REPUBLIC OF ALBANIA
OFFICE OF THE OMBUDSMAN
NATIONAL PREVENTIVE MECHANISM AGAINST TORTURE

ACTIVITY OF THE OMBUDSMAN OFFICE IN ITS CAPACITY AS THE NATIONAL PREVENTIVE MECHANISM AGAINST TORTURE

ANNUAL REPORT

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The Danish Neighbourhood Programme

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ACTIVITY OF THE OMBUDSMAN OFFICE IN ITS CAPACITY AS THE NATIONAL PREVENTIVE MECHANISM AGAINST TORTURE

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1. Legal framework on NPM operation

The Ombudsman Office operates on the basis of attributes provided for in the Constitution of the Republic of Albania, as well as in Law no. 8454, dated 04.02.1999 "On the People's Advocate", as amended. This body has the power of supervising compliance with standards set forth in various international instruments, which have in their focus protection and respect for human rights.

With Law no. 9094, dated 03.07.2003 "On the ratification of the *Optional Protocol* to the *Convention against Torture and other* Cruel*, Inhuman* or *Degrading Treatment* or Punishment" came the obligation to set up a national structure for torture prevention[1], a key role of which would be to monitor all public institutions where individuals are deprived of their liberty, in order to assess the extent to which human rights are respected within such institutions; prevent violations; improve standards of treatment for persons deprived of their liberty, and promote constant respect for their human rights.

The Ombudsman Office, a constitutional independent body with particular focus on human rights and the "Paris Principles", was designed by the Parliament as the appropriate authority to guarantee the professional and independent functioning of NPM. Legal recognition of NPM, as a specific structure of the Ombudsman Office in Albania, became effective upon entry into force of Law no. 9888, dated 10.03.2008 "On some amendments and additions to law no. 8328, dated 16.04.1998 'On the rights and treatment of prisoners' ", as amended.

The National Preventive Mechanism against Torture (NPM) operates on the basis of national legislation, guided by principles set forth in international instruments: The European Convention on Human Rights and Fundamental Freedoms, and its supplementary protocols, ratified by the Republic of Albania with Law no. 8137, dated 31/7/1996; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ratified by the Republic of Albania with Law no. No. 7727, dated 30/06/1993; the Optional Protocol of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), ratified by the

[1] According to Article 17 of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, OPCAT, "Each State Party shall maintain, designate or establish, at the latest one year after the entry into force of the present Protocol or of its ratification or accession, one or several independent national preventive mechanisms for the prevention of torture at the domestic level. Mechanisms established by decentralized stations may be designated as national preventive mechanisms for the purposes of the present Protocol if they are in conformity with its provisions.". Further, Article 18 provides "The States Parties shall guarantee the functional independence of the national preventive mechanisms as well as the independence of their personnel… When establishing national preventive mechanisms, States Parties shall give due consideration to the Principles relating to the status of national institutions for the promotion and protection of human rights".

Republic of Albania with Law no. 9094, dated 07/2003; European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, ratified by the Republic of Albania with Law no. 8135 dated 31/7/1996. This list of legal instruments guiding the work of the said Mechanism is not exhaustive, as there are a number of recommendations in place, particularly those of the Council of Europe, which are crucial in guaranteeing the rights of persons deprived of their liberty. Nevertheless, these instruments are the "cornerstones" to the already several years long NPM work in Albania.

NPM operates under the national legislation, a tool in the Albanian citizens' hands to ensure they enjoy their rights stipulated in: the Constitution of the Republic of Albania; the Albanian Criminal Code; the Albanian Criminal Procedures Code; Law no. 8454, dated 04/02/1999 "On People's Advocate", as amended; Law no. 9749, dated 04/06/2007 "On the State Police"; Law no. 44/2012, dated 08/05/2012 "On Mental Health"; Law no. 8331, dated 21/04/1998 "On the execution of criminal decisions"; Law no. 9887, dated 10/03/2008 "On personal data protection"; Law no. 10032, dated 11/12/2008 "On Prisons Police"; DCM no. 187 dated 17/3/2010 "On some additions and amendments to the Council of Ministers Decision no. 303, dated 25/03/2009 'On approval of Prisons' General Regulations'", Law no. 9069 dated 15/05/2003 "On Military Police in the Armed Forces"; Law no. 8432, dated 14.12.1998 "On Asylum in the Republic of Albania"; Law no. 9959 dated 17/7/2008 "On foreigners"; DCM NO. 589, dated 28/8/2003 "On the set-up and operation of the Reception Centre for Victims of Trafficking". Again, this is not an exhaustive list; there are a number of Decisions of the Council of Ministers in place, as well as other handbooks and working documents, the enforcement of which will be a guarantee to the enjoyment of the said rights.

The Albanian legislation, starting with the Constitution of the Republic of Albania, provides that "No one may be subjected to torture, cruel, inhuman or degrading punishment or treatment" (article 25), and that "No one may be required to perform forced labour, except in cases of the execution of a judicial decision, the performance of military service, or for a service that results from a state of war, a state of emergency or a natural disaster that threatens human life or health", (article 26). The NPM efforts follow along the same lines, as stipulated in article 15/1 of the Constitution: "The fundamental human rights and freedoms are indivisible, inalienable, and inviolable and stand at the base of the entire juridical order". Every person deprived of liberty according to article 27 is entitled to a humane treatment and respect for his dignity.

Pursuant to law 9888 dated 10/03/2008 "On some additions and amendments to law no. 8328, dated /04/1998 "On the rights and treatment of prisoners", as amended, the NPM operates as a separate structure under the authority of the Ombudsman office; it oversees the implementation and enforcement of this law on protection of rights of prisoners and has the following powers:

- regularly monitors treatment of persons deprived of their liberty in places of detention, arrest and in prisons, in view of strengthening, whenever appropriate, protection of individuals against torture, cruel, inhuman or degrading treatment or punishment;
- makes recommendations to relevant bodies in view of improving treatment and conditions of persons deprived of their liberty and preventing torture or cruel, inhuman or degrading treatment or punishment;

Similarly, pursuant to article 74/2 of the same law, NPM in carrying out its tasks, is guaranteed:

- to obtain any sort of information on the numbers of individuals deprived of their liberty in detention facilities, the numbers of detention facilities and their location;
- to obtain all available information on how these individuals are treated, as well as on the conditions of their detention;
- free access to all detention locations and facilities;
- to conduct private interviews with persons deprived of their liberty or with any other person that may provide relevant information, without any witnesses, either in person or with an interpreter, if deemed necessary;
- to freely select the facilities it wishes to visit or persons it wishes to interview.

Article 74/3 provides for the forms of NPM monitoring, which is conducted following:

- admission of prisoners or detainees' requests or complaints, directly or in a written form;
- submission of information, requests or complaints from prisoners or persons being granted the visitor's status, persons from state institutions or NGOs, who have inspected or visited the facility, according to powers granted by law; or from the lawyer of the detained or the prisoner;
- requests for information from the institution's administration;
- conduct of private interviews with persons deprived of their liberty or with any other person that may provide relevant information, without any witnesses, either in person or with an interpreter, if deemed necessary;
- examination of documents, objects, equipment or premises relating to the prisoner or detainee, inside or outside the institution;

NPM can hire specialists of relevant areas during the monitoring process. Regardless of whether infringement or irregularities are ascertained during the examination process, NPM experts shall at all times keep minutes/records, which are later signed by the head of the relevant institution, or by the official appointed by him, with the right to reflect observations.

Pursuant to Law No. 44/ 2012, dated 08.05.2012 "On Mental Health", article 31 "The People's Advocate, by means of the National Preventive Mechanism against Torture, Inhuman or Degrading Treatment acting as a special structure under its authority, monitors on a regular basis, through periodical inspections, compliance with the rights and standards for mentally ill persons in specialised in-treatment psychiatric wards and submits recommendations to relevant bodies, in light of improving patients treatment and conditions and guaranteeing full respect for human rights in mental health care institutions". This right, stipulated by law, guarantees NPM's free access to all mental health care locations and premises and ensures provision of any sort of information, in line with the legislation in force.

Pursuant to article 19/1of law no. 8454, dated 04.02.1999, "On People's Advocate", as amended, NPM members, as persons authorised by the Ombudsman, "have at all times, without restriction or prior authorisation, but by informing the head of the institution, the right of access to all public administration bodies, prisons, locations where arrested or detained persons (pre-trial detainees) are held by the police or the prosecution, in wards or state institutions, psychiatric

hospitals, nursing homes, foster homes, and any other facility where data/information may be provided and where it deems that there is a possibility that human rights and freedoms are violated.”. Pursuant to the same law, access to such premises may be granted not only on grounds of investigating a complaint lodged with the Ombudsman, but also for purposes of inspection or study.

2. NPM organisational structure, institutional representation and cooperation

With the purpose of guaranteeing the functional independence of the NPM and its staff, as provided for in the OPCAT, the Ombudsman office conducted appropriate recruitment procedures, as specified in Law no. 152/2013 “On the Civil Servant”, to structure, complete and renew staff with new members, whose professional expertise would meet the requirements for a multi-disciplinary team, able to fulfil institutional needs. In April 2014 the then existing staff of assistant commissioners, consisting of two legal experts, was completed with an additional legal expert, a psychiatrist and a clinical psychologist in the capacity of the head of NPM, that was basically coordinating work among equals. This process of selection of professionals as part of NPM staff and direction would enable merit-based and smooth work progress, unconditioned by restrictions of time.

During 2014 the National Preventive Mechanism against Torture worked in close cooperation with the Committee for Prevention of Torture (CPT) and the Stationed Nations Sub-Committee for Prevention of Torture (SPT), the Association for Prevention of Torture (APT) and the OSCE Presence in the countries of the Region to ensure a quality oversight and reporting system. Cooperation with the said structures is achieved through joint meetings and direct contacts and aimed at sharing experience and assessing needs and appropriate tools, in an effort to protect the right of persons deprived of their liberty, in compliance with OPCAT.

In October 2014, the Albanian NPM, accepted the Network members’ merit-based proposal, and officially took over the Presidency of the South East Europe NPM Network, for a one year period. This Network, established in 2013, on the basis of the South East Europe Declaration of Cooperation, signed by the Ombudsmen of Albania, Austria, Bulgaria, Croatia, Macedonia, Montenegro, Slovenia, Serbia, Bosnia and Herzegovina, Hungary, Greece and Romania, aims at enhancing cooperation, experience sharing and arrangement of further joint activities with a view to fulfilling to the highest extent possible the NPMs’ role in the region, as specified in the Optional Protocol to the Convention against Torture and Cruel, Inhuman and Degrading Treatment or Punishment.

During 2014 NPM was an active part of the Working Group on Prison Reform, set up and chaired by the Ministry of Justice in cooperation with the OSCE Presence in Albania. During the same year, NPM has closely cooperated with the General Prisons Directorate (GPD) on delivering training courses aiming at building capacities of the administrative and security staff within the system. Cooperation with the GPD enabled the establishment of mailboxes for the complaints of detainees in all the penitentiary institutions across the country to enhance General Prisons Directorate transparency and provide prisoners and detainees with the possibility of lodging their complaints directly to the Ombudsman of Albania.

The Ombudsman in its capacity as NPM collaborated during 2014 with FRONTEX and Border and Migration Police Directorate to monitor Albanian Citizens Repatriation operations from EU countries and Schengen area member states. The purpose of such operations was to ensure a smooth and dignified transfer of Albanian citizens, subject of a repatriation decision, from EU member states and Schengen states to Albania. NPM was member of the monitoring team of the said repatriation operations, thus accomplishing its legal and constitutional role as a guarantor and acting in compliance with Directive 2008/115/EC of the European Parliament on common standards between EU member states and third countries on independent monitoring by NPM of citizens repatriation from EU countries to their countries of origin.

Over the same year, NPM has been an integral part of the meetings convened by the National Committee on Mental Health, discussing key issues of organisation and smooth functioning of mental health system. NPM has provided concrete suggestions and recommendations on establishing relevant standards of respect for the fundamental human rights and freedoms of persons treated in in-treatment mental health facilities.

Compliant with its legal duties, the National Preventive Mechanism against Torture has closely collaborated during 2014 with local Civil Society Organisations, specialised and active in the area. Beneficial was the collaboration with the Albanian Helsinki Committee, Perthyerje Association, Tirana European Institute and Albanian Criminal Lawyers Association in conducting inspection visits[2], training sessions or other promotion activities[3] on the rights of persons deprived of their liberty. Thus the NPM activity marked quality progress in preventing violations, promoting best practice, enhancing transparency and strengthening the dialogue with state authorities.

In order to promote human rights in Albania, NPM experts have been actively involved during 2014 in the Press and Electronic Media, via press conferences, joint meetings with journalists, articles and interviews, attendance in TV shows, etc., in view of raising awareness on problems and achievements regarding human rights of persons deprived of their liberty.

3. Monitoring visits, recommendations and progress of matters relating to cases of violence

The People's Advocate, in its role as National Preventive Mechanism for Torture Prevention, conducted 115[4] inspections, re-inspections, thematic checks and monitoring visits to all detention places in the Republic of Albania, (penitentiary institutions, police stations, psychiatric hospitals, military bases containing security rooms, centres handling foreigners, asylum seekers and victims of trafficking).

The target of the NPM work, during the monitoring visits, was to collect information on:

[2] Annex 2: NPM activities
[3] Annex 3: Table of inspections carried out by NPM during 2014, on the bases of the annual inspections plan in collaboration with Cvil Society organisations.
[4] Annex 1: Cooperation with Civil Society Organisations

- Detainees’ treatment in penitentiary institutions and identification of cases of psychological pressure, degrading and discriminating treatment, torture or use of physical force beyond limits provided for in relevant normative acts;
- Extent of implementation of Safeguards, checking their compliance to domestic legal acts in force and to international standards;
- Material conditions of persons held in detention facilities, focusing on such aspects as food and timely provision of meals, natural and artificial lighting, aeration/ventilation-aspiration and heating system, possibilities for personal hygiene, sanitary facilities, clothing, overcrowding, living conditions, etc.;
- Assessment of respect for detainees’ rights to contact legal counsels and their own families; to make phone calls; to be informed of their rights in a language which is understandable to them; to be provided access to electronic media and press; to be informed on recruitment procedures and compensation for work performed; to be involved in outdoor activities; to practice religion, etc., according to specificities and nature of the institution;
- Provision of compulsory education courses, vocational training and recreational and rehabilitating activities;
- Quality of health care, etc.

Unlike other NPMs, which conduct thematic or random selection-based inspections, the Albanian NPM, along with NGOs involved in the area, chose to follow its own best practice established over the years of its operation, thoroughly inspecting all the above-mentioned institutions.

Compliant to its inspection methodology, NPM experts, during the visit, contacted the head of the penitentiary institutions, heads of sectors and inspected all facilities/areas used by the persons held in those institutions. It is worth mentioning that inspections were conducted in a good spirit of cooperation in almost all visited institutions. NPM was allowed to perform its institutional, constitutional and legal tasks and was guaranteed full access to examine all documents and facilities and the possibility to contact the persons deprived of their liberty, without the attendance of the penitentiary institution staff.

3.1. Recommendations

The activity described above resulted in 81 specific recommendations[5] on the issues and problems identified. These recommendations are submitted, through official mail, to the relevant bodies.

<table>
<tr><th>Institutions</th><th>Number of recommendations</th><th colspan="2">Details on recommendations</th></tr>
<tr><td rowspan="4">Penitentiary institutions</td><td rowspan="4">26</td><td>22</td><td>Recommendations on inspections’ findings</td></tr>
<tr><td>1</td><td>Specific recommendation on the penitentiary institutions’ overcrowding issue</td></tr>
<tr><td>2</td><td>Recommendations on ad-hoc visits</td></tr>
<tr><td>1</td><td>Recommendation from inspections on initiative</td></tr>
</table>

[5] Annex 4 Table of recommendations submitted by the NPM, based on 2014 findings.

Police stations	47	44	Recommendations on inspections' findings
		1	Specific recommendation on the overcrowding issue in security facilities.
		1	Recommendation on illegal immigrants' repatriation procedures from the Schengen area.
		1	Recommendation on the examination of a case of violence.
Armed forces	2	2	Recommendation on visits conducted to military bases to examine conditions and treatment of detainees in security cells.
Psychiatric hospitals	3	3	Recommendation on the improvement of conditions and treatment of persons with mental health disorders in these institutions.
Centres	3	1	Recommendation on improving conditions and treatment of Asylum seekers in the National Reception Centre for Asylum Seekers in Babrru.
		1	Recommendation for improving the conditions and treatment of Foreigners in the Closed Detention Centre for Migrants (foreigners), Kareç,
		1	Recommendation for improving the conditions and treatment of Victims/Potential Victims of Trafficking in the National Reception Centre for Victims of Trafficking, Linzë.
TOTAL		**81**	

Feedback to the recommendations indicates that they are accepted and have stirred institutions into action to meet their obligations. Nonetheless, there is still need to follow up with further measures to improve conditions of individuals held in these institutions. Issues identified need to be addressed by higher state authorities, through a decision-making process, as they are, for the most, the result of a tougher criminal policy, shortage of funds and failure to issue relevant subordinate legislation bringing about significant improvement in the system, both in terms of form and contents.

3.2. Cases of torture, ill-treatment and violence in police stations and penitentiary institutions

The NPM collaborated with the Special Section of the Ombudsman Office to conduct *ad hoc* inspections on cases of excessive use of force, as identified during the inspections or from the complaints submitted via mail or telephone, thus fulfilling both the preventive and reactive respective functions of both structures.

NPM and the Special Section have handled, during 2014, 35 complaints lodged by citizens, on a disproportionate use of force and violence by the State Police or Prisons Police officers. There were 28 complaints with regards to Police Commissariats and 7 with regards to Penitentiary Institutions.

Examination of those cases showed that 8 of the complaints were grounded; 20 were not grounded and 7 were beyond the relevant jurisdiction, (the same complaints were being investigated by the Internal Control Service or the Prosecution). A recommendation for 2 out of 8 cases of violence ascertained is given to the Prosecution office to place the police officers

under investigation for the criminal offence of 'Torture', in collaboration with others[6]. A recommendation is submitted to the State Police and Penitentiary authorities, to enquire into the claims regarding the 6 remaining cases[7].

Feedback to those recommendations indicates that: the Prosecution Office has initiated an investigation into the employees of the Operational Station in Tirana Regional Police Directorate and the police officers in the Lezha Police Commissariat; 1 disciplinary measure is imposed against the police officers of Commissariat no.4; Disciplinary proceedings are initiated following a recommendation on two complaints lodged against Commissariat no.4; No administrative measure is pronounced for the recommendation submitted to Vlora Penitentiary Institution, following two complaints, but the recommendation is accepted. The recommendation on a case of violation, as ascertained by the NPM and the Special Section in Drenovë, Korçë, did not meet agreement.

4. Extent of respect for the rights of persons deprived of their liberty

4.1. Extent of respect for prisoners and pre-trial detainees' rights in Penitentiary Institutions[8]

Inspections of Penitentiary Institutions aimed at assessing the extent to which the rights of individuals deprived of their liberty are respected, as provided for in Law no. 9888, dated 10/03/2008, "On some amendments and additions to Law No. 8328, dated 16.04.1998 'On the rights and treatment of prisoners' ", as amended, as well as in relevant by-laws. A number of issues were identified during the inspections, which involve a pressing need for consideration and improvement. A summary of the findings is outlined below:

- It is observed that overcrowding in the penitentiary system has reached alarming rates – with up to 1500 persons beyond capacity. Particularly worrying was the situation in pre-trial detention facilities. Jordan Misja, Fushë-Krujë, Rrogozhinë, Elbasan, Berat, Drenovë, Vlorë, Tepelenë, Sarandë, Durrës and Lezhë penitentiary institutions operate most of the time considerably over official capacity. Some of the penitentiary institutions - namely that of Jordan Misja, Drenovë and Saranda – do not carry out observation activities, followed by accommodation in appropriate rooms according to eligibility criteria, due to overcrowding.
- Ministry of Justice and Ministry of Health agreement on the establishment of a Special Medical Institution pursuant to Law no. 44/2012, dated 08/05/2012, "On Mental Health", for the accommodation and treatment of individuals under the "obligatory medical

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[6] Recommendation of 25/2/2014, addressed to Lezha Prosecution Office.
Recommendation of 10/3/2014, addressed to Tirana Prosecution Office.

[7] Recommendation of 24/06/2014, addressed to Tirana Regional Police Directorate, Commissariat no.4 Tirana.
Recommendation of 06/01/2015, addressed to Tirana Regional Police Directorate, Commissariat no.4 Tirana.
Recommendation of 14/01/2015, addressed to General Prisons Directorate, Vlora Penitentiary Institution.
Recommendation of 24/06/2014, addressed to General Prisons Directorate, Drenova Penitentiary Institution.

[8] 26 recommendations were drafted following NPM inspections to penitentiary facilities.

treatment" and "temporary hospitalisation" court measure, was not enforced during 2012. Handling such individuals in penitentiary institutions - in circumstances of shortage of psychiatrists and in a time when access to psychiatric consultations in regional mental health hospitals or in the Prisons' Specific Health Institution for episodic acute cases, seems difficult – remains unlawful and impacts the general overcrowding issue.

- There were claims from prisoners and pre-trial detainees of physical and psychological violence by penitentiary staff, mainly in the Mine Peza, Peqin, Korçë and Vlorë penitentiary institutions. Thorough enquiries followed these claims, along with recommendations to relevant penitentiary institutions and to the PGD, inviting them to take appropriate action against the persons held responsible for such occurrence.
- Disciplinary procedures in the Juvenile Detention Centre in Kavaja and in the Juvenile pre-trial Detention Section in Vlora penitentiary institutions were not adequately enforced. The new disciplinary educational measures were not taken into account by the relevant educational staff, and were not in compliance with juvenile educational and disciplinary procedures and policies, as set out in the GPD administrative manual. Juveniles in such institutions were abandoned in conditions similar to solitary confinement – lasting for up to 20 days - which may have compromised their physical and/or mental integrity.
- Basic compulsory education was not provided in a number of penitentiary facilities, i.e. in Lezhë, Lushnje, Vaqarr, Tepelenë, Fushë-Krujë, Burrel, in line with the current Agreement of Ministry of Justice and Ministry of Education on the 9-year basic education.
- In all facilities, (with the exception of Burrel penitentiary institution), reward for good work consisted in reducing the term in prison, which implies a presumption of guilt for the pre-trial detainees. Similarly, no social insurance coverage was paid for the work performed by the pre-trial detainees, which means that work performed did not count as job seniority. The prisoners were not provided with an employment card (booklet) and the social insurance record.
- As for the infrastructure, the bulk of the penitentiary institutions suffer dilapidation, dampness, power and water cuts, lack of natural light and fresh air in the cells, bugs; the toilets, kitchen areas, showers, airing areas, confinement rooms fall short of appropriate standards; teaching rooms, religion or sports facilities are missing, etc. Zahari-Krujë, Kosovë of Lushnjë, Rrogozhinë, Burrel, Sarandë, Tropojë, Lezhë, Tepelenë, Jordan Misja, Ali Demi, Mine Peza penitentiary institutions and Prisons' Specific Health Institution presented pressing infrastructure problems.
- Family visitation areas, particularly those for juvenile detainees, were inappropriate in all the penitentiary institutions,.
- In a number of penitentiary institutions outdoor (airing) areas were quite small and did not allow for any other activity to take place in them; Jordan Misja penitentiary institution in Saranda and the observation areas in Korca penitentiary institution did not allow for standard airing conditions, due to lack of relevant space.
- A number of penitentiary institutions were not refurbished; outdoor and indoor areas did not meet set standards, thus harming the psycho-social rehabilitation of prisoners/pre-trial detainees.
- A limited number of activities took place in these institutions due to lack of proper facilities, turned into resident rooms, because of overcrowding and lack of funds to

ensure didactical tools. Penitentiary institutions of Burrel, Korçë, Durrës, Lezhë, Tepelenë, Jordan Misja, Mine Peza, Kosovë-Lushnje, etc., are the most problematic in this regard.

