the Icelandic authorities address the shortcomings in the outdoor area of the Psychiatric Department of Reykjavik University Hospital and take measures to ensure that secure areas in all the establishments visited are either equipped with outdoor yards or that patients in seclusion are taken daily for outdoor exercise outside the secure area.**

3. Staff and treatment

54. Staffing levels were satisfactory in all the psychiatric establishments visited.

The Psychiatric Department of Reykjavik University Hospital[138] employed 11 full-time psychiatrists and five junior doctors in training, specialising to be a psychiatrist. The nursing staff consisted of 47 part-time nurses and 27 part-time orderlies. Further, there were three part-time psychologists, four part-time occupational therapists and four part-time social workers.

The forensic ward and the secure ward in Kleppur[139] were altogether staffed with one full-time psychiatrist (a head doctor), a part-time junior doctor (psychiatrist) and a part-time general practitioner, as well as ten part-time nurses and two part-time orderlies. Further, there was one part-time psychologist, one part-time social worker, and one part-time occupational therapist.

The psychiatric ward at Akureyri Regional Hospital[140] employed three full-time psychiatrists, 17 part-time nurses, and six part-time orderlies. As regards other staff qualified to provide therapeutic and rehabilitative activities, the ward employed three full-time psychologists, five part-time occupational therapists and two part-time social workers.

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135 A closed space between two hospital wings.
136 Special premises where an agitated patient would be kept in seclusion (see paragraph 58 below).
137 One patient from the forensic ward in Kleppur campus had not had access to outdoor exercise for three weeks.
138 Official capacity - 56 beds.
139 Together having a capacity of 17 beds.
140 Official capacity – 10 beds.

55. As regards treatment, the psycho-pharmacotherapy provided to patients in the establishments visited does not call for any particular comment. The treatment available was based on an individual approach, involving the drawing up of a written treatment plan for each patient (with the participation of a patient concerned who signed a "therapeutic contract") and subsequent monitoring of its implementation.

56. By contrast, the delegation was not able to find in any of the psychiatric establishments visited reasonably detailed written records of patients' somatic status (including as regards any injuries observed upon their arrival). The Committee must thus reiterate its view that all newly-arrived psychiatric patients should be examined somatically by a doctor within 24 hours of their admission.[141] Such somatic screening should be repeated at suitable intervals. A patient's personal medical file should contain diagnostic information (including the results of any special examinations which the patient has undergone) as well as an on-going record of the patient's mental and somatic state of health and of the treatment.

The CPT recommends that the Icelandic authorities take steps to ensure that the aforementioned precepts are effectively followed in practice as regards patients in all psychiatric establishments.

57. Patients could participate in some therapeutic and rehabilitative activities, including occupational therapy, but the overall range and frequency of activities on offer was rather limited. The situation was of even more concern on the psychiatric ward at *Akureyri Regional Hospital* where the delegation learned that all the activities were organised in the out-patient clinic to which involuntary patients did not have access because they were not authorised to leave the ward.

Furthermore, despite the existence of aforementioned individual treatment and rehabilitation plans, the delegation's impression was that other (than doctors) members of the multi-disciplinary team, namely psychologists, social workers and occupational therapists were not sufficiently involved in the development and implementation of these plans; indeed, psychologists were mainly engaged in assessment and evaluation upon admission (as assigned by the treating psychiatrist) and only occasionally in some treatment.

The Committee recommends that the Icelandic authorities take the necessary steps to provide all patients with a wide range of rehabilitative and recreational activities as part of their treatment plans; efforts must be made to strengthen the involvement of all members of the multi-disciplinary teams in the development and implementation of such plans.

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141 Reference is also made here to more detailed standards contained in the substantive section of the CPT's 23rd General Report ("Documenting and reporting medical evidence of ill-treatment"), in particular in paragraphs 73 to 82 (document CPT/Inf (2013) 29, https://rm.coe.int/1680696a9b).

