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Deaths in prisons

In the period from 1 September 2019 to 1 September 2020, 17 people died in Estonian prisons. Of these, 13 deaths were caused by different health problems. Four people committed suicide. No killings have occurred in prisons since 2011.

In the case of two of the deaths caused by a health problem, the prison developed a suspicion whether proper medical care had been provided to the person. In one case, the prison contacted the expert committee on the quality of healthcare services operating under the Ministry of Social Affairs, and based on the committee's opinion criminal proceedings were initiated to establish more precise facts. In the second case, the prison initiated criminal proceedings which were discontinued after the results of the expert assessment were received. The circumstances of death of eleven people dying as a result of a health problem or a serious illness did not arouse suspicion and no investigation was initiated in respect of them.

Prisons effectively investigated cases of suicide among prisoners. In two cases, the prison internal audit service investigated the precise circumstances within administrative supervision proceedings. The internal audit found that the prison could not have prevented those deaths. Nevertheless, recommendations were given as to how to more effectively prevent deaths in the future. In two cases, the Ministry of Justice initiated disciplinary proceedings against officers. Within disciplinary proceedings, the Ministry of Justice has thoroughly and in detail investigated and assessed the work of officers on duty at the time of an incident of death. Disciplinary

proceedings found that officers had breached their official duties and a disciplinary sanction was imposed for this.

Deaths could be prevented even better if the health of people in solitary confinement were monitored daily, if the risk of self-injury and suicide by persons arriving in prison were assessed, and if the prison had enough officers using the principles of dynamic security in their everyday work. It would also help if it were ascertained what furnishing items may prevent effective supervision of a person, and if the necessary changes were made.

It is important to underline that all people committing suicide during the above-mentioned period did so while in solitary confinement – being subjected either to the disciplinary cell or the reception regime or being held as remand prisoners. Several studies have established that it is precisely these types of regimes where prisoners are under high risk of self-harm and suicide.[1]

I dealt with problems related to solitary confinement in a recommendation sent to Tartu Prison and the Ministry of Justice in 2021. Inter alia, I pointed out that in order to assess the effects of solitary confinement a healthcare professional must examine everyone in solitary confinement every day. Regular monitoring of a person's physical and mental health helps to prevent self-harming and suicides.

Of concern is the explanation provided in the summary of administrative supervision proceedings No 3-3/19/9-2: "The detainee had […] the status of a remand prisoner, so that no risk assessment was carried out in respect of them and thus the prison could not assess their mental state nor did it have information about possible earlier suicide attempts."

People detained by the authorities are in a vulnerable situation due to their condition and it is the state's duty to protect them. The right to life enshrined in Article 2 of the Convention for the Protection of Human Rights and Fundamental Freedoms gives rise to the state's positive duty to take reasonable steps, within its competence, to protect the life of prisoners prone to suicide. The positive duty has not been fulfilled if the prison was or should have been aware of a real and immediate danger to a person's life but failed to take measures to prevent the risk which could have been expected from the prison based on a reasonable assessment.[2] Since the state has a positive duty to prevent suicides in prison, in order to comply with this duty the prison must collect material information about the condition of a person arriving in prison and assess that person's risk of self-harm and suicide.[3]

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has consistently stressed (including in its 2019 report to Denmark, paras 60−61) the important role played in suicide prevention by the initial medical screening of persons remanded in custody which should take place within 24 hours of their admission to a place of detention. The

[1] See e.g. WHO, Preventing Suicide in Jails and Prisons, 2007; N. Konrad *et al.*, Preventing Suicide in Prisons, Part I: Recommendations from the International Association for Suicide Prevention Task Force on Suicide in Prisons, The Journal of Crisis Intervention and Suicide Prevention, 28(3), 2007; J. Shaw *et al.*, Suicide by prisoners: National clinical survey, The British Journal of Psychiatry, 2004; S. Zhong *et al.*, Risk factors for suicide in prisons: a systematic review and meta-analysis, The Lancet Public Health, 2020; Kriminalvårdens Reprocentral, Prison suicide in 12 countries. An ecological study of 861 suicides during 2003 – 2007, 2010; L. Favril *et al.*, A 17-Year National Study of Prison Suicides in Belgium, The Journal of Crisis Intervention and Suicide Prevention 40(1), 2019.

[2] See e.g. the ECtHR judgment of 22 January 2013 in *Mitić v. Serbia* and the case-law cited therein.

[3] About the state's duty in alleviating risks, see e.g. the ECtHR judgment of 4 February 2016 in *Isenc v. France* and the case-law cited therein.

prison must assess the risk of self-harming and suicide of everyone admitted to prison (including remand prisoners).[4]

The incidents of death analysed also indicate a shortage of officers, so that supervision of prisoners is not sufficiently effective. Due to understaffing of teams, officers have little if any time to get to know people in their care and observe their behaviour and condition. Communication merely during roll-call, serving food and other similar procedures is not sufficient to establish meaningful contact with a person. I drew attention to the importance of meaningful human contact and implementation of dynamic security in prisons in my recommendation in 2021.

Suicides could be even better prevented if prisons were to pay more attention to furnishings in cells that remain outside the range of vision of an officer observing an inmate in the cell through the cell's observation window and the food hatch. For example, in one instance a person had used the drying pipe in the toilet to commit suicide. Placement of fittings and furnishing items in cells to which it is possible to attach a string should be carefully considered – for instance, a drying pipe could be brought from the toilet to the cell, the pipe could be installed lower, or the like.

Summaries of disciplinary measures have revealed that supervision could also be complicated due to arrangement of furniture in cells, as well as the metal grating installed in the observation window or lighting in the corridor. Prisons, in cooperation with officers coming into direct contact with prisoners, should assess what engineering and furnishing items in cells might obstruct visual supervision, and find alternative solutions. For example, furniture in a cell can be rearranged, the metal grating in the observation window replaced with impact-resistant glass, the intensity or location of lights adjusted, and the like.

Please send feedback to recommendations by 21 June 2021.

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[4] See also M. R. Labrecque, M. W. Patry, Self-Harm/Suicidality in Corrections in M. Ternes *et al*. (Eds), The Practice of Correctional Psychology, 2018. (pp 235-257).