- It was observed that all the penitentiary institutions completed the psycho-social files like a mere formality; i.e. training objectives, individual training programmes, monthly notes, individual or group counselling were recorded in the file, but in fact they did not happen.
- Except for Vlora penitentiary institution, health care facilities in prisons were inadequate for medical examination or tests, overall. There was shortage of back-up materials.
- Delays in providing health cards to prisoners/pre-trial detainees caused in most penitentiary institutions failure to apply the reimbursement scheme and difficulties in being provided with the relevant medication.
- Difficulties were observed in most penitentiary institutions to see a doctor, be examined, run specific laboratory tests outside the facilities.
- Dentist's services were not regularly provided in the penitentiary institutions due to lack of adequate equipment or back-up materials. Dental services, with the exception of tooth extractions, were offered, albeit with difficulty, in public polyclinics or private clinics, all at the expense of the prisoners.
- Central heating was not working in almost all the penitentiary institutions where such a system existed, due to technical deficiencies or shortage of fuel. The prisoners/pre-trial detainees mostly used their blankets or bed linen as the only heating device.
- All penitentiary institutions had shortage of supply of basic personal hygiene products, (toothpaste, toothbrush, shampoo, etc.) and of necessary cleaning products.
- Uniforms and gloves were not used when distributing food.
- Most of the rooms lacked wardrobes. The prisoners/pre-trial detainees kept their clothes in plastic bags or sacs, usually below their beds. Such was particularly the case in the penitentiary institutions of Lezhë, Tepelenë, Korçë, Durrës, Jordan Misja, Mine Peza, Sarandë, Kukës and Tropojë.

4.2. Extent of respect for escorted, detained, arrested persons in police stations[9]

Inspections of police stations aimed at examining the facilities and collecting and assessing relevant data on action undertaken and practices used by the police in view of meeting standards set forth in law no. 9749, dated 04.06.2007 "On the State Police" and the Handbook on "Rules of treatment and security of persons arrested and detained in Police Stations". Those inspections were also looking at the steps taken to meet requirements set forth in these documents and at the extent of fulfilment of Ombudsman recommendations on the construction of escort and security rooms in line with legal standards; removal from use of rooms that fall short of relevant criteria and compliance with law requirements when escorting or arresting/detaining citizens. Findings of inspections conducted in police stations are as follows:

- Claims of violence and physical and psychological maltreatment of citizens, particularly those suspected to be criminal offenders, by police officers in Commissariats no. 1, 2, 3, 4, 5, 6 of Tirana Regional Police Directorate, in Shijak Commissariat of RPD Durrës, in

[9] 47 Recommendations are drafted following NPM inspections to Police Stations.

Lezhë, Mirditë Commissariats, in Shëngjin Police Station, RPD Lezhë, in Mat Commissariat of RPD Dibër and in Devoll Commissariat of RPD Korçë.

- Police or health care staff in detention facilities failed to meet the legal obligation to report cases of violence against arrested or detained persons – in Tirana RPD and Lezha RPD.
- Police officers behaved unethically when addressing the citizens – in RPD Tirana and in Commissariats no. 2 and no. 3, Tirana and Fier.
- Seizure and unlawful retention of escorted arrested and detained persons' personal effects, as it happened in Police Commissariat no.4, Tirana.
- Escorting citizens to police premises, contrary to the law, as happened in Tiranë, Durrës, Kavajë, Shijak, Elbasan, Peqin, Krujë, Kurbin, Fushë Krujë, Mamurras, etc. Police Commissariats and Stations.
- Escort facilities in many commissariats and other police premises were not built or adapted according to relevant provisions of law no. 9749, dated 04.06.2007 "On the State Police" (i.e. 3 escort rooms, 1 for adult males, 1 for women and 1 for juveniles).
- Escort rooms in most commissariats fell short of standards and infringed the dignity of people held there; they were dirty, unpainted, lacked basic furniture (chairs, benches, tables). Where such equipment existed, it was damaged.
- 80% of security premises were not built or adapted according to standards set and adopted by International Conventions and domestic legislation.
- There were no updated records on escorted or arrested/detained persons in most of the police commissariats, (i.e. in Durrës, Kavajë, Shijak, Elbasan, Peqin, Krujë, Kurbin, Fushë Krujë, Mamurras etc.),. Thus, data on the reasons of their escorting or whether their families or relatives were notified (telephone numbers, time of notification, etc.) was missing, contrary to the requirements set forth in relevant provisions.
- There were no posters on display containing information on the escorting process and the legal rights of escorted persons, (i.e. Tiranë, Kavajë, Peqin, Krujë, Fushë Krujë, Kurbin, Mamurras etc. Commissariats and Police Stations).
- Due to overcrowding Commissariats no. 4 and no. 6 in Tirana were using as security facilities formerly abandoned premises that failed to meet minimum living standards and criteria.
- For most of the time Tirana Regional Directorate, Lezha Commissariat, Elbasan Commissariat, and Commissariat no. 3 and no. 5 in Tirana were operating beyond official facility capacities; in some cases 3 or 4 times beyond capacity. Overcrowding was due to an increased number of arrests and detentions conducted over the year over criminal offences recently included in the Criminal Code. It was also due to delays in the take-over by the General Prisons Directorate because pre-trial detention facilities were overcrowded in equal measure.
- Arrested persons, already being ruled a security measure of up to 20 days by the court, were still held in RPDs security rooms.
- Medical registers and medical files were not properly completed and the health care provided in the RPDs was deficient; health care facilities were inadequate. In a considerable number of Police premises, medical checks were conducted beyond the 12-hour time limit set out in the Albanian State Police Handbook.

4.3. Extent to which the rights of persons being imposed the 'disciplinary detention' measure in the Armed Forces are respected.[10]

General inspections of the Training and Doctrine Command; the Troops School, Bunavi, Vlora; the Military Police Battalion, Sauk, Tirana, the Land Force Command, Zallherr, and the Land Force Command Vau i Dejës, Shkodër aimed at assessing compliance with standards set forth in Law no. 9069, dated 15.5.2003 "On Military Police in the Armed Forces of the Republic of Albania and the implementation of rules contained in the Guarding Service Guidelines by the Head of Disciplinary Detention Rooms in Military Police" on conditions in the disciplinary detention rooms, procedures for imposing the measures, respect for the rights of the military officers subject to disciplinary action, as well as the extent of implementation of Ombudsman recommendations provided over the past years. A number of issues requiring improvement were identified during the inspections:

- Conditions in security rooms in the Military Police Battalion in Sauk, Tiranë were inadequate and could not provide the military officers subject to the "disciplinary detention" measure an accommodation compliant to set standards, respecting their dignity.
- A camera monitoring system (CCTV) was missing in the hallways around security rooms in the Military Police Battalion in Sauk, Tiranë and in the Land Force Command, Military Unit no. 1010, Vau i Dejes, Shkoder.
- Conditions of family visitation rooms were not in compliance with the set standards.
- Electric bells in security rooms were missing.
- The military held in these rooms were not provided with the necessary personal hygiene items/products.
- The disciplinary detention registers were not adequately filled. This was the case in the Military Police Battalion in Sauk, Tiranë and in the Land Force Command, Military Unit no. 1010, Vau i Dejes, Shkoder.
- There were found items assisting use of force, a rubber baton and handcuffs in the Head of security cells office at the Military Police Battalion, Tiranë.
- There was no heating in the security cells of the Military Police Battalion in Sauk, Tiranë and in the Land Force Command, Military Unit no. 1010, Vau i Dejes, Shkoder.

4.4. Extent of respect for human rights in Psychiatric Hospitals[11]

Monitoring visits to Elbasan Psychiatric Hospital, in Vlora Psychiatric Hospital and the Mental Health In-treatment Ward in Shkoder, in addition to the general target of the visit, had a specific purpose: assessing the extent to which the rights and standards for persons with mental disorders in special in-treatment mental health care facilities are in line with Law no. 44/2012, dated 08/05/2012 "On Mental Health"; assessing procedures of involuntary admissions in hospitals; the coercive measures and physical restraints; conditions in which these persons are held, medical and rehabilitation treatment provided for them; the extent to which the recommendation

[10] 2 recommendations are drafted following NPM inspections to the Armed Forces.

[11] 3 recommendations are drafted following the NPM inspections in the Psychiatric Hospitals.

of the previous years are implemented. These facilities have the function of providing a more specialised treatment and enabling rehabilitation of mentally ill persons when all possible ways of getting such a service in the community are exhausted and there is no possibility to treat them in ambulatory conditions; or when there is need of psychiatric consultations due to requests coming from the Emergency Rooms in general hospitals. The findings of these monitoring visits during 2014 are as follows:

- Non-compliance with the necessary living space requirements, inadequate conditions in hospital rooms, these persons were kept in hospital for longer periods of time / they were turned into residents of the Elbasan and Vlora psychiatric hospitals.
- Hospitalising mentally disabled people in Vlora and Elbasan Psychiatric hospital, contrary to the laws in force.
- Lack of seclusion rooms, lack of CCTV system. The Ministry of Health failed to provide unified registers to all the three above-mentioned facilities, allowing them to record involuntary hospitalisations and use of physical restraints.
- Deficiencies in completing staff with psychiatrists at Shkoder Psychiatric Hospital and failure to provide nurses and caregivers to the one in Elbasan.
- Problems of compliance with procedures of involuntary hospitalisations, as provided for in the new law on mental health and relevant by-laws – in Elbasan and Shkoder Psychiatric hospitals and to some extent, even in Vlora.
- Shortage of physical restraints in Elbasan, Vlora and Shkoder Psychiatric Hospitals.
- Lack of anti-psychotic medication, mood stabilizers anti-depressants, etc. – in Elbasan Psychiatric hospital.
- Delays in the revocation of the "compulsory treatment" measure for persons who were subject to such measure in Shkoder Psychiatric Hospital.
- Shortage of a dental clinic that complies with the set standards, lack of an ECG machine.
- Sanitation and hygiene in all the hospitals was very poor and there was significant dampness.

4.5. Extent of respect for the rights of persons in the Centres[12]

4.5.1. National Reception Centre for Asylum Seekers

Pursuant to Law no. 8432, dated 14.12.1998 "On Asylum in the Republic of Albania", the NPM inspected the National Reception Centre for Asylum Seekers. The target of the inspection was to assess whether the treatment of foreign nationals being handled in this Centre was in line with their rights to a treatment respecting their dignity and aiming their rehabilitation. The monitoring visit found that part of the recommendations formerly provided by the Ombudsman were implemented. Current problems and issues are outlined below:

- Need for a jurist/lawyer, who would deal with the papers necessary to any individual sheltered in the centre, as they are foreign nationals.
- The envisaged staffing did not meet needs for teachers, caregivers and medical staff.

[12] 3 recommendations are drafted following NPM in Centres.

- There was no agreement in place with the Ministry of Social Welfare and Youth to allow possibilities for vocational training in the Vocational Training Centres under the said Ministry, or possibilities for employment by the Regional Employment Offices to all interested persons in this Centre.
- There was no financial assistance granted to the persons housed in the NRCAS, according to Law no. 10060, dated 26/01/2009,"On some amendments and additions to Law no. 8432 dated 14/12/1998, "On Asylum in the Republic of Albania".
- Persons housed in the NRCAS were not provided with clothing according to seasons and age-groups.
- There was a children's playground, but shortage of relevant equipment.

4.5.2. Closed Centre for Migrants, Kareç

The Closed Centre for Migrant in Kareç was set-up by DCM no. 1083, dated 28/10/2009, pursuant to Article 100 of the Constitution and paragraph 2, article 83 of Law no. 9959, dated 17/07/2008, "On Foreigners". The aim was to accommodate illegal migrants in the territory of Albania, who are subject to a detention measure, according to the legislation in force. The inspection of the centre aimed at assessing conditions and treatment of the persons held there. The Closed Centre is a facility under the Migration and Re-admissions Directorate, in the Border and Migration Police, General Police Directorate, under the Ministry of Interior. Inspection findings are as follows:

- There was shortage of staff able to speak the prevalent language of the immigrants, or to provide psychosocial, legal, and medical services.
- Recreational and sports areas lacked relevant equipment.
- There were no payphones, TV sets and antennas to provide information on what was happening outside the centre, or in the migrants' home countries.
- Cultural, recreational or sporting activities were lacking; the only sporting activity was the possibility of a football game, in an inappropriate pitch.
- There were no activities for babies, children and women.
- Cameras surrounding the building were broken.
- Heating system was out of order.
- There was shortage of sanitation and hygiene items, or personal care items, according to age-groups.

4.5.3. National Reception Centre for the victims of trafficking, Linzë

Inspection of the National Reception Centre of Victims of Trafficking, housing persons identified according to Standard Operation Procedures for the Identification and Referral of (potential) Victims of Trafficking, was conducted with the purpose of assessing treatment conditions of persons handled in this centre. This closed high security centre is established by Order of the Council of Ministers no. 589 dated 28/08/2003 "On the set-up and operation of the Reception Centre for the Victims of Trafficking", which, apart from setting forth the functional duties of the institution or services provided in it, specifies that the centre accommodates also

clandestine migrants, transiting through Albania. The findings of the monitoring visit are outlined below:

- Need for amendments to the legislation on the operation of the NPCVT, taking into account the comments made above.
- Lack of periodic supply of personal care items, according to age-groups.
- There is no agreement in place with relevant institutions to ensure continuous training for the beneficiaries.
- Need for internal and external refurbishment of both buildings.
- The heating system was not working.
- There were no appropriate facilities to conduct activities for babies.
- Computers were out of order.
- Shortage of a full-time psychologist and a full time interpreter in the centre.

5. Recommendation submitted following the inspections conducted during 2014 in Penitentiary Institutions

5.1. Penitentiary Institution of Rrogozhine – Dated 01.02.2014 / Doc. No. 201400174

Preliminary remarks

Pursuant to constitutional and legal powers regulating its activity, the Ombudsman, being made aware through the Media of a fire outbreak on 31/01/2014 in the Rrogozhinë Penitentiary Institution, deployed a monitoring team at the scene on 01/02/2014, to conduct administrative investigation.

In line with the methodology of the fact-finding visit and investigation procedures, the team initially met with the Head of the Penitentiary Institution and the Police Chief, explained the purpose of the visit and enquired after the situation in the facility and the wellbeing of the pre-trial detainees affected by the fire on the night of 31/1/2014. The experts visited the pre-trial detention sector affected by the fire outbreak and met with the detainees found in the room at the moment of the occurrence. As the purpose was to monitor the general health condition of all persons affected by the fire, the monitoring team paid a visit to Kavaja hospital and contacted in particular the pre-trial detainees transferred to Peqin Penitentiary Institution in the aftermath of the fire.

A number of issues were identified during the visits and interviews, which, following a legal analyses in view of international acts and the domestic legislation in force, are listed below:

Pursuant to Order no. 329, dated 15/01/2009 “On security categorisation of the Penitentiary Institutions”, as amended, “the Penitentiary of Rogozhina is categorised as an ordinary security facility, with a pre-trial detention section”. Maximum capacity of the facility is 115 pre-trial detainees. At the moment of the fire outbreak, on 31/01/2014, at around 20.00hrs, the pre-trial

section housed 217 persons.

The representatives of the institution informed that there was a fire outbreak on 31/01/2013 at around 20.00hrs in building no. 3, room 1 of the pre-trial detention section, serving as observation room, putting at risk both the lives of 21 persons housed in that room and the lives of many other detainees in the remaining 6 rooms, due to toxic smoke/fumes.

Prisoners of the ordinary security section provided immediate and effective assistance and helped the on-duty officers, who were limited in number, to open the doors and remove the window cages, in order to allow the pre-trial detainees outside the building, the hallways and the rooms engulfed by flames and suffocating smoke.

According to the managers, preliminary investigation conducted by Kavaja Police JPOs, and the Penitentiary Institution security officers into the night of the occurrence, proved that there are reasonable grounds to believe that the fire was intentionally set by two pre-trial detainees, who, the Head of Security said had confirmed the facts. This was also supported by CCTV recordings. The Director informed that 21 persons were sent to Kavaja hospital with respiratory problems and 1 person suffering injuries from the fire. 78 pre-trial detainees were transferred to Peqin Penitentiary Institution in order to manage the situation and reduce overcrowding.

The monitoring team requested Xerox copies of the service report, relating to the event, but they were told that they were not completed, as that night brought other priorities. The video tape of the occurrence, according to the Police Chief and as indicated in the relevant register in the CCTV control room, was submitted, following a verbal order, to the GPD. Under such conditions, the team was unable to monitor the video tape of the occurrence in the pre-trial detention facilities.

Treatment

The pre-trial detainees present at the scene of the fire, during one-on-one and private discussions with the team of experts, complained that the Police Chief maltreated physically citizen L.GJ., to force him admit fire allegations, (minutes of the interview with this person were submitted to the team).

The monitoring team visited the areas damaged by the fire. No detainee was by that time in the facility, as it was totally evacuated. Building no. 3 and room nr.1 and the corridor were damaged by the fire and smoke. Thermal insulated ceilings with polyester layers of 10 cm and mattresses and bedding laid on the floor were the main cause of the rapid outbreak of flames and suffocating smoke. 21 persons were accommodated in this room, 14 of which were sleeping in 7 bunk beds, 5 other were sleeping on mattresses on the ground. 2 remaining detainees used one bed in turns, or were sharing the same bed.

The detainees were concerned about living conditions in the pre-trial detention facilities and claimed that their complaints were not taken into consideration by the relevant staff; in most of the cases no solution was provided. This room, 6 x 7m, served as observation room. Residents were suffering overcrowding since more than two month. The representative of the penitentiary

institution said that all this was due to overcrowding and shortage of accommodation areas for pre-trial detainees. This resulted in a reduction of floor space per capita and of the standard living space per detainee. Room 1, building 3, size 6mx7mx2.50m, housing 21 persons is a clear indication of non-compliance with the legal standards regarding living space and floor area per capita. Overcrowding caused repeated cases of pre-detainees sleeping on the floors, an indication of inhuman and degrading treatment.

The monitoring team found that some rooms had sufficient beds, but they were not fairly distributed. The same was found during the Ombudsman monitoring visit in November 2013. Disparity of treatment sheds suspicions of a differentiated treatment by the relevant staff.

The major issue of overcrowding hinders fulfilment of functional duties by security, health care staff and educational psychologists, etc. Overcrowding deteriorated even further the already poor hygiene situation of common areas or cells and delayed the food-distribution process.

All the four sectors of the institution used the same showers. Detainees took a shower once a week, according to a schedule put together by the staff. The team received complaints about the limited use of showers due to overcrowding and water cuts, which caused interminable lines for the shower, delays and occasionally, impossibility to stick to the shower schedule. The bulk of the detainees showered using improvised means, as in almost all the common areas shower heads were missing and there were water cuts.

The monitoring team paid a visit to Peqin Penitentiary Institutions to look into the treatment and situation of pre-trial detainees transferred from Rrogozhinë Penitentiary institutions. The team was informed that by order of the GPD, at around 3.00 AM, of 10 February 2014, 78 pre-trial detainees were transferred from Rrogozhinë. Out of these, only 2 persons arrived a bit later from Kavaja hospital, having been subject to examination and specialised medical tests for respiratory problems caused by fire. The rest of the transferred were not residents of room 1, building 3, which went under fire. According to them, the transfer served to draw attention away from the numerous problems in Rrogozhinë Penitentiary Institution.

According to the transferred persons, problems causing discontent and were cause for the incident were:

- Excessive overcrowding in pre-trial detention and deterioration of services provided.
- Shortage of water and lack of sanitation services.
- Lack of showers due to power problems with water heaters.
- Consistent power cuts and lack of heating in the rooms; broken windows are not repaired.
- No healthcare services and very poor quality of food. They served the same food for 1 year, on a daily bases.

The transferred pre-trial detainees were provisionally accommodated in family visitation areas, in the high and medium security section, sleeping on mattresses on the ground. Each room contained 8-10 persons. The Head of Internal Regime explained that they would be provisionally accommodated in such conditions until next Monday; when they would be definitively

accommodated in pre-trial detention rooms. The detainees coming from Kavaja hospital were immediately accommodated in pre-trial detention rooms, separate from the rest of the transferred detainees.

The transferred pre-trial detainees complained about humiliating and unsafe transportation. The 6 seater police minivan transported around 15 detainees at once, plus police officers escorting them. Admission procedures were compliant to the regulation, with the presence of an admission committee.

The monitoring team visited Kavaja Hospital to check out the condition and treatment of the pre-trial detainees suffering fire injuries. The head of ER informed that in the night of 31 January 2014, 21 pre-trial detainees were hospitalised and treated in the Emergency and Resuscitation Room. One of the detainees A.H. was transferred to "Shefqet Ndroqi" hospital in Tirana, to have burn related injuries treated. 2 other persons, M.Q. and I.N. were sent to Tirana Sanatorium to get treatment for respiratory problems.
The rest, after running x-ray tests and being medicated, passed the night in hospital. The decision of the ward director was to release them from hospital, due to their stable and good condition. Kavaja hospital staff did their best to provide a quality treatment to the patients, and the security staff did not interfere with their job.

In conclusion, NPM monitoring experts found that material conditions and essential services to pre-trial detainees in Rrogozhinë penitentiary facility were considerably downgraded. This was a result of extreme overcrowding, causing a climate of discontent and tension, allowing room for incidents. Electric cables in pre-detention rooms were uninsulated and exposed and posed a constant threat to detainees and service staff.

Following those findings, the Ombudsman office deemed that investment for the maintenance of the penitentiary institution, solving of the overcrowding issue and improvement of the relevant material conditions should be a matter of priority.

It was recommended as follows:

1. The Institution must take the necessary steps to allow the Prosecution Office conduct further investigation into arson for detainees L.GJ and J.M.
2. Taking immediate measures so that the Prison Police staff strictly complies with legal standards and requirements and uses no physical and psychological violence against them.
3. To take immediate measures to examine relevant needs, in order to provide the sleeping cells with necessary equipment and furniture.
4. To take immediate measures to accommodate any person sleeping on the floor in the rooms of the "privileged" detainees containing free beds. Priority to be given to the pre-trial detainees found in the observation rooms that have exceeded the observation period required by law.
5. To clarify the situation of discrimination by the pre-trial detention staff; take immediate measures against those persons who have, intentionally or not, allowed such situation.
6. To take immediate measures to ensure running water 24 hours a day, 7 days a week, by

fixing the water tanks and the existing electric water pump. Complete showers with shower heads.

7. To take immediate measures to remove or repair provisional and exposed electric cables in the rooms and toilets as they pose a threat to the life of the pre-trial detainees.
8. To examine and draw relevant conclusions with regards to the evacuation plan in case of fire outbreak or similar incidents.

5.2. Penitentiary Institution of Peqin - Dated 11.02.2014 / Doc. No. 201400237

Preliminary remarks

The monitoring team, in line with the monitoring visit methodology, convened in the first place a meeting with the Head of the Penitentiary Institution, explaining the purpose of the visit, i.e. to examine the situation of the hunger strike of detainees transferred to this facility. The team enquired about the situation in the facility and the treatment of the pre-trial detainees transferred from Rrogozhinë penitentiary institution in the night of 31 January 2014. 59 pre-trial detainees were still accommodated in the family visitation area - turned into sleeping area, and their transfer to Rrogozhinë facility was pending repair of the fire damaged building.

Treatment

The monitoring team found humiliating material conditions and lack of essential services to the 59 pre-trial detainees accommodated in the visitation area. This was a result of the impossibility of accommodating them in the excessively overcrowded regimes in Peqin penitentiary.