4. Seclusion and other means of restraint

58. The delegation noted that mechanical restraint was never applied and that seclusion or chemical restraint were used only as a last resort in the psychiatric establishments visited.

All three establishments had secure areas[142] where an agitated patient could be secluded as an emergency intervention. Guidelines developed locally by the respective managements included provisions describing under what circumstances seclusion could be applied, practical means of its application, supervision required and action to be taken once the measure was terminated.

The delegation was informed that seclusion in a secure area or in the room in the secure area was applied for the shortest duration possible and that there were always two staff members together with a patient in the secure area.[143] The delegation noted, however, that despite the CPT's past recommendations, there were still no registers documenting all instances of the application of means of restraint (including chemical restraint).[144]

The CPT reiterates its recommendation that dedicated registers for the use of means of restraint be created in all the psychiatric establishments visited; this will greatly facilitate the management of such incidents, the oversight into the extent of their occurrence and may also enable measures to be taken to reduce their occurrence.

59. The Committee welcomes the fact that Icelandic psychiatric establishments have developed internal policies on restraint as recommended by the CPT in its previous report. It is important to note, however, that in the Committee's view, all types of restraint and the criteria for their use should be regulated by the law.[145] **The CPT recommends that the Icelandic authorities regulate the use of means of restraint in the legislation instead of leaving it solely to the discretion of the psychiatric establishments.**

60. The CPT is concerned by the fact that the practice whereby uniformed police officers could on occasion be called to help the health-care staff control patients with aggressive behaviour still existed in the psychiatric establishments visited,[146] despite the fact that – after the 2012 visit – the Committee had recommended the aforementioned practice be stopped immediately.

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142 Each secure area contained a room (of some 12 m²) equipped with a bed only, a bathroom (a toilet, a washbasin and a shower), a sitting room with a TV and a smoking room. See also paragraph 53 above.

143 If a patient was secluded in a room in a secure area, one staff member constantly supervised him/her through the glass window in the door.

144 Application of means of restraint was recorded in patients' personal files and in special forms that were later submitted to the management.

145 See also "Means of restraint in psychiatric establishments for adults (Revised CPT standards)", document CPT/Inf (2017) 6, https://rm.coe.int/16807001c3.

146 The delegation was told that in some cases police officers would be present while the staff manually controlled a patient and gave him/her an injection; in other cases, police officers held a patient while an injection was being given.

The CPT must reiterate its view that, apart from in very exceptional circumstances (e.g. extreme violence), an intervention by the police on a psychiatric ward is inappropriate and frightening for the patient concerned, as well as for other patients observing them. Moreover, police officers are not specifically trained to manage psychiatric patients. Psychiatric establishments should have a sufficient number of properly trained staff to manage agitated patients without recourse to the police.

The Committee calls upon the Icelandic authorities to put an end to the practice of involving police officers in managing agitated patients in psychiatric establishments. Further, **all nursing staff in psychiatric establishments should be trained in the appropriate ways of managing agitated patients and refresher courses should be organised at regular intervals.**

61. The CPT's delegation was also concerned to learn that, in cases when patients from *Akureyri Regional Hospital* had to be transferred to the *Psychiatric Department of Reykjavik University Hospital*, the transfer was always carried out by the police, sometimes accompanied by hospital staff.[147] On occasion, patients would spend the entire 5-hour car journey to Reykjavik wearing a body belt.[148]

In the Committee's view, the police should not be the agency responsible for transfers from one psychiatric establishment to another. Persons with mental health-care needs should, in principle, always be transported by health-care staff and police only involved in very exceptional circumstances. **The CPT recommends that the Icelandic authorities take urgent measures to stop the above-mentioned practice and to ensure that transfers of psychiatric patients are carried out in conditions ensuring their safety and dignity. In particular, body belts should not be used in the course of such transfers.**