Personal and private discussions with the pre-trial detainees in the adapted visitation area found many complaints. 12 persons were accommodated in a room of 4 x 5m, all sleeping on mattresses on the floor. Basic furniture or equipment was missing. Lack of proper floor area due to overcrowding created discontent and a climate of tension – the pre-trial detainees were refusing food and were submitting group complaints. Discussions indicated that outdoor space (airing), showering, telephone calls and health care services were at their minimum, due to overcrowding and inadequate accommodation areas.

Actual examination of the situation of the 59 transferred pre-trial detainees to the emergency accommodation areas in Peqin Penitentiary on 31 January 2014 showed that there was a risk of incidents and disorder in case there would be no transfer or proper accommodation, in line with standards, within the scheduled time frames, i.e. on 15 and 16 February 2014. Taking measures for urgent transfer was of critical importance; international acts and the legislation in force consider such treatment a blatant violation of human rights.

It was recommended:

1. To take immediate measures for the transfer of the 59 pre-trial detainees accommodated in the visitation areas in Peqin Penitentiary institution, within the scheduled dates: 15 and 16 February 2014.

2. To take immediate measures to accommodate the pre-trial detainees in the pre-trial detention rooms and their treatment according to legal standards.

5.3. Penitentiary Institutions of Zahari, Kruje - Dated 03.04.2014 / Doc. No. 201401246

Preliminary remarks

Krujë Penitentiary Institutions is categorised as a special institution, consisting of the section of mentally ill persons; the section of senior detainees over 65 years of age; the section of chronically ill persons and the section of persons with disabilities. Its maximum capacity is 180 persons. At the time of the inspection the institution housed 189 persons, 95 out of which were prisoners, while 94 were issued the 'medical treatment order' by the court. 6 of the latter were under temporary hospitalisation by court order, the remaining 88 were under compulsory treatment by court order.

Of concern to this institution is accommodating persons under "compulsory treatment' order in blatant conflict with the law and international standards. Regardless of its special status, the institution should have a pre-trial detention section, although it is not accommodating such persons since a long time.

In line with the monitoring procedure, the inspection team convened an initial meeting with the deputy/head of the institution, who expressed his willingness to collaborate in achieving the goal of the inspection. He informed that the building continued to be in a dilapidated condition due to lack of funds. To solve the issue of water cuts, the deputy director informed that a well was built enabling constant running water in the facility. The deputy/director informed of insufficient floor space per capita.

Treatment

The information collected and private group discussions with the prisoners did not find any flagrant case of torture or excessive use of force.

Most of the rooms accommodated 4-6 or 9 persons. In general, rooms had no sink, toilettes or shower. Rooms equipped with a sink, toilettes and shower, accommodating a single person were very scarce. This was a clear indication of discrimination, tolerated by the institution staff.

Rooms for mentally ill persons were inadequate, did not allow normal living conditions, due to dilapidation and dampness.

Safeguards

In Krujë Penitentiary Institution there was a regime consisting of men, broken down according to categories of sentenced prisoners, the ones under temporary hospitalisation order and the ones under compulsory treatment order. This division was respected; no violations were found.

The right to contact their families was strictly observed. The prisoners were entitled to no less than eight telephone calls per month (using a pre-paid card). However, conversations with the staff indicated that the mentally ill prisoners were, as a rule, abandoned by families. Inspection found that the telephone in sector B1 was out of order. Staff informed that steps were taken to fix the problem. In the meantime, all sentenced prisoners scheduled to make phone calls on that day could use the internal telephone (the one at the police office), so as not to be deprived of their right.

The Admission commission was fully operational. The data was recorded in a special register. The doctor is part of both the Admission Commission and the Disciplinary Commission. Pursuant to the CPT Recommendation to Albania for 2010, the NPM pointed out that the medical doctor should not be part of the Disciplinary Commission, but he has an obligation of checking, on a daily basis as a minimum, the condition of the prisoners subject to the disciplinary measure. Whenever he deems that seclusion is harming the prisoner's health, he should immediately inform the Director of the Penitentiary Institution.

Material Conditions

The Penitentiary institution is broken down in two sections, section A (A1 / A2) and section B (B1 / B2). As confirmed by the Deputy/Director and found by former inspections, premises were in a very bad state of repair and dampness. Not all rooms observed the living space per capita standard. Referring to data on detainees' population in the facility, as mentioned above, the inspection team found that Krujë penitentiary institution was overcrowded. Due to this, the physical seclusion room (section A) and the infirmary were turned into residential rooms. The physical seclusion room (section A) was provided with an immovable bed, with restraints for the limbs and the back.

Material conditions at the mentally ill persons' section were inadequate. Hygiene, both of the rooms and of the persons, was quite poor. Bedding was unchanged and dirty. Rooms were in disorder. It was found during the visit that seclusion rooms for persons with mental illness were turned into a normal room accommodating sick prisoners.

Common areas: toilets, water-basins and showers, in all the floors, were in a bad state of repair and dampness. Some of them were out of order. Water was provided via water tanks. There were water cuts, particularly during summer.

The paraplegic persons' section: there was lack of space and auxiliary areas adapted to this category of persons, i.e. wheelchair ramps, restrooms and showers.

Diabetics were treated in a special way by the kitchen, within allowed parameters. Food samples were preserved in a freezer, in line with set standards.

There was a laundry in the facility, containing 3 washing machines, 2 of which (a big and a small one) were still in working condition.

One room in sector A1/A2 contained a TV set, chairs and tables; it did not belong as such to the domestic regime, it was like an annex; the exit to the airing areas was found next to it. This room served also as library and housed the daily activities organised by psychological social staff. Material conditions met minimum standards, and were in a good state of repair (not dilapidated). A prisoner was employed as librarian to take care of the library. Due to its structure and function the room did not offer proper possibilities for individual counselling sessions, but was quite adequate for group counselling.

One room in sector B1/B2 containing a TV set, a table-tennis and a library, belonged directly to the domestic regime of this sector. This room was similar in structure, function and equipment to the one in sector A and provided similar service.

The institution had no central heating system in place.

The regime and activities

The team of experts found during the inspection that all schedules of indoor and outdoor activities (airing) were not put in display in the resident areas, but only in the police premises, making it impossible for the prisoners to have access.

Airing time was allowed once a day, for three hours. Supplementary airing time was provided for prisoners that according to the medical staff assessment, suffered from an illness. The Police chief informed that the airing time was increased during the summer season and was broken down in two parts (morning/afternoon). There were a total of four airing rooms, separated by wire mesh; one of them served as football, basketball or volleyball field, as appropriate.

The Institute contained two worship rooms (mosque/church). The Catholic Church and the Christian Association of Albanian Prisons were active and delivered religious services.

The psychological social service staff consisted of four employees, a clinical psychologist and three educators. Psychological social activities were carried out in each sector: sector A 8.00-11.00; sector B 11.00-13.00. Main activities delivered by the staff varied from individual counselling or group counselling to free discussions, etc. A number of other indoor activities took place as well, like table games: table tennis, chess, domino, backgammon, etc. Sporting activities were organised outdoors, like football, etc.

No teaching programmes or official or non-official vocational training courses were delivered, although 3 illiterate individuals were identified in the institution. All this because of a GPD order that has suspended such activities based on the composition of population in the institution. Such suspension deprived those persons of the right to education and has restricted the action of the psychological social intervention plan, as a rehabilitating and therapeutic tool.

Files prepared by the psychological-social staff were locked away. Examination of psychological-social files showed that medical diagnosis, as described in the medical cards, were reflected in them, but there was no specific intervention plan, as per the relevant diagnosis. According the social care staff, Individual Treatment Programmes (ITP) were in place for all the

prisoners, but not all of them were reflected in the psychological-social files. Given the special nature of the institution, and that half of its population - most of which is mentally ill - were subject to the “compulsory treatment” measure, the files must provide parallel information to the medical file, such as intervention plans in line with the psychological-social needs of the prisoners, proving that the prisoners are subject to multidisciplinary medical intervention.

At the time of the inspection, 20 prisoners were employed at the institution doing works like domestic warehouse keeper, sanitary worker, assistant chef, library worker, in charge of sports facility maintenance, etc.

Health care service

As per the organisational set-up, the health sector consisted of two psychiatrists (vacancies not yet filled), a toxicologist, a medical physician, a dentist, a chemist, 12 assistant physicians, 3 caregivers, 5 sanitation workers.

During the interviews with all the prisoners under compulsory medical treatment, other mentally ill prisoners, paraplegic prisoners and prisoners over 65 years old, it was noticed that in general they had a good impression of the healthcare system. But they had many complaints about lack of medicines for emergency and chronic diseases. There was also a need for consultations and more rigorous follow up of the cases of mental disorder, and also the cure prescribed for these cases needed to be reassessed. The paraplegic prisoners complained for the lack of 24 hours sanitary service for them.

The ambulance of the institution was depreciated and out of order. Even though there was a bio-chemical lab, it was not operational because there was no lab technician foreseen in the organizational structure of the institution. There was also an EKG device, but it was not operational because there was no specialized nurse to use it.

The dentist’s room was lacking dental tools and materials. The infirmary room although maintained in order, was facing deficiencies in terms of medicines.

The finding of the inspection was that the medical documentation was kept in order. Both registers and medical files were kept in a locker. Based on the documentation, the mentally ill prisoners under medication were 92; 14 prisoners were suffering from diabetes, 7 were paraplegics and the rest suffered from chronic diseases.

All prisoners were provided with healthcare booklets and the medicine reimbursement scheme was working until a few weeks ago. Because of the delays in settling the financial debt with the pharmaceutical warehouse as per the contract that the institution had concluded, this scheme was not working anymore.

As for the above, the following was recommended:

1. Taking immediate measures to accommodate the persons sentenced with “compulsory medical treatment” in institutions administered by the Ministry of Health, until a special institution for the treatment of this category of prisoners is established.

2. Taking immediate measures to decrease the overcrowding at all regime sectors and promote respect of personal space.
3. Taking immediate measures related to hygienic-sanitary conditions of all regime facilities, especially related to the level of humidity and depreciation of all indoor facilities of the institution.
4. Taking immediate measures to provide the buildings with appropriate shower facilities.
5. Taking measures to improve the conditions of the toilets.
6. Taking measures to equip, adapt and create living conditions in compliance with the General Regulations for Prisons for the observation/solitary rooms.
7. Taking measures for the Physician not to be a member of the Disciplinary Commission, because this affects the quality of doctor-patient relationship.
8. Taking measures to make the solitary room available, as a necessary tool for specific cases of treatment (psycho-motor agitation or suicidal attempts).
9. Psycho-social staff to take measures to draft individual treatment plans customized for the vulnerable groups in the institution.
10. Taking immediate measures to provide the pharmacist’s room with emergency medicine, as well as other medicine for chronic diseases.
11. Taking measures for a reassessment of the medical cure of the mentally ill persons through periodical consultations with the psychiatrist, adapting the dosage and types of neuroleptics to the conditions of the prisoners.
12. Taking measures to supply the dentist’s room with dental tools and materials.
13. Taking immediate measures to re-implement the medical reimbursement scheme.
14. Taking measures to provide urgently the institutions with a new ambulance.
15. Taking measures to make the EKG and the lab operational, by completing the organizational chart of the health sector with the respective specialists
16. Taking measures to ensure paraplegic prisoners are provided access and their moves to all premises of the institution are facilitated, especially as far as toilettes and showers are concerned, which must also be provided with accessory equipment to fit their needs.

5.4. Juvenile Detention Institute in Kavaja - Dated 16.04.2014 / Doc. No. 201400765

Preliminary remarks

The Juvenile Detention Institute in Kavaja has a capacity of 40 persons, to include a prison sector with a capacity of 20 persons and a pre-detention sector with a capacity of 20 persons. During the inspection, 26 juveniles were present in the premises of the institution, 24 of which pre-detained and 2 prisoners. 25 juveniles were acquitted by the amnesty proclaimed with the Decree of the President of the Republic No. 8523, dated 24.03.2014.

In compliance with the monitoring procedure, the inspection group first met with the Director of the Institution, who was willing to cooperate to reach the goal of the inspection, During the meeting, the inspection group, taking into account that the Juvenile Detention Institute in Kavaja is an institution that has been built recently and in compliance with highest European parameters, first requested an information related to the rights and treatment of juveniles, as well as the institution's approach to tackle problems encountered during the previous inspection of this institution in 2013. The Director of the Institution informed the experts that, the individuals who

were accused of use of violence and undignified treatment of juveniles in the institution, were investigated and the appropriate administrative sanctions were taken against them. Related to the issue of facility maintenance and services provided to juveniles, which were identified as problems during the previous visit, the representative of the institution clarified that the possible measures had been taken to minimize or put an end to the problems identified.

At the time of the inspection, there were no juveniles in the observation rooms. Also, there was no person under disciplinary sanction in the solitary room.

During the inspection, there were 24 pre-detained juveniles in the institution, which means 4 persons over the normal capacity and 2 detained. During the inspection it was found out that there were 2 persons in the pre-detention facility who had just turned 18.

With reference to the information obtained and confirmed with the official list of the employees, during the monitoring process, 6 pre-detainees were hired by the institution.

Treatment

From the information obtained from group discussion and private conversations, the monitoring group did not find out any flagrant case of torture. With regards to cases when the excessive use of force had occurred, administrative disciplinary sanctions had been taken against responsible persons by the management of this institution. These cases were found registered in the register for the identification of physical damage as a consequence of use of force which had been treated by the medical staff. Two cases of use of physical force from the security personnel against juveniles were recorded in the register. With regards to these two cases, the NPM experts administered all the documents of the administrative disciplinary sanctions against responsible persons.

Despite the measures taken in this regard by the management of the institution against these intolerable acts, the inspection group of NPM found out through the interviews it carried out in private with the juveniles, that, beyond claims and reasonable doubts, in this institution there were still persons part of the security staff who exercised physical and psychological violence as a form of pressure and punishment. Also, it was found out that even the psycho-social staff used the disciplinary measures as a form of pressure without being aware that it is a psychological violence. The inspection group of NPM referred this information and concrete data to the management of the institution clarifying that this cannot be tolerated and must be punished in accordance with the legislation in force.

The institution's administration informed the experts that the good, harmonic and respectful behavior of the juveniles with each-other but also towards the institution's employees, was the reason that for a long time there had not been any disciplinary sanctions against the juveniles. The experts of the NPM appreciated this fact, because juvenile solitary confinement is a measure which compromises their physical and psychic integrity, and as such must be implemented in very rare cases and must be considered as the most extreme disciplinary measure to be given for a very short period of time while ensuring their airing as well as didactic and fiction literature reading time remains intact. As such, the GDP recommendations on the implementation of the European best practices in the field of juvenile justice regarding the application of alternative

disciplinary sanction in the institution, instead of the "solitary confinement" measure, were highly praised.

The new educational disciplinary measures were not properly understood by the education staff and they were being implemented contrary to the disciplinary and educational procedures and policies for juveniles, as provided for by the administrative guidelines of the GDP. In order for the educational measures to serve their pedagogical purposes, they must be implemented in a fair, proper and unbiased manner. The procedure of giving the measures must be transparent and the juvenile must be heard during the decision-making and must be given the opportunity to explain the reason and his actions. The procedure must be simple and easy to understand by the juvenile. Regarding the type of educational measures and their duration it is foreseen:

a. Suspension/Expulsion from the educational activity from 10-15 minutes up to 25-30 minutes in case of lack of reflection. (The educational staff can give this measure).
b. Expulsion from any of the favorite activities of the juvenile, not more than 50-60 minutes. (This measure can be given by the education staff with the approval of the Social Care Chief of Sector).
c. Expulsion from daily group activities and staying in the room during the day. In such a case, staying in the room cannot be longer than 15 hours (this measure can be given by the Director of the Institution based on the written approval of the Social Care Chief of Sector).

Contrary to the above, the inspection group found out about a juvenile who was given an educational measure exceeding the procedural powers "expulsion from the activities for a day" by the educational staff, and to be more precise one of the educational specialists, signed by the Chief of Social Care Sector. Furthermore, the juvenile was not informed and he was not given the opportunity to provide explanations related to the issue of the alleged behavior or the duration of the disciplinary sanction. The legal procedures, which also entail an educational function, must be observed, when a decision to give a disciplinary measure and its termination is made. In this case, point c was not observed.

During the meeting with the juveniles, the inspection group came to know of juvenile P. Xh., date of birth 11.04.1997, who allegedly committed the criminal offence of "manufacturing and sale of narcotics", article 283/2 of the Criminal Code, with the respective security measure "jail arrest" for a period of 30 days. The juvenile was arrested on 07.03.2014 and as a consequence based on article 250 of the Criminal Procedural Code, item 1, which foresees that "pre-detention effects start at the moment of arrest or detention", the security measure should have terminated on 07.04.2014. On 16.04.2014 when the inspection group carried out its visit, the juvenile was still kept in the pre-detention facilities, uninformed and unclear on the reasons why he was still in detention. The inspection group met the Chief of the Legal Sector and he informed the group that the institution was expecting a communication from the Prosecutor's office, which would either release the juvenile or submit him to another security measure. The monitoring group was informed by the Chief of Sector that he and the Juvenile Detention Institution in Kavaja had identified and were aware of the concrete issue. The issue was more prominent for the pre-detained juvenile with a fixed term security measure, because the notification of the prosecutor's office was almost always with a delay. Even though the chief of the legal sector explained that in such cases, along with the written correspondence with the respective prosecutor’s office, he

personally maintained a telephone communication with the prosecutors assigned to the cases, in the instance of the above-mentioned juvenile he had not undertaken any written correspondence leaving the juvenile uninformed and furthermore in principle, deprived of his freedom without a valid legal document. The chief of the legal sector, following the discussion with the monitoring group for this case, in the course of the last meeting, informed us that he had had in the meantime a telephone communication with the case prosecutor who informed him that the juvenile was given another security measure, for which the juvenile had not been informed.

Based on article 35, item 1, of the Criminal Procedural Code, juveniles must be provided with legal and psychological assistance, in the presence of the parent or other persons "upon juvenile's request approved by the proceeding authority". Furthermore, in article 14, of the law no. 8331, dated 21.4.1998, "On the enforcement of criminal sentences", as amended, "For the juvenile prisoners, the enforcement agencies inform preliminary the parent or legal custodian". When the inspectors met with the juvenile, other juvenile detainees and the staff, they were informed that the juvenile had not had any contacts with his relatives since the day he was arrested until the day he met with the monitoring group.

Safeguards

The Admission Commission operated ordinarily. Data was recorded in a special register. The physician of the institution kept a special register for the violence cases identified by the Commission. The Doctor was part of the Disciplinary Commission, but only as an observer, with no voting right during the process.

During the inspection of the internal facilities, it was found out that there was a special room for the Admission Commission and two meeting rooms which met the standards to enable a meeting of the juvenile with the visitor without obstacles.

The rights and the obligations of the juveniles were posted on the walls and halls of every floor. The solitary room and the observation rooms were provided with beds and linen, with some flaws in the electrical system (electrical wires out of the boxes) and the hydraulic one (problems with the water, taps and WC) making it inadequate for residential purposes. There were no surveillance cameras along the corridor where these rooms were located.

Almost all juveniles confirmed that they could talk to their relatives anytime using the public pay phone located in the common facility.

There was a request/complaint system in place. Juveniles would fill in a simple form drafted by the institution, which they would submit to the educator. The latter would pass that on to the Director of the institution who, usually within a day would meet with the juvenile and provide him with a solution for his request/complaint.

Material conditions

The institution was provided with ventilation and central heating system, as well as a fire protection system. The institution also had a sports ground (soccer pitch), a laundry room, a

modern kitchen, a lab for wooden and metal work as well applied arts, a facility as a cult room, a library, a medical unit, as well as a gym considered by the institution as out of order.

The pre-detention facilities were detached from the prison ones. The sectors where the residential facilities of the pre-detainees and the juvenile prisoners were located, were organized as it follows: living rooms, common facilities, counseling rooms, classrooms, a common outdoor bathroom and shower facilities. The pre-detention sector in Kavaja is organized in three sections: one in the first floor and two in the second floor of the building. Each of the sections had five rooms with a capacity of 2 persons per room, as well as separate shower facilities for each section. The rooms were properly furnished and were provided with bathrooms. The premises of one of the pre-detention sectors were cleaner in terms of hygiene. During the inspection it was noticed that the facility was being painted. The toilets of the living rooms of the pre-detention and prison facilities were in need of immediate intervention to avoid humidity and in some cases installation of artificial lighting systems and sinks.

There was no issue with the uninterrupted supply with electricity and hot water for the showers. However, the latter presented an issue with humidity and depreciation: in a total of 9 showers, only 3 of them were functional, whereas all 12 sinks installed in the same facility were out of order. Electricity was absent and the water was leaking in one of the shower facilities in the pre-detention sector. Generally speaking the shower facilities were too cold (no heating) for them to function normally.

Heating was an issue for other premises too, for the central heating was turned on for a few hours in the evening and it was turned off again, only when the temperatures were below 5 degrees they were turned on.

There was a premise used as a laundry room with 5 washing machines but two of them were out of order. Drying was carried out in the same facility with two cloth racks and chairs.
The kitchen was clean and well equipped. The daily menu was posted and food samples were preserved in the fridge in a plastic sealed box. The food quality and variety was an issue and the juveniles complained to the inspection group. They also had an issue with specific products like the eggs; meat and milk, which besides the unpleasant scents were served in dirty plates and glasses.

The gym had been closed since 3 and half months with the justification that the equipment was defective and as such dangerous for the juveniles. The inspection group examined the gym and verified that it is in optimal conditions and that only few of the tools needed minimal repair.

With regards to the supply with toiletries or personal or common hygiene products, the juveniles confirmed that supply with items such as toothbrush, toothpaste, toilet paper etc., was insufficient and that they were mainly provided by the families.

The issue found out during the last inspection related to the lack of possession of a debit card for the purchase of items at the shop close to the institution remains a problem. Thus the juveniles could not purchase items to their will, but they were dependent on the items provided by the families.

Regime and activities

Airing time was identified as a problem by the inspection group. The management of the institution was not aware that the new legal changes require that the juveniles spend up to three hours in open air. They declared that by regulation the juveniles were spending 2 hours a day in the open air and that the sport activities were included in this period of time. Whereas the juveniles informed us that they would spend circa 45 minutes in the open air before noon and the same in the afternoon, but even this was selective thus applying double standards of behavior in the treatment of juveniles within the same institution, even within the same section. Juveniles confirmed that airing time was conditional upon the will of the security personnel in terms of duration and time of the day.

The juveniles were given the opportunity to pursue the compulsory 9-year education, divided in the first and second cycle. Requests for education for the newcomers were submitted to the respective Regional Education Directorates/Education offices where the juveniles were coming from, based on their needs. Teaching was provided by “Rilindja” school, Kavajë. Enrollment in the relevant classes was based on the documents (when such a document was in possession) or based on testing. Upon the completion of the class or release/transfer of the juvenile, the latter was provided with a certificate equivalent to that provided by the schools of the same level outside the Institute.

Vocational training (classes for welders, plumbers and carpenters) was carried out by the Instructors of the Vocational Training Center in Durres, from Monday to Friday from 14.30 to 16.00.

The juveniles were entitled to go to the library and to take part in the reviews of books and discussion of social topics organized by the educational staff through the relevant educators.

Sports activities consisted mainly of table games, soccer, basketball and volleyball.

Religious activities were carried out in cooperation with the Orthodox Church and the Mufti in Kavaja, respectively one hour a week.

The psycho-social service was assessed based on the examination of the documents, meetings with the juveniles and communication with the staff. The psycho-social files were kept in a locker. Each file had been filled by the respective specialist. In general, the special notes were recorded on a monthly basis, but they had been written in a standard and unspecified manner. Not all the topics of the individual treatment programs were filled, even when they were included. There were cases when the intervention plans were missing. The diagnosis tests were missing. With regards to the individual counseling, they seemed to have been carried out not in compliance with the professional standards (psychological). Free discussion of social topics was considered as group counseling. The juveniles complained about the quality of the psychological support.

Healthcare service

The healthcare staff was complete and composed of a full time physician, a full time pharmacist-assistant physician, a part time dentist and four other assistant physicians. The interviews with the pre-detained and the detainees of the institution revealed no health issues. They reported they were happy with the follow up and the care taken by the physician for every complaint they had, and the healthcare service in general. There were no juveniles suffering from a chronic disease. The identified health issues had been taken care of in a proper manner. The physician of the institution, when encountering during the check up an issue that requested a more specialized opinion, would recommend the respective medical consultation with the districts hospital or/and the QSB Tirane, depending on the organic pathology of the patient. On the inspection day, based on the document examined, one pre-detained juvenile (S.M) following a diagnosis of femoral sinister formation had been sent to QSB-Tiranë for a thorough medical consultation and planning of the surgery.

With regards to the mental health issues, there was only one juvenile prisoner diagnosed with minor mental disability. However, during the inspection, one of the juveniles manifested sleeping disorder, anxiety and mood swings, and there was a need for the psycho-social staff and the specialized physician (psychiatrist) to make an assessment of the situation and provide the proper therapeutic recommendations.

The inspection of the physician's, pharmacist's, dentist's and infirmary rooms revealed that they were in good hygienic-sanitary conditions, neat and well maintained, but there was a lack of medical instruments for various manipulations. The unit in the dentist's room had some operational flaws (the chair was defective, cuspidor was missing water) and the autoclave and other dental tools were missing. The ambulance of the institution was out of order.

During the examination of the medical staff documents and in particular of those kept by the physician, it was found a register for the identification of the cases of use of force. All the forms related to relevant medical checks were kept in order. Two cases of use of force by the individuals of the rapid reaction group were identified, and the management staff had undertaken the appropriate measures against them. The 24 hours information registers kept by the nurses were in order. The medical files were filled in properly and were kept locked.

Only two prisoners and six of the pre-detained juveniles were provided with healthcare booklets. There were no healthcare booklets for the rest of the 18 pre-detained juveniles. The staff of the inspection group was informed that not all the juveniles were provided with healthcare booklets because they were lacking identification documents. The new reimbursement scheme for medicine was not yet being implemented at the institution.

As for the above, the following was recommended:

1. Taking immediate measures to provide a monitoring system (cameras) for all the areas uncovered, especially in the vicinity of the observation and solitary rooms and in classrooms.
2. Taking measures to make all washing machines operational and to ensure appropriate premises to dry clothes.

3. Taking immediate measures to ensure equal treatment of all juveniles with regards to cleanliness, airing time, other activities, etc.
4. Taking immediate measures to repair and provide the toilets located in the living area with artificial light, sinks and insulation in order to avoid the humidity.
5. Taking immediate measures to repair the showers, sinks and artificial light in this area, providing heating to the facility in order to ensure showers are taken in a heated facility and the health is not endangered, as well as provide insulation to avoid humidity might put in danger the health of juveniles if it affects the electrical system.
6. Taking immediate measures to improve food quality, by providing a variety in the menu, improving the quality of milk, eggs and meat and to improve the hygiene of the kitchen utensils and serving sets.
7. Taking immediate measures to ensure the uninterrupted heating of the living area.
8. Taking measures to enable the juveniles to buy goods at their will from the shop close to the institution. In the response no. 448 Prot., dated 04.03.2014 provided to the Ombudsman, the Juvenile Detention Institution explains the measures undertaken to address this issue with the bank and to have the juveniles provided with debit cards. However the issue remains the same, thus refraining the juveniles from customized purchases.
9. Taking immediate measures to repair the equipment in the gym, thus making it immediately operational.
10. Taking immediate measures to supply the juveniles with toiletries and personal and common hygiene items.
11. Taking immediate measures for a more rigorous follow up by the medical staff of the mental conditions and the generic psycho-emotional condition of the pre-detained/imprisoned juveniles, taking into account the trauma that institutionalization can cause.
12. Taking immediate measures to repair the ambulance or to provide the institution with a new auto-ambulance.
13. Taking immediate measures to provide the dentist's room with an autoclave and other dental equipment.
14. Taking immediate measures for the supply of the pharmacist's room with medicines, especially the emergency ones.
15. Taking immediate measures to provide all the pre-detainees with healthcare booklets.
16. Taking immediate measures to implement fully the medicine reimbursement scheme.
17. Taking measures to rigorously implement the Administrative Guidelines of the GDP related to the application of the educational measures for juveniles and respect of legal procedures during the application of the measures.
18. Taking measures to increase surveillance and attention paid to the alleged cases of use of force, offence or threat against juveniles by any of the security personnel with such inclination.
19. Taking measures to improve the quality of provision of psychological counseling.
20. Taking measures to improve the quality of completing the psycho-social files.
21. Drafting an agreement between the General Directorate of Prisons and the Prosecutor General in order to provide an immediate solution to all the delays in the communication between the judicial districts prosecutor's offices and IEVP-s related to revocation, termination or substitution of the precautionary measures, especially when it has a set

term. Delays in the above-mentioned communication lead to unjust deprivation of liberty of juveniles. With regards to the case identified by the monitoring group, the Juvenile Detention Institution of Kavaja must immediately inform the Ombudsman regarding the issue.

22. Regarding recommendations 17 and 18, an analysis of the treatment of the relevant cases must be conducted and relevant conclusions and suggestions must be made.

5.5. "Ali Demi" Penitentiary Institution (325), Tirane - Dated 30.04.2014 / Doc. No. 201400926

Preliminary remarks

The institution has a maximum capacity of 148 persons and is composed of a penitentiary sector for men prisoners with a capacity of 80 persons and a penitentiary sector for women with a capacity of 68 persons. At the time of Inspection 39 women and 52 men were in the institution for a total of 91 prisoners. 86 persons had benefited from the amnesty proclaimed with the Decree of the President of the Republic No. 8523, dated 24.03.2014, to include men and women.

In accordance with the monitoring procedure, the inspection group first met with the Director of the Institution who was willing to cooperate for the accomplishment of the goal of the inspection. The Director of the Institution informed the experts that the depreciation of the building, lack of funds to address such an issue remained a problem, despite all the efforts undertaken to ensure a better environment for the prisoners detained in this penitentiary institution. He informed the group that there had been various donations and projects by NGOs, but they were oriented towards services beneficial to the prisoners and not about the maintenance of the institution.

During the inspection it was found out that both women's and men's sectors possessed an observation/solitary room. There were 2 persons in the men's observation and solitary rooms, respectively one in each of them. There were 3 women with mental disabilities in the women's sector, which were accommodated in two rooms detached from the rest of the living area, though under the same regime. The observation and solitary rooms were located in this particular section as well.

The women's area was provided with a nursery composed of 4 rooms which were clean, neat and offered a friendly environment for children up to 3 years old. At the time of the inspection there were no infants accommodated in this area.

Based on the information provided and confirmed with the official list of the employees, at the time of the inspection 6 men prisoners and 23 women prisoners had been employed by the institution.

Treatment

The main objective of the monitoring group was the collection of information for the identification of cases of use of psychological pressure, excessive force beyond the limits provided for by normative acts, as well as cases when disciplinary sanctions had been imposed.

The monitoring group did not identify any flagrant case of torture or excessive use of force based on the information provided, group conversation and private conversations held with men and women prisoners.

At the time of the inspection, it was found out that some of the prisoners were mothers of 3-5 year old toddlers and they requested to be given priority in terms of the procedures implemented for good conduct time allowances, based on the needs and the interest of the children to have more frequent meetings with the parent.

Safeguards

The Admission Commission functioned normally. All the data was recorded in a specific register. The physician was part of the Admission Commission and of the Disciplinary Commission. With regards to the latter, NPM, based on the CPT's recommendation for Albania for 2010, pointed out that the physician should not be a Member of the Disciplinary Commission, but he must check at least once a day the health conditions of the prisoner under a disciplinary sanction and any other case that he considers that the health of the prisoner is endangered as a result of the time spent in solitary, and whenever there is a need, he must inform the Director of the Institution.

During the inspection of the indoor premises of the institution, it was found out that there were two meeting rooms (one for the women's sector and another one for the men's sector) which allowed for 3 families to meet at the same time.

The solitary and isolation rooms were within the women's special sector, which together with the solitary and observation rooms of the men's sector turned out to be very problematic.

The women prisoners complained that the distribution of persons in rooms was unfair. Some of them requested the distribution of women prisoners to be in compliance with the criminal offences they had been convicted for.

There was a request/complaint system in place. A box placed in the library in the women's sector served as a mail box and as a pigeonhole for the prisoners to place their requests and complaints. Security personnel was opening the box and delivering the letters. The same system existed in the men's sector. The inspection group noticed that such a system does not meet the requirement of the GDP order where it is specified that the administration of the boxes rests with the educational sector.

All the prisoners of the men's and women's sector when interviewed confirmed that they could speak with their relatives whenever they wanted with the public payphone located in both sectors (3 operational phones located in each of the sectors, where the Ombudsman's number was visibly posted as well). However, as far as the procedures implemented during the telephone conversations of the prisoners with families, relatives and friends are concerned, it was found out that the institution was still observing the Instruction of the GDP no. 597 dated 24.01.2007, which prevented the telephone conversations to happen in privacy. The security staff reported that this instruction was still applicable because of many problematic phone calls between the prisoners and third persons. The inspection group pointed out that this instruction has been

replaced with new standards which give the contact the prisoners have with the outer world a new meaning and dimension in terms of rehabilitation.

Material conditions

As confirmed by the Director of the Institution and as found out by the previous inspections, the facilities at both sectors were depreciated and damp. The living rooms in each sector accommodate 2-8 persons, thus respecting the standard of the living space per person, of the natural light in the rooms and of the equipment of the rooms with the necessary furniture and supply with hot water of the showers. There was no central heating system in the institution.

The inspection of the physician's room revealed that it was inadequate in terms of space, humidity and minimum conditions to carry out visits. It was the same situation with the pharmacist's and infirmary rooms. The latter had inappropriate conditions to preserve medicine, there was no fridge and the sink was out of order. The dentist's room in general met the parameters, equipped with a good unit and an operational autoclave, but it lacked dental equipment and materials.

As far as security is concerned, both sectors were lacking security surveillance cameras. Each of them was provided with 3 surveillance cameras, which could cover the perimeter of the sector from three different angles, but there were no cameras in the halls of solitary/observation rooms.

The women's sector, even though the prisoners together with the relevant staff had managed to create a clean and neat environment indoors and outdoors, remained problematic in terms of general depreciation, especially humidity.

The monitoring group found out that women prisoners did not have a sports facility. There was a tailoring, a hairdresser's and a library room where various classes for the prisoners took place, most of which provided by non-governmental organizations which the Directorate had a cooperation agreement with. The tailoring room also served as a room for religious services.

The library room was clean and neat, it had a considerable number of publications which were carefully administered by a prisoner who had been hired there. There was a special register to keep track of the books taken and returned. The prisoners had posted in the same room their handicrafts, which had been used to take part in various fairs and exhibitions. There was also a TV set in the library and the prisoners could watch their TV shows as per the schedule. Same premises were used to organize English and baby-sitting classes.

Bathrooms and showers were installed out of the living rooms, in the women's sector. Bathrooms were assigned to room numbers and despite the conditions of a general depreciation they were clean and in order. The bathrooms had a facility for the laundry and a facility with 8 sinks with uninterrupted running water. The inspection group was informed that despite the schedule of the water supply, the institution had managed to provide water tanks so that there would be running water all the time. There were 8 showers in the sector. At the time of the inspection, the NPM found out that one of the boilers was broken and as such was dangerous to use. They were expecting a plumber to come and fix it. Two of the shower heads were defective.

Toiletries, and personal and common hygiene products were provided by the institution, as well as by various NGO-s and the families of the prisoners.

The primitive, but neat kitchen located in the women's sector was used by both groups. There was a cook and 3 convicted women employed as assistant cooks. The food samples were preserved in compliance with the standards. There was also a cafeteria where the prisoners who wished so, could cook, other than only eat. The cafeteria, relatively clean, was equipped with the necessary equipment and closets for each of the prisoners.

The women prisoners were also employed in the greenhouse of the institution where they would sow vegetables for their own use. They admitted to the inspection group that they were happy with this job and that another part of them were volunteering there.

Inside the women's sector, there was a special section for the mentally ill prisoners, where at the time of the inspection, three persons were accommodated. The facility was relatively clean, equipped with modest furniture.

There were two solitary and observation rooms in the same section, and this was separated from the rest of the section with an iron-bar door with a locker. Both rooms did not meet the standards, measuring 2 x 2.5 m, a bed with a mattress, no furniture such as table, chair etc. The bathroom provided with a shower which did not meet the minimum privacy conditions was located in the hall measuring 6 x 1.5 m. These premises were used also by the special section of women with mental health issues and as a result of the intensive surveillance to prevent attempts of suicide, the privacy of the premises used by the women in the solitary/observation regime was not meeting any standard.
Also, the women regime had a building which was equipped and was used as a nursery for kids up to 3 years, but at the time of the inspection there was none. The nursery was subordinated to the health sector. The premises were well organized and separated in four rooms for kids: one room for mothers with children, one room only for children, a room for toys and a room for the teacher. All of them were well furnished, meeting the standards for the furniture and the necessary health and informative books for mothers with children. The nursery had a staff of 5 persons, 2 teachers, 2 nurses and one nanny.

The inspection group found out that a commissioned purchase service was in place, for purchase of goods allowed in the penitentiary institution but the list of products and the respective prices were not posted. One of the women prisoners had been employed to manage the purchase requests, and she was keeping all the necessary documentation in an orderly fashion.

Men's sector was comprised of a space that was used for sports activities and some equipment which improvised an outdoor gym. There was a workshop, which at the time of the inspection had not been provided with working tools, it had a depreciated ceiling and was facing huge issues with the electrical installation. There was a common space, which from the institutional point of view was a cafeteria, but considering that the prisoners were having their meals in their rooms, it had been turned into a room where they played Ping-Pong, chess etc., especially on rainy days. The room was poorly equipped and damp. There was also a library in the sector.

There were two rooms of solitary/observation located at the entrance of the men's sector, separated from the rest of the sector. At the time of the inspection there were two persons in these rooms. In one of the rooms the prisoner R. SH., who was transferred from Fushë-Krujë Penitentiary Institution, was kept for four days in this room because of an old conflict with a prisoner of this institution. For security reasons, the management of 325 Penitentiary Institution decided to keep the prisoner in the solitary room until the transfer in another prison. The request for transfer was done by the institution and addressed to GDP, but in such cases the procedure takes weeks and sometimes even months. The prisoner complained about the material conditions of the cell and the humidity and coldness of the room.

The room according to the inspection group measured 2 x 2 m with a bunk bed, no other equipment and a little window with bars, which did not permit the penetration of the natural light in the cell. The level of humidity was high and the bedding set did not fit with the low temperature in the room.

The other inmate A. Sh. was punished with a 10 day disciplinary sanction, imposed by the Disciplinary Commission for breach of the regulation. The prisoner was aware and accepted the disciplinary sanction, but he complained about the conditions. Even this room was identical with the first one and did not offer the minimum respect for human dignity.

At the time of the inspection, the prisoners were being served lunch, and because of the absence of the table and chairs, the prisoners were eating in a denigrating manner. The material conditions and the isolation of the prisoners in this premise (more than 3 days) are considered degrading and inhuman treatment.

Regime and activities

Life was organized in an open regime in both men’s and women’s sector. The monitoring group noticed that the team spirit during the joint activities and leisure time, helped in creating a non-conflicting climate.

Daily schedule was posted on the doors of regimes, to include time to wake up, making the beds, cleaning the rooms and the common space, time for educational and professional work etc.

Professional and vocational classes were provided in this institution, categorized as per age group: 18-21 years (4 prisoners), women (39 prisoners), men (29 prisoners). The inspection group was informed in the course of the interviews that women were offered twice per week tailoring, hairdressing, babysitting and English classes. The latter two were organized at the library. Men were offered computer classes which were organized at the library. They were mainly involved with sports activities such as football, basketball, Ping-Pong etc.

Men’s sector was provided with a religious service room where the religious prisoners could practice their rituals and take part in the prayers led by spiritual leaders of the religious communities who visited the institution in accordance with a schedule determined by the institution. The library in the women’s sector was used for this purpose.

The psycho-social staff organized its activities mainly in the library for both, men's and women's sectors. Women's sector possessed an advisory room too, which, other than being used by the psycho-social staff, was used for religious rituals as well.

The psycho social staff kept in an orderly fashion all the relevant documentation such as the monthly reports on the activity of the sector, the psycho-social files, as well as the individual programs for the treatment of the mentally ill prisoners, for age group 18-21 and/or the substance abusers.

Healthcare service

The medical staff organizational chart was composed of a physician, a dentist, a pharmacist, four assistant-physicians and the nursery of the institution, composed of two teachers, two assistant-physicians and a nanny.

During the inspection of the men's sector it was noticed that the opinion for the healthcare service in general was positive, for the physician, nurses and the dentist. The prisoners were happy with the medical service and praised the readiness of the entire staff to provide medical assistance.

Nonetheless, the inspection group encountered mentally ill prisoners in the men's and women's sector. Four women were displaying anxiety disorders, somatoform disorders and personality disorders. Under these conditions, they needed a more specialized assessment and treatment by the psychiatrist. There was a newly transferred prisoner to the men's sector of this penitentiary institution, who had been under methadone cure. The inspection group was informed that all the procedures for the transfer of the necessary documentation to ensure the quickest follow up of the treatment had been carried out.

The pharmacist's room was lacking a variety of medicines, especially the emergency ones. There were cases when the prisoners received their treatment with medicines from the family, because they were not satisfied with the quality of the reimbursed medicine.

During the visit in the special sector for the mentally ill prisoners, the group of experts found out that their mental condition was generally speaking stabilized. They were satisfied with the service provided by the medical staff.

The examination of the medical files revealed that the medical treatment of some of the prisoners needed a reassessment: one patient suffered from tasikinesia neuroleptic and needed to be treated with antipsychotic atypical instead; another one being treated with tri-cyclic anti-depressant needed a replacement of the medication with a new Anti-depressant (SSRI), because the patient was senior and she was on medication for Arterial Hypertension.

During the examination of the physician's documentation, medical checks forms, visits register, fundamental register for the files and the register for the identification of the use of force cases were kept in an orderly fashion. Also, the medical files were properly filled in. The entire physician's documentation was kept in a locker. The registers of the infirmary room were also in order.

All prisoners in women's sector were provided with healthcare booklets, while only 31 prisoners from the men's sector were provided with booklets. The rest of the prisoners who had just been transferred to this penitentiary institution were expecting the transfer of the relevant documentation from the previous penitentiary institution. The reimbursement scheme was fully operational and there were no delays in its implementation.

With regards to the above, the following was recommended:

1. Taking measures for the prioritized treatment in the procedures implemented to grant good conduct allowance for convicted mothers of 3-5 years old children, based on the needs and the interest of the children to have more frequent meetings with the mother.
2. Security Sector to take measures regarding the implementation of new regulations and instructions of the GDP on the rights and standards of the contacts of the prisoners with the outside world such as the visits with the family and friends, as well as the phone conversations.
3. The educational sector to take measures about the strict implementation of the GDP order regarding the address of the complaints/requests.
4. Taking measures to post the list of goods and respective prices in the joint area.
5. Taking measures to improve the conditions of the toilets and showers, especially their electrical equipment/installation.
6. Taking measures to equip and adapt the toilet and shower facilities in the solitary/observation section, in accordance with the privacy and human dignity, as reflected in the General Prisons Regulations.
7. Taking measures to have camera surveillance of the halls in the vicinity of the solitary/observation rooms.
8. The security experts to take into consideration the possibility to distribute the prisoners in the respective rooms taking into account the criminal offences and respective sentences, based on article 20 of the General Prisons Regulation.
9. Taking immediate measures to transfer the prisoner from the solitary/observation cell to a regular regime.
10. Taking measures to equip, adapt and provide living conditions in accordance with the standards set forth by the General Prisons Regulation for the solitary/observations rooms.
11. Taking measures to enable periodical psychiatric consultation for the reassessment and specialized treatment of the prisoners with mental health issue.
12. Take measures so that the physician is not a member of the Disciplinary Commission, because this affects the quality of doctor-patient relationship. The physician must check at least once a day the health conditions of the disciplinary sanctioned prisoner, to make sure that the discipline sanction does not harm the patient's health, and anytime when he thinks that the health of the prisoner is endangered by the isolation, he must inform the Director of the institution, as provided for by the CPT Recommendation for Albania for 2010.
13. Taking measures to enable periodical psychiatric consultations for the assessment of the prisoners who result undiagnosed, but who display issues of mental health.
14. Taking measures to provide an appropriate room for the physician, pharmacist and the nurses, in order to meet the requirements for a good healthcare service.
15. Taking measures to equip the dentist's room with dental tools and material.

16. Taking measures to supply immediately the pharmacy with emergency medicines, with medicines necessary to cure the chronic patients as well as other fundamental medicines.

5.6. Vaqar 327 Penitentiary Institution - Dated 07.05.2014 / Doc. No. 201401019

Preliminary remarks

"Vaqar" penitentiary institution is an ordinary security institution, which does not have a separate section for the juveniles or the prisoners of 18-21 years old. The institution has a maximum capacity of 176 persons. At the time of the inspection, there were 164 prisoners. A considerable number of prisoners had benefited from the amnesty proclaimed with the Decree of the President of the Republic No. 8523, dated 24.03.2014.

In compliance with the monitoring procedure, the inspection group conducted a meeting with the Director of the Institution, who was willing to cooperate to reach the goal of the inspection. The director of the institution informed the experts about the general depreciation of the building and that lack of funds in this respect remained an issue. The inspection group was informed that taking into consideration the previous recommendations of the Ombudsman, the disinfection would be carried out every six months and the upcoming disinfection was planned for June 15th.

Because of the issues with the running water and the volume estimated for each prisoner, which, according to the director of the institution was insufficient, the latter informed us that they had opened a well and as a consequence, the water supply was uninterrupted.

At the time of the inspection, there were 5 solitary/observation rooms and 5 persons were in these rooms. They were there not because of some disciplinary sanction, or because they had just arrived at the institution. The prisoners were in these rooms because some of them had some health issues.

With reference to the information obtained and confirmed with the official list of the employees, at the time of the inspection 27 prisoners were employed by the institution.

Treatment

The objective of the monitoring group was gathering information regarding the treatment of the prisoners, identification of cases of use of force beyond the limits provided for by normative acts or the psychological pressure against this category, and cases of disciplinary sanctions. The monitoring group did not identify any flagrant case of torture or excessive use of force based on the information provided, group conversation and private conversations held with the prisoners.

At the time of the inspection at "Vaqar" penitentiary institution, there were a considerable number of foreigners who confessed when interviewed by the inspection group that they were happy with the treatment provided. Nonetheless they had complaints about the way their criminal offences had been handled, mainly related to their requests for transfer addressed to the relevant authorities. Some of them claimed that the documents of the trial were only in Albanian and not in their native language.

Prisoners complained about the expensive prices at the shop of the institution, lack of medicines and use of the laundry rooms based on preferences. There were also complaints regarding food, about the quality and the variety of the meals. There were also complaints regarding specific diets for some of ill prisoners, especially those suffering from diabetes. The cook informed the inspection group that according to the regulation, the names of the prisoners who needed a specific diet were posted in the kitchen, but the prisoners preferred to eat the food their families would bring, and not what was provided by the institution.