5. Safeguards in the context of involuntary hospitalisation

62. From the outset, the Committee must stress with deep concern that, despite the CPT's long-standing recommendations, the Icelandic authorities have done little to improve the legal safeguards in the context of involuntary hospitalisation; amendments introduced to the Legal Competence Act in 2015 have failed to bring about the necessary changes. Consequently, the Committee cannot but note that most of the problems identified in the reports on previous visits, some of them dating back to 15 years ago, have still not been addressed.[149]

63. As regards initial placement, according to the Legal Competence Act, a medical doctor may decide to hospitalise a person against his/her will in a psychiatric establishment for up to 72 hours if a person suffers from a serious psychotic disorder, or if this is deemed highly probable, or if the person's condition is reasonably deemed analogous to that leading from such a disorder.

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147 This was based on a framework agreement signed between the hospital and the police in Akureyri. The delegation was informed that there were approximately 3 such transfers on average each year.

148 A "body belt" consisted of a belt applied around the abdominal area to which the hands were attached in front of the body, thus limiting any arm movement. It was part of standard police equipment in Iceland.

149 See paragraphs 77 and following of the report on the CPT's 2004 visit to Iceland (CPT/Inf (2006) 3), https://rm.coe.int/1680696c17 and paragraphs 83 and following of the report on its 2012 visit (CPT/Inf (2013) 37), https://rm.coe.int/1680696c40.

A doctor may also decide to involuntary hospitalise a person if the person concerned suffers from a serious craving for alcohol or excessive use of drugs.

The CPT continues to find the aforementioned criteria for involuntary hospitalisation to be rather vague and subject to possible misinterpretation to the detriment of the persons concerned. **The Committee reiterates its recommendation that the Icelandic authorities amend the Legal Competence Act and introduce criteria which would ensure that involuntary hospitalisation takes place only when a patient's placement is absolutely necessary to prevent danger to the patient or to other persons.**

64. After the initial 72 hours, involuntary hospitalisation may be extended by decision of the competent District Commissioner[150] (a copy of the decision must be sent to the person concerned who has a right to receive legal assistance and to challenge the decision in court) for no longer than 21 days. Subsequently, a judge can decide to extend involuntary hospitalisation for up to 12 weeks. The request for extension must be accompanied by a statement from the doctor indicating that the hospital and the patient had attempted (but failed) to reach an agreement to continue the treatment and that an extension is necessary.

The CPT's delegation learned that during the process of extension of involuntary hospitalisation (by decision of the District Commissioner and later by the court) no other doctor, independent from the hospital, was usually involved and asked to provide an opinion. In this context, the Committee considers that an opinion from a second doctor who is independent of the hospital would offer an additional, important, safeguard.

The CPT recommends that the Icelandic authorities take steps to ensure that a psychiatric opinion (independent of the hospital in which the patient is placed) is always sought in the context of extension of involuntary hospitalisation.

65. Another issue, repeatedly raised by the Committee during its previous visits to Iceland, is the automatic linking of involuntary hospitalisation to the deprivation of legal competence. The CPT has stated many times in the past that the restriction of a person's rights should not be based on the mere fact that he/she has a mental disorder and is involuntarily hospitalised. However, after the most recent amendments in 2015, the Legal Competence Act still foresees that in order to extend involuntary hospitalisation beyond the 12 weeks originally granted by a court, a person has to be deprived of his/her legal competence (for a minimum of 6 months but possibly up to several years).

The Committee calls upon the Icelandic authorities to amend the Legal Competence Act to ensure that the deprivation of legal competence (which may well be necessary to protect the patient's personal and financial interests) requires additional grounds and a separate procedure.

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150 District Commissioners are senior officials representing the complete administrative branch of the Government locally, one in each of the 8 districts in Iceland. They perform *inter alia* the functions of Regional Commissioners of Police and regional Chiefs of Customs, and are responsible for the collection of various fees for the State, execution of judgments and various matters in the field of Family Law and the Legal Competence Act.