The prisoners during the interviews complained to the inspection group about the transfers. They claimed that there were no criteria about the transfers, and in some cases they were used as a form of punishment. The prisoner A.B. informed the experts that he had been transferred 3 times within 2 and a half months and currently his documentation had not yet arrived at the institution, while according to the legislation in force, the documentation is transferred together with the prisoner. Such delays in the transfer of the files of the transferred prisoners were identified in the course of the interviews conducted by the group of experts during the inspection.

Safeguards

The Admission Commission operated normally. Data was recorded in a special register. The physician was a Member of the Admission Commission and of the Disciplinary Commission. Regarding the latter, based on the CPT's recommendation for Albania for 2010, NPM reiterated that the physician must not be a member of the Disciplinary Commission, but he must check at least once a day on the health conditions of the prisoner under disciplinary Sanction and every time he considers that the health of the prisoner is endangered as a result of the isolation must inform the Director of the Institution.

The inspection of the internal facilities of the regime revealed that there were 3 vising rooms which were small and in poor hygienic conditions, one of which was being used for the Reception Commission and the Disciplinary Commission, other than for meetings with the family members and the little children. The other room was used for meetings with the attorney and senior people. The third facility for the visits was not clean, it had an iron-bar door and the relatives were on one side of the door and the prisoner on the other.

The solitary and isolation room were part of the regime, but outside of the living area which resulted to be problematic.

There was a request/complaint system in place. There was a box at the entrance of the building which served for the prisoners to place their requests and complaints. A security staff opened the box and distributed them. The inspection group noticed that such a system does not meet the criteria of the GDP order, where it is clearly specified that the administration of the boxes must be rests with the educational sector.

All the interviewed prisoners confirmed that they could speak any time they wanted with their relatives with the public pay phones located in the sector (there were two telephones on each floor, and the service provided by Albtelecom was interrupted, while the service provided by Mobitel was twice as expensive. Ombudsman's phone number was not posted there.

As far as the security is concerned: there was a lack of security cameras in the regime. There were cameras installed in the halls, but angles remained uncovered. There were no cameras in the halls of solitary/observation rooms.

There was artificial light in the halls of the living area, but the electrical installations were on the surface.

The inspection group found out that most of the disciplinary sanctions were imposed because the security personnel found forbidden items such as cell phones during the inspections. In this respect, the monitoring group asked for further information such as whether an investigation regarding the "provider" of the forbidden item had been initiated. The Director of the Institution and the chief of security informed the inspection group that no such investigation was initiated, excluding themselves from such investigations. The inspection group noticed that if such investigations are not initiated, this enables and leaves room for things like this one.

The inspection group also found out that a person under disciplinary sanction continued to stay in the solitary rooms despite the fact that the measure had ceased its effects 24 hours ago. The director of the institution informed us that the person had conflicts with some others in the sector, therefore, upon his request he was spending more time there.

Material conditions

As confirmed by the Director of the Institution and as found out in previous inspections, the facility was pretty depreciated and damp. The living rooms would accommodate 4, 6 or 8 persons, but the living standard for the space per person was not observed in every room. Nonetheless, in general, rooms had sufficient natural light, they were equipped with the necessary furniture and provided with hot water from showers, installed in the bathrooms inside the living rooms. The inspection group found out that apart from the fact that the living rooms were highly depreciated and very damp, the showers were also problematic, shower heads were missing and in a room the boiler's switch had been ripped off and the wires were uncovered thus constituting a threat for the life of the prisoners who showered there. It was also found out that insects were an issue in some of the rooms.

There was no central heating system in the institution.

During the examination of the physician's room, dentist's room, pharmacist's room and infirmary room it was found out that they were depreciated and needed painting and refurbishment. The pharmacist's room was lacking medicines for chronic disease and emergency ones. The dentist's room was equipped with an autoclave, the unit was operational but they were lacking dental tools and materials and as a result they could not perform tooth extraction and filling.

The monitoring group found out that there was an outdoor sports facility, used also for airing purposes and some equipment that improvised an outdoor gym. The cafeteria and the classroom, at the time of the inspection were under reconstruction. The library was relatively clean but it only had few boos. A part of the library room was used by a prisoner to paint. There was also a

TV set in the library where the prisoners could watch their favorite shows. The same facility was used to organize counseling meetings with the psycho-social staff.

The kitchen was primitive and in poor hygienic-sanitary conditions. A cook and 3 prisoners hired as assistant cooks were working there. Food samples were kept in an unlocked fridge, thus not meeting the standards. All the prisoners were eating in their rooms, where they could also cook if they felt like doing so.

There were 5 solitary/observation rooms in the sector, detached from the living area. None of the rooms was meeting the standards, measuring 2 x 2.5 m in space, with bunk beds, no other furniture and a little window with bars, the majority of which had no glass windows and the natural light could not penetrate the room. The level of humidity was high and the bedding sets provided were not in proportion with the low temperature of the rooms. The toilets and the showers were not meeting the standards. The solitary/observation sectors were not under camera surveillance. The inspection group found out that at the time of the inspection, the solitary/observation rooms were not being used for the legal purposes they had been established in the first place. The persons that the inspection group found in these rooms were there upon their own requests because they were facing health issues (cardio-vascular and pulmonary diseases etc.).

The inspection group found out that there was a service in place for commission and purchase of the items allowed at the penitentiary institution and the list of products and relevant prices were posted. The management of the prisoners' requests for purchases was handled by a person hired for this purpose who was assisted by one of the prisoners. The shop had a variety of products but the prisoners were concerned by the expensive prices.

The regime and activities

The Schedule of activities was posted on each floor of the residential building, including the wake up times, the cleaning of the rooms and common areas, educational and professional work, etc. Supplementary airing time provided for the sick individuals that according to the medical physician needed airing, was also posted. This sector mainly carried out sports activities (football and basketball). Professional training courses were not delivered. Computer and English training courses used to be delivered, but not for the last two months due to lack of teachers and materials. No hand sports, ping – pong or chess were practiced either, due to the fact that the their facilities were under construction.

The library room was used as a cinema, counselling room and chapel for religious services. Such services were delivered on separate rooms respectively: on Friday's Muslim services and on Mondays christen services. NGOs that had cooperation agreements in place with this institution included The Christian Association for the Albanian Detenies, Jehovah Witnesses and the Autocephalous Orthodox Church that offer Bible education courses, religious films, etc.

As per the Organisational Chart, the Social Service employed a psychologist and four social workers (educators).

During the examination of the psychological – social staff documentation, such as: monthly reports on the sector's activity, both psychological – social files and individual training programs were carefully arranged and locked away. Individual training programs were separated according to vulnerability groups, respectively for the mentally ill individuals, for persons addicted to narcotic substances, for prisoners between 18-21 years old, as well as for prisoners that were about to be released.

At the moment of inspection, 27 prisoners were employed at this institution doing works like loading/unloading, domestic ware housekeeper, sanitary worker, painter, welder, assistant chef, barber, library worker, in charge of sports facility maintenance, gardener, accountant, etc.

Health Care Service

As per the organisational chart, the health sector employed a medical physician, a dentist, a chemist and four assistant physicians.

During the inspection of the domestic regime, general information was gathered on the health care service, on which the Experts Team received complaints with regard to the presence of the medical physician during the regime. Likewise, the prisoners complained on the provision of healthcare service, in terms of delays in visits (consultation visits in the regime or hospital visits). There were some chronic prisoners that were diagnosed and receiving medication, but still needed a more frequent reassessment of the progress of the disease and as a result of the cure. The prisoners complained about how the institution was covering medication for the chronic patients. Even though the prisoners had been issued health books and the reimbursement scheme was being applied, there were delays in its application. It was found that there were delays in administering the food based on a special diet according to the protocol for treatment of the category of people suffering of diabetes. The Inspection Team also found that the prisoners that were addicted to drugs or others suffering from anxiety and personality disorder were treated with benzodiazepine for a long period of time, which increased the risk to addiction to these substances

The examination of the physician's documentation identified that the documentation, including medical check-up forms, visitation logs, fundamental files' register and the register for identification of cases of physical violence were kept in order. The medical files and the rest of the documentation were locked away in a cabinet. The registers kept by the assistant physicians were also found to be correctly kept.

On all of the above, the following were recommended:

1. Immediate measures for the disinfection of the resident premises.
2. Immediate measures regarding the hygienic – sanitary conditions throughout the premises of the regime, especially regarding dampness.
3. Immediate measures on storing food samples in line with the standards provided for in the Regulation on Prisons.
4. Immediate measures to be taken by the Education Sector on the rigorous implementation of the GPD on the process of addressing complaints/requests.

5. Taking measures on improving the conditions of toilettes and showers and especially their electrical installations/devices.
6. Taking measures on the equipment and adaptation of the toilet and the shower rooms in the isolation/observation section regarding privacy and human dignity as reflected in the General Regulation of Prisons.
7. Taking measures on CCTV coverage for the hallways near the isolation/observation rooms.
8. Taking measures for equipping, adapting and creating living conditions in the isolation/observation rooms, in line with the General Regulation of Prisons.
9. Taking measures regarding the initiation of investigations for the "supplier" in cases of disciplinary measures issued after finding forbidden items.
10. Taking measures for the physicians to no longer be members of the Disciplinary Commission, as this affects the physician – patient relationship. In order for the physician to ensure that the prisoner is able to sustain the punishment of disciplinary measure, they have to check the health condition of the prisoner subject to a disciplinary measure at least once per day and when assessing that the health of the prisoner is in danger as a result of solitary confinement, they should inform the Director of the Institution, as is foreseen in the CPT Recommendation on Albania 2010.
11. Taking measures for enabling continuous consultation and physician visits in the regime for an adequate assessment of the disease progress and supervision of the respective medication.
12. Taking measures for creating better conditions in the visitation rooms.
13. Taking measures for applying the medication reimbursement scheme in full efficiency and without delays.
14. Taking measures for completing the dentist office with dental instruments and materials.
15. Taking measures for enabling the immediate supply of the pharmacy with emergency medication, medicine necessary for chronicle – ill and other basic medicine.

5.7. Kosovë Penitentiary Institution, Lushnje - Dated 14.05.2014 / Doc. No. 201401020

Preliminary remarks

Kosovë Penitentiary Institution in Lushnjë is an institution of normal security, with no special section for juveniles of prisoners of age group 18 – 21 years old. At the moment of inspection, 221 sentenced persons were found at the institution premises. Even though previous prisoners that were in this institution had benefited from the amnesty promulgated by Decree of the President of the Republic No. 8523, dated 24.03.2015, overcrowding was one of the issues identified in the situation of 45 prisoners over the official capacity.

In line with the monitoring procedure, the inspection team initially met with the Director of the institution, who was willing to cooperate in fulfilment of the aim of the inspection. During the meeting, the inspection team initially asked for information on the rights and treatment of the prisoners and on the method the institution uses to address issues identified by previous inspections of the institution.

The manager of the institution brought to the attention of the experts that at the moment of inspection, there were 16 prisoners within the age group of 18 – 21 years old. He also informed that the amortization of the building, the time restrictions in running water supply and lack of funds in this respect remained an issue.

At the time of monitoring, the observation/isolation rooms were located at Building No. 2, first floor, which due to overcrowding had been turned into resident premises. As a result, these rooms had lost their legal aim and this was in violation of the standard of living space per person.

Reference to the information obtained and confirmed by the official list of employees, at the time of monitoring the institution employed 36 prisoners.

Treatment

From the information gathered, from group and private discussions with the prisoners, the Monitoring Team did not identify any flagrant cases of torture or excessive use of force.

At Kosovë Penitentiary Institution in Lushnjë, at the moment of inspection, there were complaints by the prisoners on the high prices at the institution shop and on the lack of medicine. There were additional complaints about food, in terms of quality of cooking as well as the fact that it was monotonous. There were complaints on the remuneration for the work done by employed prisoners, who according to the legislation in force are rewarded with deduction of prison days by 3.9 days per month. Prisoner P.M. complained about the issue of home leave, which according to him, he had not benefited from during the last year. The Inspection Team verified the given case and found out that a disciplinary measure had been taken against this prisoner on 29.04.2014, and as a consequence, according to the legislation in force, he was not entitled to home leave for the following year.

Safeguards

The Admission functions normally. Data is recorded in a special logbook. The physician is part of the Admission Commission, as well as of the Disciplinary Commission. Regarding this fact, based on CPT recommendations on Albania 2010, NPM highlighted the fact that the physician should not be part of the Disciplinary Commission, but should check the physical condition of the prisoner who has been subject to a disciplinary measure minimally once a day and in any case when it is assessed that the health of the prisoner is endangered as a result of their stay in isolation, they should notify the Director of the institution.

During the inspection of the internal regime premises, a separate facility for meetings of prisoners with family members with 5 very small partitions not in good hygienic conditions, without stools/chairs for the family members to sit on, was observed. The room has certain iron bar partitions to keep family members separate from the prisoners.

The seclusion and isolation rooms were within the regime but resulted very problematic and were not monitored by surveillance cameras.

There was a request/complaints system in place. A box for the requests and complaints of the prisoners was placed at the entries of both buildings. The box was accessed by a security staff, which would then send the letters to the Secretary and on to the Director of the institution. Requests and complaints were protocol led and submitted to the Director who either replied in writing or met with the prisoners, according to the legislation in force. The Inspection Team noticed that such a system did not meet the criteria set out in the GPD Order, which provides clear guidance on the administration of the boxes by the education sector. All interviewed prisoners affirmed that they could talk to their family members as often as they wished using the card phones at the regime premises.

In terms of security, there was lack of CCTV in the regime. The hallways to the observation/separation rooms had no CCTV coverage.

Material conditions

As confirmed by the Director of the Institution and as observed during previous inspections, the premises at the regime in both buildings remained dilapidated, with dampness and serious sewage problems, which also reflected in the heavy smell that characterized the inside and the outside of the premises.

The residence rooms house 4, 6 or 8 persons, but not all rooms respect the standard of the vital living space per person, taking into consideration that rooms in both buildings under regime were overcrowded. In building No.1 which housed 92 prisoners, only 2 of the rooms had fully partitioned toilets. The rest of the prisoners shared toilettes, 2 in each floor - 8 rooms per floor, for their personal needs. The shared toilets were in very bad hygienic – sanitary conditions. There was an antechamber/ that could be used for showers, even though it didn’t even meet the minimum requirements. The presence of insects was also present in some of the rooms.

In general, the rooms had sufficient natural light and were equipped with the necessary furniture. Running water was supplied with time restrictions and there were no showers in the regime in building 1. 2 small premises just outside the resident building were improvised to serve as washing rooms, but they had no windows or washing devices and were in very poor hygienic – sanitary conditions, with deep dampness. The prisoners would get hot water from the boilers mounted in one of the above – mentioned premises and wash themselves in a primitive manner in the other. There were a total of 2 boilers, one of which posed danger to the prisoners’ lives, because of the electric installation of the panel being totally exposed. The institution had no central heating system.

The Inspection Team examined the physician room, the pharmacist room and the assistant physicians room and concluded that they were dilapidated and in need of painting and reconstruction. The dentist’s room was compliant to standards. The pharmacy room had great deficiencies of medicine for chronic diseases and emergency medication. The dentist’s room was equipped with an autoclave, the unit was new and functioning well, but there was an absence of dental materials. As a result, tooth extractions and fillings were not performed. The dentist would, in emergency cases, use dental material and medicine that he would supply privately.

The Monitoring Team observed that there was an outdoors space that was used for airing. Close to the first building was a gym with a ping – pong table and a few modest fitness tools, and immediately after was the classroom used for professional training courses. The classroom had a few desks and 4 computer screens, which the staff wasn't aware of. The gym, just like the classroom, were in very bad hygienic – sanitary conditions as it was damp and the window lacked glass.

The library was relatively clean, very small, with a small number of titles and a prisoner employed as librarian. Counselling with the psychological – social staff was also offered in this environment.

In the regime, outside of building No. 1, there was a small room in poor hygienic – sanitary conditions, which was used by a prisoner working as a barber.

The kitchen was dilapidated and in very poor hygienic – sanitary conditions. It employed a cook and 4 prisoners as assistant – cooks. All prisoners had their food in their cells and the food was distributed by prisoners hired for this purpose.

The Inspection Team observed that the service for placing orders and purchasing allowed items at the Penitentiary Institution was in place and the product price lists were posted. Prisoners' purchase requests were managed by a prisoner hired for this purpose. The store had a variety of products; however prisoners expressed their concerns related to the high prices.

The regime and activities

The schedule, including the wake up times, times for room and common areas' cleaning, educational and professional work, etc., was not posted. From discussions with the prisoners, the Inspection Team learned that the airing activity was done in accordance with standards. According to the schedule, airing times were between 0800 and 1300 hrs. Activities that prisoners carried out were mainly sports activities in the gym according to a schedule and table games mainly in the library, which only had a small number of books. There was an absence of professional education training courses, which used to have a comprehensive program including vocational training courses on mechanics, generics, computer skills, foreign language skills, etc.

The Chief of the Psychological – Social staff informed the Inspection Team that the classroom would be put in use very soon, as one of the non – profit organizations that supported the institution would rebuild it in the framework of a special project for that purpose. However, the psychological – social sector also organised activities on specific topics involving a considerable number of prisoners in both resident buildings. Staff held counselling sessions within prisoners' rooms in the regime.

The psychological – social staff informed the Inspection Team of a special facility that used to exist in building 1 used to offer religious services, but which, due to overcrowding had been turned into a rooms for prisoners. The religious services were currently being offered in the library and only on religious holidays.

According to the approved organisational chart for the psychological – social care sector, this service employed a chief of sector and 5 specialists, 2 of which had a degree in 'social work' and 'psychology'.

Examination of the documentation of the psychological – social staff, such as monthly reports on the activity of the sector, psychological – social files as well as individual training programs showed that they were well – kept and locked. Individual training programs were offered according to vulnerability groups, for the mentally ill persons, persons addicted to drugs and 18 – 21 year old prisoners, respectively.

At the moment of inspection there was a total of 36 prisoners that were employed at the institution, doing jobs like loading/unloading, domestic ware housekeeper, sanitary, painter, welder, assistant cook, barber, librarian, territory maintainer, etc.

Healthcare service

The health sector organizational chart included a part – time physician, a pharmacist, a dentist and four full – time assistant physicians.

At the moment of inspection in this institution, the Expert Team generally received high regard for the healthcare service by the prisoners. They were happy with the healthcare service provided. In both sectors, the prisoners said that there was willingness shown by the healthcare staff regarding their health requests and complaints. The prisoners suffering from acute and/or chronic diseases said that there were no delays in consultations outside the institution, either.

The only issue observed in both sectors was the absence of medicine. However, at the moment of the visit, the need for a more adequate separation of the prisoners according to their diseases was identified. A mentally ill prisoner was observed staying in the hallway, in conditions that were not appropriate at all and which had an impact on aggravating his psychological and emotional state. Another prisoner that was suffering from a chronic dermatological condition (Psoriasis) was also observed staying in conditions that were not appropriate at all and which did not facilitate his recovery but which, in fact, worsened his condition. There was a total of 25 prisoners with chronic, cardio – vascular, pulmonary, endocrine, gastro – hepatic, haematological and neuro – psychiatric diseases.

The institution had an ambulance in good condition.

The examination of the medical staff documentation, especially of the physician, identified the existence of a fundamental register for the visits of chronically – ill prisoners. All medical check-up forms were filled in correctly. The 24 hour information registers were filled in correctly by assistant physicians. Medical cards were correctly filled and locked away. Health booklets had been issued for 125 prisoners. The rest of them had been transferred from other Penitentiary Institutions and were awaiting completion of respective documentation before they could continue with the procedure for receiving health booklets.

The recommendations for all of the above include:

1. Taking immediate measures to decrease overcrowding in the regime and to respect vital living space per person.
2. Taking immediate measures regarding hygienic – sanitary conditions throughout all regime premises, especially regarding dampness and wastewater sewage.
3. Taking immediate measures for equipping the buildings with appropriate shower facilities.
4. Taking measures for improving the situation in the toilets.
5. Taking immediate measures regarding disinfection of residence rooms.
6. The education sector to take measures for the rigorous implementation of the GPD order on the process of addressing requests/complaints.
7. Taking measures to open an office for psycho – sociological counselling within the regime.
8. Taking measures for camera coverage of the hallways near the observation/seclusion rooms.
9. Taking measures for equipping, adapting and creating living conditions in the observation/seclusion rooms, according to the standards set out in the General Regulation of Prisons.
10. Taking measures for the physicians to cease to be members of the Disciplinary Commission, because this affects the physician – patient relationship. In order for the physicians to ensure that the prisoner can sustain the punishment of disciplinary measure, they should check the health of the patient who has been subject to a disciplinary measure at least once a day and when they assess that the health of the prisoner is endangered as a result of staying in isolation, they should inform the Director of the Institution, as foreseen in the CPT Recommendation on Albania 2010.
11. Taking measures for separating 18 – 21 years old prisoners in a separate sector.
12. Taking measures to place the prisoners with chronic diseases in separate and appropriate rooms.
13. Taking urgent measures for supplying the pharmacy with medicine and the appropriate furniture for their storage.
14. Taking measures for supplying the dentist room with dental material.

5.8. Peqin Penitentiary Institute - Dated 13.06.2014 / Doc. No. 201401474

Preliminary remarks

Peqin Penitentiary Institution was classified as a high-security prison comprising of 4 sections: the high-security section, the normal security section, the pre-detention section and the observation section. The maximum capacity of the institution is 600 persons. At the moment of inspection, there were 750 prisoners/pre - trial detainees at the premises of the institution. The institution did not shelter juvenile pre - trial detainees/prisoners.

In accordance with the monitoring procedure, the Inspection Team started with a meeting with the Director of the Institution, during which the aim of the visit was communicated. The given

manager expressed his personal willingness and the willingness of his staff to meet all the requirements of the Monitoring Team. During the meeting with the Peqin Penitentiary Institution Director, who at the time of the visit had been in post for only two days, the Monitoring Team was informed about the general situation at the institution. There were 4 prisoners between 18-21 years old that were held at a separate section. There were 4 prisoners secluded as a punishment with disciplinary confinement, 2 of which were sentenced prisoners and 2 were pre - trial detainees. There were 33 prisoners with mental health problems, but there was a special section for them. The organisational chart was filled but there were vacancies with regard to the health sector due to temporary disability at work (2 physicians were on long sick leave).

The institution had 6 observation rooms, which due to overcrowding in the sentence sectors had lost their function and were being used as living rooms for prisoners with conflicts who had yet to adapt to the regime. Additionally, the institution also had 6 rooms for seclusion from common activities.

Treatment

From group and private chats with the prisoners and pre - trial detainees, it was observed that the overall condition regarding cases of torture, degrading and discriminatory treatment, excessive use of force and violence or psychological violence exercised by the Penitentiary Institution staff was not problematic.

The Monitoring Team identified that the institution facilities were missing posters with the rights of the prisoners/pre - trial detainees.

Another unsolved issue regards the lack of sufficient supplies of prisoners/pre - trial detainees with common and personal hygiene products, such as detergents, trash bin bags, shampoo, etc.

Safeguards

Regarding the admission of prisoners/pre - trial detainees in the institution, the functioning of the Admission Committee and filing registers and personal prisoner files, it was observed that the reception of prisoners in the institution was done in respect of legal standards.

The physical examination of the respective register showed that the right of the prisoners to submit complaints to the institution and outside the institution was respected, but their complaints were rarely answered. All sections were lacking complaint/request boxes and the prisoners handed the requests/complaints to the educators, who would then submit them to the secretary of the institution.

A serious incident had occurred at the institution on 9 June 2014 when prisoner M.B. had been hit by 4 other prisoners. The prisoner had gotten injured and had a cut in his head. Stitches had been put on the cut under the observation of the institutional physician by an assistant physician at the infirmary in the institution. Based on the observation of the prisoners' medical history and after gathering information and clarifications on the incident by the staff, the Inspection Team assessed that the prisoner should have been sent to the Peqin hospital for specialized surgegical assistance, but such a thing had not happened because the institution was lacking an ambulance.

NPM experts carried out a thorough investigation of the event, examined the footage and administered documentation that reflected the circumstances of the event and actions or lack thereof of the respective sectors for the management of this event. The incident was a serious one for the security of the prisoner's life and as regards the violation of the institutional security. Footage showed that the stand – by team had intervened only after the four prisoners had hit citizen M.B. for a few minutes and injured him badly. This delay in the intervention requires for a deep analysis of the drafting and application of the security scheme and actions for this institution because protection of life at the Penitentiary Institution should be primary. Investigation also identified that Security Sector had not respected procedures in the notification of the Institutional Directorate and the Legal Office for delegating the competence of the Criminal Decisions Execution Sector at the Elbasan Prosecution District and that there had been attempts for this decision – making to be given as a personal choice to the injured person.
In terms of the monitoring system environments with cameras, Peqin Penitentiary Institution does not appear to be problematic, due to its modern structure. However, monitoring identified that the space of descending stairs to the second floor of High-security sectors to go to the airing facilities was not monitored by cameras.

Material conditions

Overcrowding had, among others, caused disfunctioning of the observation rooms as such, because in Peqin Penitentiary Institution, taking security measures to avoid incidents in the sentencing sectors had forced the managers of the institution to use all the space for housing residents.
The common activity rooms in the normal security section were poorly furnished, however the prisoners requested to use them for as long as possible.

Furnishing with housing items, such as table and chairs was appropriate in the facilities for sentenced prisoners. The same situation was found in terms of quality of blankets and sheets. However, absence of sufficient wardrobes in living rooms was a problem for the detention facilities, and he pre - trial detainees/prisoners were forced to keep their clothes in plastic bags or in a sack, mainly under the bed.

Running water continued to be supplied based on a restriction schedule. However, the Department had taken measures for showers to be taken once in every seven days according to a schedule. The showers in the normal security section were not functioning well, due to poor maintenance and institutional budget difficulties. The showers in the detention facilities were shared. The given facility had 10 partitioned showers, with only half being functional and even they were missing shower handles or heads.

The situation in four high-security sectors seems to be problematic, because the respective rooms have no fully partitioned toilets. As regards this fact, it should initially be noted that the absence in question had come as a result of a recent failure to foresee it in the restoration project for this Penitentiary Institution. The situation appeared quite problematic, as 60 prisoners of the two high-security sectors on the first floor and the same number on the second floor, were forced to share toilets. The given toilet facilities were being used for other purposes, as well, like for

example to draw water, to wash personal clothes etc., which had consequently brought hygiene problems and damages to the hydro-sanitary equipment.

The laundry room in the Peqin Penitentiary Institution was functional and was being used to meet the needs of the institution to wash the prisoners/pre - trial detainees' bedclothes, but not their personal garment. Pre – trial detainees/prisoners could not use the laundry room in the institution to wash their personal clothes; instead they had to wash them by hand in their rooms.

The food in the institution was served three times daily. In general, sentenced prisoners complained about the quality of food and that it was monotonous. The visit to the kitchen identified that the food prepared for that day's lunch was of satisfactory quality, but the food warehouse needed hygienization and disinfection because it contained kitchen insects (bakers). Employees wore gloves when they worked in the kitchen. Daily menu samples were being stored in the refrigerator. Kitchen staff said that there was different food cooked for prisoners with conditioned food regimes due to their illness (for ex.: for persons with diabetes). However, the monitoring group did not find any food samples for this category of residents being stored.

The regime and activities

The Monitoring Team was informed of how prisoners' right to be in contact with their family members was respected and they observed the visitation rooms. Like in other Penitentiary Institutions the absence of an appropriate child – friendly visitation facility was noted. The conjugal visitation room was dirty and poorly furnished.

All pre - trial detainees/prisoners went out to spend time in the open air twice a day. The airing facilities were adequate, but there was a need to cover a part of them because their use became impossible on rainy or very hot days.

Healthcare service

As per the Organisational Chart, the Health Sector should have employed three physicians, but only one was found to be working in this institution. There was a dentist, an assistant physician/pharmacist, a laboratory technician and 7 assistant physicians.

The inspection in the institution and the interviews with the prisoners showed that the healthcare service was poor and problematic in terms of timely reaction to requests for visits to the physician and the visits to specialized physicians in the regional hospital. This was also due to the lack of physicians, as there was a need for three physicians in this sector to cover the capacity of this institution.

The Healthcare service was provided in a separate facility that served as a hospital, consisting of 4 rooms that housed 4 prisoners hospitalized for physical health problems, including cardiac, nephrological, neurological pathologies, etc. These prisoners also complained about the absence of medicine, services and consultations outside the institution. There were chronic patients who, even though they were diagnosed and under medication, still needed frequent re – assessment of the illness progress, and as a result of the medication they received. There were further

complaints about the medicine coverage for the chronic prisoners. There were delays in the application of the medicine reimbursement scheme, especially for the acute illnesses. Most of the prisoners received supplies of medicine privately, from their family members.

The healthcare sector in this institution treated 34 prisoners with mental health problems and 32 abusers of narcotics.

The overall conditions in this facility were good. Sanitary staff kept patient rooms clean and tidy.

The institution was lacking an ambulance for a long time.

The physician, the dentist room and the pharmacy room were tidy and well – kept, in good and tidy physical and material conditions. The dentist room was equipped with a unit and an autoclave in good working conditions but a shortcoming in the supply with dental material and instruments was noted.

The examination of the medical staff documentation, with special regard to the physician's documentation showed the existence of a visitation register, fundamental register for the chronic patients and the register for visitations outside the institution. All medical check-up formats were kept regularly. 24 – hour assistant physicians registers the same way. Medical files had deficiencies, were not correctly filled in and were not being stored in locked places. Only 120 prisoners had health booklets. The rest of the prisoners that had been transferred from other Penitentiary Institutions were awaiting completion of the respective documentation in order to continue with the procedure of having health booklets issued for them.

The Social Care Sector had drafted individual training programs for the pre - trial detainees/prisoners and organised joint activities, which mainly consisted of group discussions on social topics. Psycho-social files of prisoners aged 18-21 were all completed and updated with summaries of recent meetings with prisoners. A problem that was identified in the Social Care Sector was the lack of separate facilities within the sections to work with the prisoners and this had a direct impact on the quality of work the staff does with the prisoners.

Based on this, the following recommendations were proposed:

1. Taking immediate measures to reduce overcrowding in Peqin Penitentiary Institution.
2. Analysis of events dated 09/05/2014, which resulted in the endangering of prisoner M.B.'s life, review of the reasons why this event was not referred to the competence of the Sector for Execution of Penal Decisions in the Elbasan District Prosecution Office, and review of the legal grounds for the attempts to give the decision to be left with the injured person, as his personal choice.
3. Taking immediate measures to immediately fix showers in the normal security sector.
4. Taking immediate measures for the cleaning of visitation rooms and furnishing them with the necessary items for establishing a climate in respect of the dignity of prisoners and their visiting family members.
5. Review of the possibility for prisoners, especially the ones in the normal security sector, to use the common facilities even during the afternoon hours.

6. Enabling working space for the Social Care staff to work with the prisoners within the institution's sectors.
7. Taking measures to put request/complaint boxes in the sections, preferably near the telephones, to enable the prisoners to exercise their right to complain.
8. Taking measures to define a procedure for moving requests/complaints outside the sections, recording them in a register and managing replies or providing solutions within legal timelines.
9. Taking measures for posting the approved weekly menu in the kitchen.
10. Taking measures to periodically hygienist and disinfect utensils and the food warehouse.
11. The institution to find a solution for providing laundry services for the prisoners (for their personal garments).
12. Maintaining regular contact between the Peqin Penitentiary Institution and the Sector for Execution of Penal Decisions in the Elbasan District Prosecution Office as a legal obligation, and notifying them about serious cases, such as: injuries of prisoners (M.B. case in Peqin Penitentiary Institution), should be mandatory. Peqin Penitentiary Institution management staff and legal sector shall get familiar with this obligation through an Instruction issued by the Director of the Institution.
13. Taking urgent measures to increase staffing by at least two physicians in the organisational chart for the healthcare sector.
14. Taking urgent measures to supplying the hospital's pharmacy room with medicine in application of the national health insurance scheme.
15. Taking immediate measures for a re-assessment of the diagnosis and medication for the chronic prisoners.
16. Taking immediate measures for providing an ambulance for the institution.
17. Taking measures for issuing health booklets to all prisoners, by accelerating the procedure for completion of respective documentation in cases of transfers from one Penitentiary Institution to another.
18. Taking immediate measures for supplying the dental service with dental instruments and materials.

5.9. Shën Koll Penitentiary Institution, Lezhe - Dated 16.06.2014 / Doc. No. 201401240

Preliminary remarks

Shën Koll Penitentiary Institution, Lezhë is a normal security institution with a detention section and a juvenile detention section. Its official maximum capacity is 700 persons. On inspection day, 753 were found in the institution's premises and this figure clearly shows overcrowding in the institution. The internal regime in this institution comprised of 5 buildings for 2 sections and an observation/seclusion section. The detention section had 2 buildings whereas the prison section had 3. The solitary confinement room was in a separate building. 8 persons were found in the juvenile detention section on inspection day.

In accordance with the monitoring procedure, the Inspection Team first had a meeting with the managers of the institution, respectively the Chief of Security, and Deputy Director of the

institution, who expressed their willingness to cooperate in fulfilling the purpose of the inspection. The experts had an end – of – inspection meeting with the Director of the Institution.

The managers of the institution made the experts aware of the fact that there was no separate section for the pre - trial detainees or 18-21 year old prisoners; a total of 48 persons at the moment of inspection, 14 of which were prisoners and the rest pre - trial detainees. There were 22 persons that had mental health problems and 4 that were treated with methadone.

They also informed on the persisting issues of building wear and tear, restricted hours of running water supply and lack of funds in this direction.

During monitoring, the observation/seclusion sector was found to be in a separate building with 11 rooms (6 for observation and 5 for seclusion) and a total of 20 residents at the moment of inspection.

Referring to information received and confirmed with the official list of staff, at monitoring time the institution employed 70 prisoners and 1 pre - trial detainee. None of them were juveniles.

Treatment

From the information received by group discussions and private chats with the prisoners, the Monitoring Team did not identify any flagrant cases of torture or excessive use of force.

At the Lezha Penitentiary Institution, at the moment of inspection there were complaints by the prisoners on lack of information in some cases of prisoner dynamics and complaints against the judiciary. Other complaints regarded high prices in the institution's store and lack of medicine. Other general complaints regarded food quality and lack of meal variety.

Safeguards

The Admission Committee functioned normally. Data was being recorded in a special register. The physician was member of the Admission Committee and of the Disciplinary Committee as well, even though in the latter he only had an observer's role. NPM, based on CPT recommendation for Albania 2010 brought into attention the fact that the physician should not be part of the Disciplinary Commission, but should minimally follow the health condition of the prisoners that had a disciplinary measure issued for them and, in any case when they assess that the health of the prisoner is endangered as a result of remaining in isolation, they should inform the Director of the Institution.

Inspection identified that there was a separate facility for the visits of prisoners with family members but the facility was not appropriate, hygiene and equipment – wise. The experts identified that for visitations with children in the special visitation room, certain furniture like tables and chairs were in very bad condition. Visitations with children without physical barriers were based on permission and special request.

Seclusion and isolation rooms in the regime were in a separate building and were found out to be problematic, though monitored by CCTV.

The system of requests/complaints was in place. Prisoners and pre - trial detainees in this Penitentiary Institution would sign a request/complaint and give it to the educator/, who would submit it to the protocol office. Following protocol procedures, the letter would be submitted to the Director of the Institution who answered in writing or met with the prisoners, as per the legislation in force. However, the inspection team identified that the request/complaint boxes were missing in almost all the sections of the regime and in building No. 2 there were claims that they did not receive replies on time or did not receive replies at all for the requests/complaints submitted.

On disciplinary measures, we were informed that the staff of the Penitentiary Institution in Lezha worked very hard to not give disciplinary measures as punishment to juveniles but replace them with meetings and consultation, which contributed to a non – conflictual atmosphere. There were a lot of disciplinary measures on adult prisoners, though, especially for finding forbidden items. 13 disciplinary measures had been issued only during June until the moment of inspection.

All interviewed prisoners confirmed that they could talk to their family members as long as they wanted using card phones at the regime premises, but no Ombudsman numbers were found displayed near the phones. There were, however, many complaints on the phone cards (Mobitel), on which they claimed they spent more that they would for other phone providers and this was a burden to the pockets of the pre - trial detainees/prisoners.

Regarding security, the regime had an external and internal CCTV system with a total of 92 cameras, only 3 of which were not in working order. There were cameras mounted in the hallways to isolation/seclusion rooms.

Material conditions

As confirmed by the Director of the Institution and as identified by previous inspections to the facilities in the regime, all buildings were thoroughly dilapidated with a high level of dampness, with serious issues of hygienic – sanitary conditions and insects.

The rooms housed 2, 4, 6 or 10 persons each but not all rooms respected the living space per person standard, given the overcrowding in the regime. There were partitioned toilets in the rooms, but they were in very bad conditions and damp. Showers were generally dilapidated, in very bad hygienic – sanitary conditions with serious dampness and posed high level danger for issues related to electrical installations. Boiler panels were a permanent danger for anyone going near them, as they were dilapidated and not properly maintained and because of electrical wires being exposed, as the electrical installations were completely exposed. The shower partitions were usually missing glass panels and blankets were used in their place to maintain privacy, but due to serious dampness levels (dripping ceilings) the blankets smelled very badly.

In general, the rooms had natural lightning and were furnished with the necessary furniture, but it needs to be highlighted that they were old. The foam mattresses were old and in most cases, the

pillows and sheets were provided by family members. Blankets provided by the institution were extremely old and in poor hygienic condition, due to the malfunctioning of the laundry room, as claimed by prisoners and pre - trial detainees, and due to the lack of a drying facility. Even though there were two drying machines in the Landry room, it was very difficult for them to do washing. Also, during the interviews the inspection team was told that the institution only provided dishwashing detergent ("test") and no other detergents or toiletries. pre - trial detainees and prisoners were not provided with all the necessary toiletries or hygienic items. Prisoners and pre - trial detainees received supplies of all the necessary items from their families.

The inspection team requested additional information regarding home appliances, following complaints received from prisoners and trial pre - trial detainees that they were forced to purchase televisions and refrigerators from the institution, instead of their families providing them. The staff of the institution informed the experts that the Order of the Director General of Prisons No. 3895, dated 04.09.2013, allowed for equipment for use in the rooms to be purchased only from the special commission of the institution. Such appliances can be purchased using prisoners/pre - trial detainees' funds allocated by the institution.

There was a separate building for solitary confinement in the regime, consisting of 11 rooms with a maximum capacity of 36 persons. At the time of inspection there were 20 confined persons, 3 of whom with mental health problems. Rooms in this facility were extremely dilapidated; windows were without glass and hygienic – sanitary conditions were very poor. Some of the persons in the observation/seclusion rooms slept in very old mattresses or bedding. The toilet and shower facilities were at the end of the hallway and they had respectively 3 functional washbasins out of 6 factual ones, 3 toilets and, out of the 3 showers, only 2 were functional. There was no electricity and no glass on the windows. The whole premises were extremely dilapidated and filthy, which made its functioning almost impossible.

Running water supply was provided and persons had access to it which made it possible for them to meet their needs normally. Despite that, there were occasional complaints, especially at the observation/seclusion rooms, that they were not allowed to take showers. The presence of insects was also observed in some of the rooms.

The institution had no central heating system in place.

The Monitoring Team observed that there were outdoor premises that were used for airing. There was a gym to be used for sports activities. The juvenile detention building had a classroom equipped with 8 computers that was used for computer training courses.

There were library rooms in buildings 1, 5 and 4 and they were relatively clean, small and offered a small number of titles that had been provided by Save the Children organisation, which had also done some repair work in building 1 serving as juvenile detention. This facility was used for counselling with the psychological – social staff.

The kitchen was in relatively good, hygienic conditions and had no absences in appliances or water. Even though the food was covered, inspects were observed at inspection time. The experts found that food samples were being stored for 24 hours, but not in the refrigerator. There were

persons suffering from diabetes in need of a special diet. The institution prepared special food for this category. However, the interviews identified that this category of people mainly cooked for themselves or had their food brought in by their family members.

The regime and activities

The schedule, including wake up times, cleaning and tidying of rooms and shared areas, education and professional work, etc., was posted. From the discussions with the prisoners, the inspection team learned that airing as an activity was in accordance with standards and based on a pre – prepared schedule.

Prisoners did mainly sports activities according to a pre – prepared schedule, including football and table games. Professional training courses were generally not offered. At the moment of inspection, there were 4 juveniles that attended primary education. Classes were delivered daily by 2 teachers between 9:00-12:00 am and the classrooms, which had been funded by Save the Children organisation, were in very good condition, with all the necessary teaching materials. Additionally, the Psychological – social Sector also organised activities on specific topics involving a considerable number of prisoners from all housing buildings and individual training programs for the prisoners. Professional training courses were not being delivered.

There were two chapels in detention centre 2, for the Christian and Muslim religions respectively. Muslim services were being held every Friday by the imam and Christian services every Monday. These premises were well – kept and clean.

According to the approved organisational chart for the social affairs sector, this service employed a chief of sector, 5 specialists – educators, one of which a social worker, and 4 social worker specialists, one of which a lawyer.

The examination of the psychological – social staff documentation, monthly reports on the activity of this sector, psychological – social files and individual training programs showed that they were all completed and updated with information on the meetings with the prisoners and the last quarterly assessments. The experts identified the lack of special premises within the regime for the psychological – social sector.

At the moment of inspection the institution employed 70 prisoners and 1 pre - trial detainee doing works like assistant cook, food distributor, assistant ware housekeeper, accountant, sanitary employee, painter, etc.

Healthcare service

The organisational chart of the healthcare sector provided for a physician who had recently been appointed and acting chief of healthcare sector, one dentist/assistant physician, one assistant pharmacist and 6 assistant physicians.

The institution had a functional ambulance.

In the Penitentiary Institution, there was a facility called the Hospital of the Institution with 3 rooms, and 8 persons were found hospitalized for health problems. The rooms were dilapidated; the beds had old beddings and were in poor hygienic – sanitary conditions. Following the last disinfection that was going on during inspection, the presence of insects was no longer observed.

The physician room that was used for visits was found to be completely out of standard; it was dilapidated and missing the necessary equipment and tools for providing an adequate service. The assistant physicians' room was also problematic, because it was outside standards and humid, it had a very old cabinet to store medicine. The dentist room was tidier; it had a unit and an autoclave in good working order. However, there was an absence of dental materials and instruments and as a consequence; the dentist could not do any work. The only type of dentist activity going on was extractions.

From the inspection in this institution and from interviews with prisoners, the experts concluded that the health care service was generally regarded as very poor, in terms of timely response to requests for visits and for consultations outside the institution with specialized physicians in the regional hospital. This is also due to the lack of physicians in the organisational chart, because there should have been at least three physicians employed in this sector, given the capacity of the institution. The fact that the institution has made attempts to partly cover the medicine issue for urgent cases and for treatment of chronic patients is to be applauded.

The health sector in this institution treated 40 chronic patients, 22 mentally ill patients and 22 prisoners that had abused drugs, who were on methadone.

The examination of the medical staff documentation, especially the physician's documentation, identified the existence of a visitation register, fundamental register for the chronic patients and the register for consultations outside the institution. The 24 hour assistant physicians' registers were also well – kept. Medical files were correctly completed but not locked away. Only 120 prisoners had health booklets. The rest of them had been transferred from other Penitentiary Institutions and were awaiting completion of respective documentation to continue with the procedure for having health booklets issued for them.

On all of the above, it was recommended:

1. Taking immediate measures for decreasing overcrowding in the regime and for respecting personal space.
2. Taking immediate measures regarding hygienic – sanitary conditions in all regime premises.
3. Taking immediate measures regarding dampness in the showers and toilets and the physical repair of such facilities.
4. Taking immediate measures regarding disinfection of resident premises.
5. Taking measures to furnish adapt and create living conditions in the observation/seclusion rooms, according to the standards set out in the General Regulation of Prisons.
6. Taking measures for creating the normal hygienic – sanitary conditions and furnishing the visitation room with the necessary furniture.

7. Taking measures for the prisoners to meet their children without physical barriers, to avoid traumatisation of children.
8. Taking measures for creating a working environment for the social care sector within the regime.
9. Taking measures that the physician is not part of the Disciplinary Commission as this affects the physician – patient relationship. In order for the physician to ensure that the disciplinary measure does not harm the patient's health, he should check the condition of the prisoner subject to disciplinary measure has been issued at least once a day and in case when it is deemed that the health of the prisoner is endangered as a result of solitary confinement, they should inform the Director of the Institution.
10. Taking measures for separating 18 – 21 year old prisoners in a separate sector.
11. Taking measures to adapt the education with the work post in the social services sector.
12. Amendment of the Director General of Prisons' Order No. 3895, dated 09.04.2013, to allow pre - trial detainees/prisoners to receive electrical appliances from their family members, thus avoiding discrimination, stigmatization and claims for abuse or favours.
13. Taking urgent measures to improve the rooms used by the health sector to offer its services, such as the visitation room, the assistant physicians' room and the pharmacy room.
14. Taking immediate measures to increase number of staff with at least two more physicians for the health sector.
15. Taking measures to supply the dentist room with dental instruments and materials.
16. Taking measures for issuing health booklets for all prisoners by accelerating the procedure for completion with respective documentation in cases of transfers from one Penitentiary Institution to another.

5.10. Kukës Penitentiary Institution - Dated 19.06.2014 / Doc. No. 201401359

Preliminary remarks

Kukës Penitentiary Institution is located in the northeastern part of the country, within the premises of the Regional Police Directorate. Kukës Penitentiary Institution came under the subordination of the General Directorate of Prisons on 1 October 2007. Its official capacity is 36 persons. On the day of inspection 27 pre - trial detainees, including one minor, one Macedonian citizen and some Kosovo citizens were found at the institution.

The Monitoring Team first had a meeting with the senior managers of the institution, in accordance with the monitoring procedure. The senior managers of the institution expressed intentions for very good cooperation. During the preliminary discussion, the Monitoring Team informed on the issues identified for this institution during the monitoring visit in 2013, which mainly regarded the thoroughly dilapidated premises, lack of conditions for carrying out different activities, etc. The Director of the Institution informed on the overall situation in the institution by identifying the fact that the Penitentiary Institution is situated partly underground as the main issue. No prisoners with disciplinary measures, mental health problems or chronic illnesses were found on inspection day. The staff was complete as per the organisational chart.

Training

Inspection identified no cases of institution's staff exercising physical or psychological violence on the pre - trial detainees. The institution's administration staff informed the experts that the pre - trial detainees demonstrated good, harmonic and correct behaviour among themselves and with the staff, hence the lack of disciplinary measures for a long time.

Pre - trial detainees' complaints mainly regarded limited airing space, lack of sports activities, lack of toiletry supply, inefficient number of shower heads and lack of dental service.

In regard to the treatment of foreign citizens, from Macedonia and Kosovo, they confirmed that they were not differentiated. Meetings, phone calls and other services were equally offered to everyone.

The institution itself organised chess and domino tournaments with different teams.

Safeguards

Verification and inspection of documentation showed that everything was being recorded at the respective register and it was duly being protocoled. The protocol secretary kept registers in a separate office.