66. Involuntary psychiatric hospitalisation should cease as soon as it is no longer required by the patient's mental state. Consequently, the need for such hospitalisation should be reviewed by an appropriate authority at regular intervals.

In this context, the CPT notes with regret that – despite its repeated earlier recommendations – there is still no requirement for an automatic judicial review of the need to continue involuntary psychiatric hospitalisation, neither for civil nor for forensic patients.

The Committee calls upon the Icelandic authorities to amend the relevant legislation as regards both civil and forensic patients; if the period of involuntary placement is unspecified (or exceeds 6 months), there should be an automatic judicial review at regular intervals of the need to continue hospitalisation.

67. The delegation found the existing arrangements for patients' contact with the outside world to be satisfactory in the psychiatric establishments visited. Patients were able to send and receive correspondence, to have access to the telephone (either payphone or their mobile phones), and to receive visits from their family and friends.

68. Patients could lodge complaints with the hospital management and a number of outside bodies, including the Directorate of Health (which also carried out periodic inspections) and the Althing Ombudsman.

Furthermore, as mentioned in paragraph 11 above, the newly set up NPM had already carried out its first visit to a psychiatric institution (the Kleppur campus) in the end of 2018.

APPENDIX I:

List of the establishments visited by the CPT's delegation

Police establishments

- Reykjavík Police Headquarters
- Akureyri Police Station
- Búðardalur Police Station
- Borgarnes Police Station
- Keflavík International Airport Police Station
- Keflavík Police Station
- Kópavogur Police Station
- Ólafsvík Police Station
- Selfoss Police Station
- Stykkishólmur Police Station

Prisons

- Akureyri Prison
- Hólmsheið Prison
- Kvíabrygja Prison
- Litla-Hraun Prison

Psychiatric establishments

- Psychiatric unit of Reykjavík University Hospital (Landspítali)
- Forensic and secure wards of the Psychiatric Department of Reykjavík University Hospital (the Kleppur campus)
- Psychiatric ward of Akureyri Hospital

APPENDIX II:

List of the national authorities, other bodies and non-governmental organisations with which the CPT's delegation held consultations

A. National authorities

Ministry of Justice

Þórdís Kolbrún R. Gylfadóttir	Minister of Justice
Laufey Rún Ketilsdóttir	Political Advisor to the Minister
Haukur Guðmundsson	Permanent Secretary
Ragna Bjarnadóttir	Director General of Public Security and Criminal Justice
Berglind Bára Sigurjónsdóttir	Director General of the Department of Personal Rights
Elísabet Gísladóttir	Senior Legal Advisor

Prison and Probation Administration

Páll Winkel	Director General
Erla Kristín Árnadóttir	Deputy Director General
Sólveig Fríða Kjærnested	Division Manager of Therapy Department

Ministry of Health

Svandís Svavarsdóttir	Minister of Health
Helga Björg Ragnarsdóttir	Political Advisor to the Minister
Guðlín Steinsdóttir	Deputy Director General of Health Services

National Commissioner of Police

Thelma Claussen Þórðardóttir	Senior Legal Officer

Public Prosecutor's Office

Sigríður Friðjónsdóttir	Public Prosecutor
Ólafur Þór Hauksson	District Prosecutor

Directorate of Immigration

Þórhildur Ósk Hagalín	Public Relation Officer

Althing Ombudsman

Særún María Gunnarsdóttir	Head of Office
Maren Albertsdóttir	Special Legal Advisor to the Ombudsman
Hjalti Geir Erlendsson	Legal Advisor, the NPM team
Rannveig Stefánsdóttir	Legal Advisor, the NPM team
Anna Kristín Newton	Specialist, the NPM team

B. Non-governmental organisations

Icelandic Human Rights Centre

The Icelandic Mental Health Alliance (Geðhjálp)

Afstaða – Association of Prisoners