The isolation room had the same conditions as every other room and there were no persons in isolation at the moment of inspection.

There was a template in place for requests/complaints but there were no boxes in the Penitentiary Institution to anonymously place a request or complaint. The open forms were handed to the social worker and then they were selected at the Director's office to determine their destination.

Telephones were working at all times and the interviewed prisoners said that they could call their family members as often as they wanted using the card phones within the regime premises.

Regarding visitations, there was a specific facility with a table and some stools in not very good conditions, where the prisoners could meet with their family members. The prisoners had no complaints regarding visitations, and said they were taking place regularly, according to a schedule and that they were supervised by the security staff.

There were internal and external cameras at the regime for the 24/7 hr surveillance of the institution.

Material conditions.

Kukës Penitentiary Institution had been commissioned during the communist times and regardless of the many alteration and modifications, it had inherited a thorough dilapidated infrastructure. The internal regime was located underground at a level of almost 1.80 m funder ground level. It lacked ventilation, airing and central heating systems and as a consequence had a

high level of dampness. Pre - trial detainees did not have an opportunity to exercise any sports apart from walking alongside the narrow airing space.

The institution had a total of 17 rooms, of which an activity room, a visitation room, a meeting room to meet with the lawyers/prosecutor, a chapel, an observation room and a seclusion room, and the airing facility. Pre – trial detainees stayed in rooms that housed 1 – 4 persons.

Due to its positioning, the institution deprived pre - trial detainees from natural lighting. Adequate airing was also lacking due to the positioning of the building, the small rooms and the narrow hallways. At the moment of inspection, pre - trial detainees raised the concern of doors not being allowed open to facilitate airing. They had submitted a request to keep doors open during the day, but the institution had rejected it.

To provide a regular description of the internal regime, the living rooms mainly housed 4 persons, there were no toilettes or washbasins in the rooms and had inefficient natural air and light. The rooms and hallways were clean. The windows in the residence rooms were secured by iron bars and dense iron partitions which made natural airing and lightning difficult. The rooms had artificial lightning and the necessary furniture. Sheets, pillows and blankets were mostly provided by family members. The foam mattresses were in good condition.

Running water supply was secured and access was made possible, which enabled persons to normally do their chores. There were, however, some complaints regarding the lack of hot water.

During the winter there were stoves that worked on wood used for heating, but there were no cooling devices to meet the needs of the institution during the summer.

Regarding electrical home appliances, some rooms were not lacking a TV set or a refrigerator, but some others did, based on the premise that the pre - trial detainees would only be staying there for a very short time.

There were some persons that that claimed the dental service was only provided earlier than a month after the request had been made. There were additional complaints on the supply with medicine.

The ambulance had been long missing in the institution.

The physician's room, the assistant physicians' room and the pharmacy room were tidy and well – kept, even though they had old infrastructure and were poorly furnished. The necessary equipment was not missing in them.

The examination of the medical staff documentation, with special regard to the physician's documentation, showed the existence of a visitation register, a fundamental register, a register for the consultations outside the institution and the register for identification of cases of violence. All medical check-up forms were well – kept. Assistant physicians' 24 – hour information registers were also well – kept. Even though they were stored in locked places, the medical files were not correctly filled and in some cases were missing the medical history.

No health booklets had been issued for any of the pre - trial detainees and as a result the supply of medicine in accordance with the reimbursement scheme was not functioning. Pre - trial detainees would have them provided privately. The pharmaceutical warehouse issue also contributed to the problem with medicine supply.

At the moment of inspection, there were three chronic patients at the institution, respectively diagnosed with diabetes Mellitus, behavioural disorder and anxiety disorder.

On all of the above, it was recommended:

1. Taking immediate measures for the immediate fixing of showers ad toilettes with the aim of offering the opportunity to the prisoners to shower, especially during the summer.
2. Taking measures for completing the visitation room with the furniture and items necessary for establishing family meetings in respect of the dignity of prisoners and their visitor family members.
3. Taking measures for putting a box for requests/complaints, as it should exist in sections, possibly near the telephone, to provide the prisoners with the opportunity to exercise their right to complaints.
4. Taking measures for opening doors to facilitate airing due to the fact that the hallway is too narrow and the rooms are located on the first floor of the building, which doesn't allow for very god airing of rooms.
5. Taking measures for the provision of an ambulance for the institution.
6. Taking urgent measures for adding one full – time physician for the health sector.
7. Taking measures for issuing health booklets for all pre - trial detainees, by accelerating the procedure for completion with the respective documentation even in cases of transfers from one Penitentiary Institution to another.
8. In conclusion, based on the conditions observed during the monitoring visit and as compared against the previous visit findings, following analysis of progress and opportunity for progress in meeting standards, the Monitoring Team concluded that this Penitentiary Institution is too dilapidated and that its conditions harm the physical and mental health of pre - trial detainees and violate their human dignity. In the situation when there is no opportunity for their correction, it is recommended that this Penitentiary Institution is closed down and the pre - trial detainees are transferred to other institutions.

5.11. Tropojë Penitentiary Institution - Dated 20.06.2014 / Doc. No. 201401358

Preliminary remarks

There was very good collaboration during the monitoring visit to this institution. The Director of the Institution offered the Monitoring Team access within the rules and without any difficulties to all persons and premises to be monitored.

The current detention building and the new building, which was not yet in use in this Penitentiary Institution were visited during the monitoring visit. Just like the monitoring visit in

2013, the managing authorities in this Penitentiary Institution reported that the works in the new building were completed and that the building would be taken over by the institution authorities. It has to be highlighted that the building had been completed and had been handed over within September 2013. The old building remained in complete amortization and inappropriate for use.

The aim of the Monitoring Team for the visit included verification of standards in the old and in the new building that was not yet put in use, hence the findings of the Monitoring Team for both buildings.

During the inspection at the Tropojë Police Commissariat**,** the Chief of Public Order informed that the commissariat had 3 security cells , located at the Tropojë Penitentary Institution, as per agreement with the latter. The exerts were informed that State Police employees worked in this Penitentiary Institution, alongside Prison Police. This was not found during the monitoring of Tropojë Penitentiary Institution that was monitored on the same day by the same Monitoring Team. Nevertheless, experts requested a copy of the agreement mentioned by the Chief of Public Order at Tropojë Police Commissariat, which was immediately made available to the inspection team. The draft – decision between the Ministry of Interior and the Ministry of Justice "On transferring the detention centre premises under the administration of the General Directorate of Prisons", No. 5740, dated 03.10.2007, and subsequently the draft – decision signed by the General Directorate of Prisons and the Albanian State Police General Directorate in implementation of the aforementioned draft – decision between the two ministries No. 1414, dated 01.09.2007 sets out that the premises transferred under the general Directorate of Prisons, shall be:

1. The Public Order Police Unit 2 – floor building and its facilities;
2. The square in front of the building (backyard garden);
3. The surface above the building until the Tropojë FPSP;
4. The police kitchen premises.

As identified, none of the draft – agreements provided for joint administration of the custody rooms of Tropojë Police Commissariat within the premises of the Tropojë Penitentiary Institution. Moreover, such a thing was not raised or reported to NPM experts during the meeting with the manager of the Tropojë Penitentiary Institution.

General data on the new (non – functional) detention centre building in Tropojë

During the meeting with the Director of the Penitentiary Institution, the Monitoring Team received detailed information on the new building where the pre - trial detainees would be transferred to. The Director said that the transfer had been hampered by lack of funds to furnish the rooms and supporting premises.

The visit at the new detention centre premises showed the monitoring team that the construction works were complete and the centre was ready for the function it would be having. The new building is expected to have an official capacity maximum of 26 persons, with 8 rooms for pre – trial detainees, 6 of which with 4 beds, one double room, one double observation room and one double seclusion room.

The building comprised of two floors and a partially underground floor (under level 0) only on one side. The latter had an exit directly above the ground level (from the other side) outside the building because the building itself was on a hilly part. There were some premises designed for this floor, partly underground and according to the explanations provided by the staff of the institution one of them would serve as kitchen or to install the furnace (it had not yet been decided) and the other would be used as a warehouse (again, not yet decided as there was another facility on the first floor (above 0 level) located on the right of the entrance that could be used as a warehouse.

The design showed that on the first floor of the building would be the visitation room to be used for meeting family members and lawyers, it would additionally be used as location for rapid intervention forces, warehouse facility (mentioned above, could also be used for the furnace) and the internal regime. The internal regime included the shower facility (two separate booths that ensures privacy) and the exit to airing. The airing facility was appropriate to organise ball games because it was also separated into two different areas.

The rooms were complete with fully partitioned toilets, but there were no doors in place. The surface that was included in the toilets was: 1.5 m^2 (1m x1.50m). Rooms had beds according to capacity: 4 bunk beds and 2 bunk beds.

The size of the rooms was measured and they were standard according to receiving capacity, concretely: for room with capacity 4 persons: 4m x 4m x 2.80m (including the toilet space separated by wall). The living surface calculated per person for the rooms for 4 persons was 4 m^2 per person. Until this moment the resident space seems in accordance with the requires standard, but if we were to deduct the toilet space from this, the resident space will be under the standard. The volume of the residence rooms with 4 persons was 11.2 m^3 per person, i.e.: above the minimum standard required by law. For the double rooms the measurements were: 4m x 2.50m x 2.80m (including the space dedicated to the toilet and separated by a wall). The resident space per person in the double rooms was: 5 m^2 residence space per person (including the space dedicated to the toilet and separated by a wall), whereas the living space was 14 m^3 per person. The parameters determined by the normative acts in force were respected in both cases. Residence rooms had windows of size approximately 1.20 x 60 and were secured with bars, which ensured sufficient lightning in the residence rooms.

The administration of the institution was foreseen to work in the space provided for on the second floor of the building and according to the information provided by the institution staff that were accompanying us, there would also be a library room and a computer room on the same floor.

From the viewpoint of the Monitoring Team the architectural separation of the premises serving to the aims of the institution was found to not be well established. Concretely, the kitchen, even though it was not yet decided where it would be, was foreseen to be outside the internal regime. If it were to be ultimately set that way food would be physically transferred from the kitchen to the internal premises, which does not meet hygienic or security conditions. Food is usually transported and distributed by employed pre - trial detainees who can be put in insecure circumstances for their lives having to go outside the wall built to decrease continuity from the

tall apartment building just outside the Penitentiary Institution to enter the kitchen and such a thing would make them targets. Likewise, the architectural solution of having the library room or the computer room on the second floor necessarily requires for pre - trial detainees who want to use them to go out of the internal regime to climb to the second floor. This can bring problems to their security, their life or health, because the second floor is visible from the given apartment building and on the other side, such a thing would require taking of measures to ensure their safety and that they do not try to escape, thus continuous surveillance and control by the institutional security forces, i.e.: more police forces in the institution.

The information exchanged with the staff of the institution clearly showed the seclusion facility, but the observation facility as a separate room was still not clear. We got the impression that the Tropojë Penitentiary Institution staff , based on their experience with the old building where some of the rooms were used by the Tropoja Commissariat for the pre - trial detainees/prisoners for up to 72 hours, would be using only a seclusion room, since they understood observation as conducted during the detention/arrest period. This provides reasonable doubt that they would be doing the same in the new building. For this reason, the Monitoring Team recommended clear determination of such a room, suggesting that the twin bed room was used as an observation room.

Treatment

The visit of the monitoring group and the private discussions during the interviews with the pre - trial detainees did not identify any cases of use of physical force, violence, psychological pressure or torture. The relations between the internal regime staff and the education staff with the pre - trial detainees seemed good and no doubt arose of any use of psychological or physical ill-treatment.

Complaints during inspection regarded limited airing space, the conditions in the toilets and the showers that were within the same, dampness and lack of natural lightning and lack of medicine and dental care service.

One of the main issues identified was the malfunctioning of the medicine reimbursement scheme, which as a consequence forced pre - trial detainees to pay for their own medication. However, monitoring showed that one chronic person’s need had been met according to his request and upon physician’s recommendation.

Safeguards

Verification and inspection of documentation showed that everything was recorded in the respective register and was protocolled. The protocol secretary kept registers in a separate office.

The seclusion room was in the same conditions as other rooms: small space, no bed, unclean. At the moment of inspection there was no one in seclusion or with disciplinary measure and this was confirmed by the private meetings with the pre - trial detainees and from the verification of the disciplinary measures. The observation in the seclusion room identified a cable that was hanging close to the floor. The internal regime employee confirmed that the room had previously

been used for purposes other than seclusion and that a pre – trial pre - trial detainee had had a TV set in that room, hence the presence of the cable which had been left there for that same purpose.

There was a special template in place for the complaints/requests but the Penitentiary institution had no box for requests/complaints to be submitted anonymously. The open requests/complaints were handed to the education staff to then be selected in the Director's office to determine their destination.
The telephones were in working order and the interviewed prisoners confirmed that they could use the card phones in the regime premises to call their family members as often as they wanted.

With regard to visitations, there was a facility where the pre - trial detainees could take visits from their family members. The facility was open and had a table and some old chairs in poor condition. There were no complaints by the pre - trial detainees on the visitation meetings; they were regularly held according to a schedule and observed from a distance by security staff. Furniture and items that would create the conditions for a family meeting in respect of the human dignity of the pre - trial detainees and their visiting family members were missing in this room.

Regarding security, the regime had internal and external cameras, but they were not working.

Material conditions

The current Tropojë Penitentiary Institution is located within the territory of the Tropojë Police Commissariat. The official capacity of this institution is 24 persons. At the time of inspection there were only four pre - trial detainees, among them no juveniles, foreigners or any persons with mental health problems. There were no pre - trial detainees at 18-21 years old. There were no secluded or employed persons, either. The schedule of actions, including wake up times, cleaning and tidying of rooms and joint facilities, education and professional work, etc., was posted. Activities begin at 07:00 and finished at 22:30.

In terms of infrastructure, this building was totally inadequate and outside standards for the function for which it exists. Tropojë Penitentiary Institution has a geographical location that deprives the pre - trial detainees of natural lighting. The institution has a total of 11 rooms, 2 of which were used by the Tropoja Police Commissariat. Of the 11 rooms, 8 were single rooms for one person, 2 were rooms with 4 beds each, and 1 was the isolation room. Two of the pre - trial detainees were placed 1 per room, while in another room were the two others. Pre - trial detainees housed in rooms for one person were sleeping on mattresses placed on a board with the height of 10 cm from the ground. Foam mattresses were in somewhat good conditions. Most of bedding and sleep layers, such as sheets and blankets had been brought and were being washed by family members. Regarding home appliances, one of the rooms with 2 pre - trial detainees had a TV set, but no other electrical home appliances were observed.

Rooms were completed according to the inventory (beds, tables, cabinets etc.), but the conditions inside the rooms were miserable and outside living standards. There was lack of sufficient ventilation because of the position of the building and the windows very small and very close to the ceiling. The hallways were also quite narrow, damp, and had not been painted for a very long time.

Toilet (a Turkish toilet) and shower were in the same space that did not meet standards of living conditions within the institution. Running water supply was provided. Bathing accessories were in poor conditions. The hot water boiler was mounted outside the building but the check showed that there was supply of hot water. The showering schedule was not posted, but the pre - trial detainees confirmed that there were no barriers or restrictions to taking showers.

During the winter heating was provided by a wood stove, but there were no ventilation equipment to meet the requirements of the whole institution during the summer, although it was considered to be a cool building in the summer due to the lack of sunrays falling onto it.

Electric cords and power wires which were thoroughly dilapidated and pose a threat to the life of staff and pre - trial detainees themselves remained a very concerning issue.

The activities hall where various programs and activities could take place was missing. Outside facilities to be used for sports activities such as football, basketball etc., were also missing. The only facility was the airing one which was space – restricted and offered limited opportunity for walking. Pre - trial detainees used this environment mainly for playing chess and dominoes, 2 hours in the morning and one hour in the afternoon, whereas during the winter these activities were done in the rooms because the regime lacked the necessary indoor space.

The library room was in the new building outside the regime and within the psychological – education staff offices. The social worker enriched the library room. He would inform the pre - trial detainees about the books to be found at the library room and then bring the books into the regime, upon request.

The visit at the kitchen of the Penitentiary Institution showed that it was small but in very good condition. This building was outside the premises of the institution and was shared with the Bajam Curri Police Commissariat. Located below ground level, it was clean and had the necessary equipment for cooking and preserving food in very good conditions. The daily menu was posted. The food prepared was of satisfactory quality and quantity was within standards. Samples of food prepared a day before were stored in the refrigerator. A cook and an assistant cook were working in the kitchen. Almost all pre - trial detainees consumed the food of the institution and confirmed that it was of satisfactory quality and taste. The only outstanding problem was lack of variety.

The meetings with the social care staff showed a very good communication and cooperation. The social worker himself accompanied the team throughout the inspection and informed on the activities, different topics and programs that were applied in the institution. The team assessed he psychological – social files and found that they were filled correctly, including summaries of the most recent meetings with the pre - trial detainees, individual and team work programs, quarterly assessments and all other supporting documentation.

Healthcare service

The organisational chart of the health sector provided for a full – time physician and three assistant physicians. There was no pharmacist and the physician of the institution did the work of the pharmacist.

Of all four pre - trial detainees found at the institution, only one of them was suffering from HTA and prostate hypertrophy and his family provided the medication for these diseases.

The monitoring visit identified that none of the persons detained in this institution had a health booklet issued in their name and as a result the medicine reimbursement scheme was not functioning. There were difficulties in terms of doing consultation visits at the regional hospital, as well, especially due to lack of specialized physicians at that hospital.

Dental care service was privately provided by a school dentist that was contracted by the institution. The latter reimbursed all dental care service expenses to the pre – trial pre - trial detainees.

The physician room and the pharmacy room were tidy, but thoroughly dilapidated. The pharmacy had been supplied with the emergency medicaments.

The examination of the documentation for this sector showed that they were being kept accordingly. The records, the visitation register and the consultation register were completed to reflect the dynamics of the health problem cases. All documentation was being stored in locked places.

On all of the above, it was recommended:

1. Taking measures for necessary repairs and changes to enable the fast transfer of pre –trial pre - trial detainees to the new premises of Tropojë Penitentiary Institution.
2. Taking measures for the activation of education and professional training courses.
3. Taking measures for support with material and financial means to enable organisation of activities of education, social, artistic, cultural and religious nature.
4. Taking measures for the implementation of the three- party agreement on medicaments in this Penitentiary Institution located in areas with no pharmaceutical warehouses.
5. Taking measures for increasing the organisational chart number by one pharmacist for the health sector.
6. Taking urgent measures for supplying the Institution's pharmacy room with medicaments for chronic and acute illnesses.
7. Taking measures for issuing health booklets for the pre - trial detainees and for the implementation of the medicine reimbursement scheme.
8. Taking measures for the assessment of the legality of the procedure that established Bajram Curri Police Commissariat security cells within the premises of the Tropojë Penitentiary Institution with double the presence of police employees.

5.12. Elbasan Penitentiary Institution - Dated 23.07.2014 / Doc. No. 201401357

Preliminary remarks

Elbasan Penitentiary Institution was commissioned in 2010 with a high standard infrastructure. Its capacity is 120 persons and the institution has 143 beds. On inspection day it housed 212 pre - trial detainees, thus an overcrowding of 92% above its capacity.

In accordance with the monitoring procedure, the team held meetings with the Director of the Institution and the Chief of Security, who expressed their willingness to cooperate. The biggest issue in their opinion was the overcrowding of the institution that brought about a lower level of quality regarding services offered to the pre - trial detainees.

The institution comprised of two big sections A and B. Before entering the sections there were 2 observation rooms and 2 transit rooms, section A was for prisoners above 21 years old and section B was for 18 -21 year olds. The sections comprised of these facilities: residence rooms, counselling rooms, outside shared toilet, one – man shower facility and warehouse. Residence rooms had been designed for 1, 2, 3, 4 and 5 persons. All residence rooms had toilet facilities. Only Sector B had shared facilities (classrooms, library room, and gym).

The institution had a sports facility (football field), laundry room, modern kitchen, religious chamber, library room, hospital/infirmary and a gym that was not yet functional.

Staffing was complete. The institution had ventilation and central heating system, as well as a system for protection against fire.

Elbasan Penitentiary Institution offered employment, but the pre - trial detainees were not paid for the work done. This detention centre did not acknowledge the decrease of sentence by four days per month in exchange of employment, either. As it resulted from the meetings, the pre - trial detainees were not informed that their work would not recognized.

Treatment

From the information received by the managers of the institution and from the private group conversations with the pre - trial detainees, the Monitoring Team did not find out about any cases of torture or excessive use of force, neither of psychological violence exercised by the staff of Elbasan Penitentiary Institution on the pre - trial detainees.

On monitoring day, the institution had an overcrowding and 40% of prisoners sleep on mattresses on the floor. There were 2 pre - trial detainees who had been separated for the disciplinary measure of solitary confinement. There were 6 persons with mental health problems, but there was no special section for them. There were no citizens of foreign nationality, apart from a pre – trial pre - trial detainee, D.M., in building B, second floor, room 1, which claimed to be of Bulgarian citizenship, but he results to be of Albanian citizenship from his documents.

The complaints that were raised at the moment of inspection mainly regarded overcrowding of rooms, food quality, lack of detergents, showers and medicaments and lack of activities and facilities (classroom, library room, gym) in sector A within the regime, like in sector B.

Safeguards

Verification and inspection of documentation showed that everything was recorded in the respective register and it was protocolled. The protocol secretary stored the registers in a separate office.

The system of requests/complaints was functional and there were all kinds of templates for requests and complaints in place and administered by the education staff. To place a request/complaint, the pre - trial detainees in this Penitentiary Institution would fill in a request/complaint template and hand it to the educator enclosed in an envelope, or not. The latter sent it to the protocol office and from there it was forwarded to the Director of the Institution, who either replied in writing or met with the pre - trial detainees, according to the legislation in force. However, the inspection team observed that the request/complaint boxes were missing in almost all sections in the regime and documents were simply handed to the persons.

Solitary confinement rooms were on the first floor of the building and proved to be overcrowded and not equipped with the necessary means for accommodation. These rooms were monitored by surveillance cameras. There were two observation rooms and two transit rooms. On the day of the inspection there were 6 persons in the observation rooms respectively divided into a room with 2 persons and a room with 4 persons. These rooms were very small, with only two beds and mattresses. Observation showed absence of chairs and bedding (sheets, blankets and pillows) in the room where only four people were found, two of which sleeping together on a mattress on the ground. Within a small hallway outside were the dressing rooms and showers for observation and transit.

During private discussions, persons in observation complained about the lack of such equipment like plates, spoons and cups. Food was offered for all meals, but they generally had preferred to receive it from their family members.

Inspection identified two persons in isolation with disciplinary measures. There had been a conflict on 13/ 06/ 2014 between the two young people F.H. and R.C. and the pre – trial pre - trial detainee A.C. These two persons, after being checked and going out to airing had hit pre – trial pre - trial detainee A.C. with their fists. Further aggravation of the conflict had been prevented on time without injuries to the pre - trial detainees. The two pre - trial detainees had received a 20 – day isolation and exclusion from all joint activities, but they had not been provided with a written copy of the disciplinary measure. According to the education staff the copy was attached to their documentation and was included in the psychological – social file.

Regarding visitations in the Elbasan Penitentiary Institution, there were two facilities where pre - trial detainees could visit with their families. These premises were separated by glass and the family members of pre - trial detainees stayed beyond the glass and they communicate by telephone with each other. There were no complaints from pre - trial detainees regarding the

visitation meetings. They were held according to plans and under remote surveillance from the security staff. If pre - trial detainees had children under three years old or elderly parents, meetings were held in the room that was used to meet with the lawyer. In fact, the Penitentiary Institution had a facility for visiting with children with all necessary furniture and walls that were painted with cartoon characters, but it was concluded that the facility had not yet been put in use.

The telephones were working at all times and the interviewed prisoners confirmed that they could call their family members as often as they wanted using card phones in the regime premises. However, there were numerous complaints regarding phone cards (Mobitel), for which it was claimed that they spent more than they would for other telephone service providers, which was a burden on the pockets of the pre - trial detainees.

During the inspection of the premises within the institution, it was observed that the telephone numbers and addresses of the Ombudsman and NGOs that work directly with prisoners and pre - trial detainees' rights were not posted, but they were to be found in the counselling room.

Regarding security, the regime had exterior and interior cameras for 24 – hour surveillance.

Material conditions

The rooms within the regime housed 1 to 4 persons per room. The institution offered 143 beds, i.e. not all prisoners had a bed. I all rooms, 1 to 2 pre - trial detainees slept on a mattress on the floor. The rooms were of different sizes, but mainly small. There were single rooms with only one prisoner and space big enough for only one bed. The rooms had toilets in very good condition.

Rooms had natural and artificial lightning. The windows were big and did not prevent sun light or clean air. The rooms had the necessary furniture such as: table, chairs and cabinet. Sheets/linen, pillows and blankets were mainly provided by family members. Foam mattresses were in good condition. Or some of the cells, hanging garments outside the windows to dry was raised as an issue as it was not allowed so that it didn't hamper camera surveillance.

The inspection team received many complaints on the fact that they were not allowed to receive electrical home appliances such as TV sets and refrigerators from family members at a time when they couldn't be purchased at the institution, due to the restriction for this purpose in the General Director of Prisons' Order No. 3895, dated 09.04.2013 that provided for appliances to only be purchased at the institution via a specific commission.

The hallways, the visitation rooms, shared facilities, toilets and the kitchen were clean. Each sector had 4 shower heads but the hygiene in them was not good, at the moment of inspection. The institution allowed pre - trial detainees to Taking showers once a week (according to a schedule) , but interviews with the pre - trial detainees showed that showers were mainly taken in the room toilets and such a thing was identified during the inspection of the showers because they were dry and smelled badly. Pre - trial detainees have requested more frequent showers, but such a thing has been rejected. The situation in the observation rooms was problematic hygiene –

wise. Such rooms shared a toilet, but taking showers was not enabled for the pre - trial detainees in these premises and they would go up to 10 days without showering.

Running water supply was ensured. However, there were some complaints about lack of hot water.

There was central heating for the winter time, but no ventilation means in place to meet the need of all the institution during the summer.

The library room was rich with a variety of book titles. It was located between sectors A and B and used by both sections, even though sector A complained that they didn't have the same kind of access as sector B.

Chapels for both religions were found in the institution. They were well – furnished and offered services for all religions for the pre - trial detainees. Activities that were supported by religious institutions were organised on religious holidays.

The visit at the Penitentiary Institution's kitchen showed that it was quite spacious and modern. The daily menu was posted. The food prepared by the cook and assistant cook was clean and of satisfactory taste. The quantity and calories were according to standards. Samples of food prepared a day before were being refrigerated. A special unit within the kitchen served as the dessert unit and it was quite modern and equipped with all the necessary appliances, but wasn't being used due to lack of necessary ingredients.

The schedule of activities, including wake – up times, cleaning and tidying of rooms and shared facilities, education and professional work, etc., was posted.

Outdoor facilities had adequate space and were being used for sports activities, such as: football, basketball, etc. The institution itself organized tournaments with the teams.

With regard to airing, apart from the talk with the pre - trial detainees, information was requested from staff and it seemed that in sectors A and B pre - trial detainees had 3 hours of airing, 2 in the mornings and 1 hour in the afternoons. The two morning hours were used for sports activities, mainly football. Not all pre - trial detainees took part in activities organised in the classrooms. For ex.: in building A the problem was that the classrooms were not within the regime like in building B. There was only a small consulting room, where it was impossible to hold activities with more than 3 people. According to the pre - trial detainees themselves, they wished to be involved in many activities, but such a thing did not happen because the staff did not have adequate space available.

The meeting with the social care sector staff showed good communication and cooperation. They informed on the activities and programs implemented in the institution and made available the pre - trial detainees' psycho-social files. The staff organized joint activities with the pre - trial detainees, mainly group discussions on social topics and sports activities, art programs through painting, drawing and artistic creations with different items. Many of the shared facilities had painted walls or paintings and artworks hanging on the walls of activity and library rooms.

Psycho-social files were well – kept and completed with the pre - trial detainees' individual training programs, summaries of most recent meetings, information on individual and group activities, quarterly assessments and all other supporting documentation.

Healthcare service

The organisational chart of the health sector comprised of 4 assistant physicians and one part – time physician.

The inspection in this institution and the interviews with the pre - trial detainees showed that the healthcare service was relatively good and the pre - trial detainees had no complaints against the staff.

Out of all the persons in this institution, only 180 had health booklets and for the rest the process of completion with the respective documentation was ongoing. Even though there was a three – party contract in place for ensuring medicaments for the chronic persons, the medicine reimbursement scheme was not functional in this institution, which as a result had serious consequences to the medicine supply for the urgency cases and the chronic persons alike. In most cases the medicine was provided privately by family members.

On inspection day, the inspection team was informed by the staff that there were 28 chronic persons in this institution, diagnosed with: Diabet Mellitus, HTA second stage, Bronchial Asthma, Psoriasis Vulgaris, Epilepsy. This included 8 pre - trial detainees with mental disorders of types: bipolar, anxiety and schizoaffective disorder. For those cases when they were problematic and had crises, like the case of E.B. in room 17 that was held in a separate room under mandatory medication, patients with mental health issues were being held in separate rooms. There was a total of 20 persons that were drug abusers, but only three of them were on methadone.

Consultations outside the institution were being provided in cooperation with the regional hospital and polyclinic without delays or obstacles.

No dental instruments or materials for providing an efficient dental care service were found in the dentist room.
The examination of the medical staff documentation, especially the physician' documentation, showed the existence of a fundamental visitation register, the register on consultations outside the institution and the register for the identification of all cases of violence. All medical check-up forms were well – kept. 24 – Hour assistant physicians' information registers likewise. Medical files were stored in locked places and were correctly filled.

The inspections in the rooms (room 22, second floor) made it possible to contact an ill person suffering from kidney stones, who had been sent to the Elbasan hospital to admit the necessary treatment before the inspection visit took place. When we met the patient, he was somewhat calmer having received the necessary treatment and the prescription that the physician would be bringing to his room. In those moments he was in good condition and he confirmed that he had received healthcare service on time.

On all of the above, it was recommended:

1. Taking immediate measures to reduce overcrowding and respect of personal space in the Elbasan Penitentiary Institution.
2. Adopt measures for the furnishing, adapting and creating living conditions according to the General Regulation of Prisons in the observation/seclusion rooms.
3. Taking measures to establish working environment for the social care sector staff within the regime for building A.
4. Taking urgent measures to increase the organisational graph numbers with one full time physician post for the health sector.
5. Taking measures to provide all pre - trial detainees with health booklets by accelerating the procedure for completion of respective documentation even in cases of transfers from one Penitentiary Institution to another.
6. Taking immediate measures for implementing the medicine reimbursement scheme.
7. Taking immediate measures to supply the dentist room with instruments and dental materials.
8. Taking measures for supplying with/improving the quality of bedding, such as: sheets, pillows and blankets for all pre - trial detainees.
9. Taking measures for putting the laundry room into use for washing pre - trial detainees garments.
10. Taking measures for the recognition of sentence days' reduction for those employed by the institution.
11. Taking measures for housing pre - trial detainees with mental health problems in a separate section.
12. Taking measures to respect the procedure for disciplinary commissions that requires providing the pre - trial detainees with a copy of the commission decision and informing it to enable the possibility of appeal at the Director of the institution and / or in court.
13. Taking measures for keeping the activity room open not only during the morning hours, but also for afternoon activities.
14. Taking measures to equip the seclusion rooms with the necessary means and providing services in these rooms in a dignified manner.
15. Taking measures to establish the possibility of operating that part of the kitchen programmed for cooking desserts and an opportunity to deliver training programs for the pre - trial detainees.

5.13. "Jordan Misja" Penitentiary Institution, Tirane - Dated 30.06.2014 / Doc. No. 201401356

Preliminary remarks

Jordan Misja Penitentiary Institution building was constructed in 1929. In 1955, when the Ministry of Internal Affairs Order stipulated that prisons were to be called units, Tirana prison "Jordan Misja" was called Unit No. 313. In November 1967, the old prison building was closed down, and in 1999 the detainees and the sentenced prisoners were placed in the same building that is nowadays used as a prison. The current building has a capacity of 320 persons. According

to the Ministry of Justice Order, this institution is a pre – detention facility of high-security divided into three sectors: women, men and juvenile sector.

On inspection day, “Jordan Misja” Penitentiary Institution was overcrowded by 223 persons and had a total of 543 prisoners and pre - trial detainees. In accordance with the work methodology, the Monitoring Team firstly contacted the management staff, the medical staff and the social care staff. The staff of the institution preliminary told the experts that regarding material conditions, the infrastructure of the institution was old and continued to be outdated even following continuous reconstruction works.

Treatment

The Monitoring Team focused on the identification and assessment of evidence collected from testimonies of pre - trial detainees during the personal and collective contacts with them in complete privacy, by conversations with the institution staff itself, as well as through the review of relevant documentation regarding aspects of the use of force or physical and psychological ill-treatment, disciplinary measures of seclusion from joint activities, etc. Generally, the pre - trial detainees confirmed good rapports between them and the security forces of the institution. They denied that there had been cases of abuse or violence by security staff.

Safeguards

The monitoring of the pre - trial detainees showed that everything had been completed in conformity with the legal requirements. According to the documentation, received pre - trial detainees went to the Admission Commission and then they were kept under observation.

The Disciplinary Measures Commission for pre - trial detainees in the institution functioned regularly. On the day of monitoring we found only one pre – trial pre - trial detainee, who was suffering the seclusion disciplinary measure for 20 days. Pre - trial detainee E.P. staying in the isolation room did not have a copy of the disciplinary committee's decision for the measure decided. Moreover, the isolation room was not equipped with the necessary accommodation items, that is why he was eating his food sitting on the floor, which makes for inhuman and degrading treatment. Following the talk with the pre – trial pre - trial detainee and after reading the report of the service on the event, the Monitoring Team assessed that the measure given was not proportionate to the offense committed.

The visit in the regime identified that there was not yet a special sector established for the juvenile pre - trial detainees (18-21years old), and the latter were living in the same rooms and carrying out joint activities with adult pre - trial detainees, in the majority of cases, as confirmed, upon their consent or request.
Request/complaint boxes were missing in all sections and pre - trial detainees would hand the requests/complains to the educators that administered the request/complaints register or the institution.

Material conditions

The Monitoring Team observed the respect of normal living standards. Pre - trial detainees were asked about the way the conditions were respected and on – site observation of their standards was also carried out.

There was extreme overpopulation/overcrowding in the institution. This brought about the violation of the living surface per resident in rooms standard and the majority of the pre - trial detainees lived in less than $3m^2$. The situation in rooms of $8.8m^2$ was even more critical, because they housed 8 persons and the living space per prisoner was $1.1m^2$.

During the visit, the Monitoring Team identified many cases when the pre - trial detainees had no beds and as a consequence had to sleep on the floor. The windows in the room were generally under the minimum standards set by the normative act for sufficient lightning and airing. Experts found that the cells did not have toilets or washbasins.

Shared toilet facilities also contained the showers and were in thorough dilapidated condition. There was no privacy ensured because neither the showers nor the toilets had any separation doors. Showers were taken according to a schedule which theoretically gave each pre – trial pre - trial detainee the right to 2 showers a week. Pre - trial detainees told the experts that this standard was impossible to be respected, due to the amortization of showers.

Tables and chairs were missing in the observation/seclusion rooms that is why the pre - trial detainees had to eat their food either standing or sitting on the bed.

Regarding the supply of pre - trial detainees with personal and shared hygiene products, pre - trial detainees informed the experts that there was a lack of trash bags, washing liquid, shampoo, toothpaste, etc. Such a thing was also observed during the monitoring. Such products were provided to the pre - trial detainees by their family members.

Food was served in three meals, on set times. The kitchen was in conformity with legal requirements regarding documentation and refrigerating of samples as well as regarding hygienic conditions. At monitoring time, they were preparing lunch in the kitchen and it resulted to be of satisfactory quality.

The regime and activities

The schedule of activities was the same for the whole institution, i.e. the pre - trial detainees in the men, women and minor sector as well as in the observation sector were all under the same regime.

From contact with the pre - trial detainees, the experts found that legal requirements were respected in terms of visitation meetings with family members and telephone calls. There were no complaints about the phone calls and meetings regimes. The monitoring group observed the visitation room for meetings with family members, with two separate entries one for the family members and one for the pre - trial detainees. They were separated by iron bars/nets and glass

and both sides had benches for sitting. The facility was inappropriate for visits with minor family members.

The institution offered employment to the pre - trial detainees in limited conditions according to the employment list approved by the AGDP. One of the main findings was that the pre - trial detainees were not being paid for the work they did and were not issued with working booklet and social and health contributions booklet, thus they did not benefit from social and health contribution scheme. They were compensated only with reduction of sentence, if they were to be sentenced. The Monitoring Team was provided with the list of employed persons that were not aware whether or not their employment was recognised. Employed pre – trial detainees did not sign their working days and were not aware of any benefits. Other pre - trial detainees were not aware of the procedure for being employed.

During meetings with the social care sector staff, the Monitoring Team was informed about the activities and programs implemented in the institution and a selected number of psycho-social juvenile pre - trial detainee files were reviewed. Joint activities with pre - trial detainees mainly consisted in group discussions on social issues as well as sports activities. The review of the psycho-social files showed that they were complete with background information and where deemed appropriate with individual treatment programs, as well. Diagnostic tests continued to not be used. Psycho-social files of juveniles were completed at the time of reception, and required updating with summaries of each meeting with the pre - trial detainees.

The men sector

In IV of men pre - trial detainees IV, complaints were raised regarding coexistence with pre - trial detainees with mental health problems which posed problems regarding peace and understanding in the rooms. Pre - trial detainees complained about lack of water, overcrowding and sleeping on mattresses on the floor, as well as iron separation bars in the visitation rooms. They also complained that they only went out to airing three times a week for only 1 hour each day. The expert team requested information from staff on the airing issue and concluded that the claims were based. Meanwhile, pre – trial pre - trial detainee E.P. was found in the seclusion room where he had been staying for 7 days as part of a disciplinary measure and he hadn’t been taken out to airing at all. We would like to highlight that airing is an important right that is guaranteed by Law No. 9888, dated 10.03.2008 "On amendments and additions to Law No. 8328, dated 16.04.1998 "On the rights and treatment of prisoners ", and its amendments and which should be provided in every case.

The women sector

During the monitoring visit the expert’s team observed thorough amortization of all the premises of this sector, overcrowding that violated the standard for vital space. Initially the inspection team visited the activity room that served as a library room, and as individual or group counselling room. It was also used to deliver informal training courses for tailoring, hairdressing, painting etc.

The sector had 42 women. Rooms were cold and humid, with insufficient natural lightning. Each room housed 4, 5, 7 women within a space that was 2mx3m, and in the majority of the cases two women shared one bed.

There were many complaints from this sector regarding physical and material conditions, but also poor cooking service. The toilets and showers were thoroughly dilapidated and there were issues with the running water supply.

Request/complaint boxes were missing in all facilities within this section and the prisoners would hand requests/complaints to the educators who administered the institutions' request/complaint register. Posters with human rights and freedoms were also missing.

Juvenile sector

Visits in the sector of juvenile pre - trial detainees, found that corridor and common areas were clean, but the rooms were equipped juveniles in some cases very poor and mattresses were inadequate and had a juvenile who had no sheets for sleeping. Juvenile complaints were mainly on the length of stay in prison custody, which came as a result of delays in the investigative process, the charges for non-violent offenses.

During the monitoring visit, some of the juveniles remain in their rooms, some were at the meeting in the library with the social worker, and a room was closed by security personnel on the grounds that they were involved in a minor altercation with another house, on Saturday (28 June 2014 13:30). Juveniles involved in this fight waiting to burst in the disciplinary committee, but until 14.00 the day of the moon, the disciplinary commission has not met yet.

The joint activities and TV room was closed during the monitoring visit hours between 0900-1300 hrs.

Health care services

Staffing of the sector consisted of a physician, a dentist, a pharmacist and assistant physicians. The staff of the sector treated 53 chronic and 12 mentally ill persons, as well as 6 drug abusers.

From conversations with female prisoners, the inspection team found that this institution provided a generally good health care service, which had deficiencies regarding overcrowding leading to delays in conducting necessary visits or consultations with specialized physicians at the hospital. Monitoring found many complaints regarding lack of medicines for emergencies as well as for chronic diseases.

This institution had an ambulance, which was fully operational. The physician room was dilapidated although it was kept clean and tidy. The pharmacy was clean and complete with medications, although the prisoners in this institution placed many complaints about supply f medicines through the medicine reimbursement scheme. The dentist room was tidy and it had an autoclave, but lacked the dental materials and instruments, thus offering a limited dental service consisting only of extractions.

The examination of the medical staff documentation, especially the physician's documentation showed the existence of a register of the visits, the chronic patients' register, register for consultations outside the institution. All medical examination formats were correctly kept. The 24- hour assistant physicians' registers, as well. Medical files were completed correctly, but were not kept locked. All prisoners were provided with health booklets. A small part of that was transferred from one Penitentiary Institution to another were awaiting the completion of the relevant documents to continue with the procedure of having them issued.

On all of the above, it is recommended:

1. Taking measures to close down this detention institution as inappropriate compared to standards of treatment of pre - trial detainees provided for in national and international legislation.
2. Taking immediate measures to reduce overcrowding in the institution and ensuring a bed and vital living space as defined by law, for all pre - trial detainees.
3. Taking immediate measures for the real improvement of material conditions in rooms, bathrooms and shared facilities for pre - trial detainees.
4. Taking measures to provide the pre - trial detainees with the necessary products for hygiene in accordance with legal standards.
5. Taking immediate measures to equip the observation/seclusion rooms with the necessary furniture and equipment in respect of the dignity of pre - trial detainees.
6. Taking measures to adapt recreational facilities to enable delivery of professional and education courses.
7. Taking measures to increase the number of consultations with the psychiatrist in compliance with the requirements of the law on mental health.
8. Taking measures to regulate the request/complaints process management, putting boxes in the sections and defining a procedure for taking requests/complaints out of the sections, record them in the register and managing their replies or their solutions within timelines foreseen by in the law.
9. Taking measures to house pre - trial detainees with mental health problems in a separate section.
10. Taking measures to ensure the right of pre - trial detainees to go out to airing and so outdoor sports activities according to legal parameters every day, and for the implementation of this right for pre – trial detainees with disciplinary measures, as well.
11. Taking measures to respect the disciplinary commissions procedure that requires providing the pre – trial detainees with a copy of the commission's decision and informing them of the opportunity to appeal to the Director of the institution and /or to court.
12. Taking measures for faster procedure to Taking the pre - trial detainees to the disciplinary commission, with advantage being given to juveniles.
13. Taking measures to ensure access to the activity room where the TV set for the juveniles with no TV sets in their rooms is, for juveniles who do not have TV in the room, not only during the morning hours, but also during the afternoon activities.
14. Taking measures to ensure hygiene in isolation rooms, and furnishing of such rooms with tables and benches and providing services to these rooms in a dignified manner.

15. Taking urgent measures to increase the staff numbers in the organisational chart by at least two physicians for the health sector.
16. Taking immediate measures for supplying the hospital pharmacy with medications in application of the medicine reimbursement scheme.
17. Taking immediate measures to reassess the diagnosis and treatment of pre - trial detainees with chronic diseases and prisoners with mental health problems.
18. Taking measures to equip all pre – trial detainees with health booklets, by accelerating the procedure of completion of relevant documentation in cases of transfers from one Penitentiary Institution to another.
19. Taking immediate measures for the supply of the dental service with dental instruments and materials.

5.14. Durrës Penitentiary Institution - Dated 31.07.2014 / Doc. No. 201401463

Preliminary remarks

The Ombudsman, in implementation of its constitutional and legal powers that regulate its activity, having been informed by the media on 31/07/2014 of an attempt of a pre - trial detainee at the Durres Penitentiary Institution to harm himself when being escorted by the Durres Penitentiary Institution security team, appointed a working group for an administrative investigation of the event.

In accordance with the fact- finding methodology and investigation procedures, the working group initially visited the Durres Regional Hospital, where they contacted with the Chief of Emergency Service, who provided an overview of the case. More detailed information was reported by the physician of the Hospital Emergency Ward. According to information received by the latter, and according to the observation sheet completed by him, the pre - trial detainee A.P. had been Taken to the Emergency Room of the hospital at 10:45 pm accompanied by the Durres Penitentiary Institution security staff. During the general examination, it was found that the pre – trial detainee had Taken three tablets of metformin (daily dose of the treatment that he had received for diabetes), given to him by the Penitentiary Institution staff. Examinations and tests run at the Durres Hospital showed that the pre - trial detainee’s vital parameters were all according to norms, including the pulse, TA, normal cardiac frequency. However, the emergency physician had decided on a more specialized assessment of the potential for intoxication and that the pre – trial detainee should be sent to the toxicology unit at the Prison Hospital of Tirana.

After administration of the medical files and relevant documents at this institution, the working group continued with the visit to the Durres Penitentiary Institution, where they met with health sector and psycho-social sector staff. All relevant data and respective documentation showed that the pre - trial detainee had previously had two other suicidal attempts, which in the judgment of the psycho-social staff and the psychiatrist of the institution, had been of demonstrative nature and in an the conditions of an emotional burden due to the pre – trial detainees; family, social and economic problems. Regarding the last attempt, the pre - trial detainee had been given the daily dose as per therapy by the health sector staff to self – administer, as he would be attending a court hearing. According to the psycho-social and health sector staff, he had used that dose to

simulate self - poisoning, in order to attract the attention of public opinion regarding his dissatisfaction with the judicial system, which at that day's hearing had reconfirmed the security measure prison sentence.

Continuing with the verifications made, the investigation team administered copies of duty shift reports of other cases of attempted suicide by the same pre - trial detainee, A.P., his psycho-social file, copies of the prisoner and pre - trial detainee movements in the regime book.
In addition, the investigation team visited the Prison Hospital, where they received written information and met with the duty shift psychiatrist. According to her, the pre – trial detainee had been brought to this institution by the Durres Emergency physician with diagnosis: multimedikamentoz intoxication. Since the first moment of arrival at the PH, the detainee had consulted the toxicologist and the psychiatrist. At the conclusion of all tests and examinations, toxic elements were not found and vital parameters were according to the norms. Although the pre – trial detainee's overall physical and mental health conditions were good, it was decided that he would be held for observation at the PH.

Later, the investigation team held a meeting with the pre - trial detainee at the observation room premises. It was found during the conversation that his condition was good. He stated that his act had nothing to do with mistreatment or degrading treatment in the Durres Penitentiary Institution, but rather with resentment against the court decision that re – affirmed the prison sentence. He also expressed his concern about his wife's health condition, as she was hospitalized in the Durres hospital.

Given the verifications in the field, the administered documentation and findings that pre - trial detainee A.P. had manifested mood swings, emotional burden expressed in the form of attempted self-harm, at different times, circumstances and places, thus endangering his life and creating safety issues to the institution, it is recommended:

1. Taking immediate measures to assess the psycho-emotional condition of the pre - trial detainee, his mental status and appropriate therapeutic interventions, keeping him under constant observation by the staff psycho-social staff and the health sector, in order to prevent the repetition of such cases.

2. The health sector staff to take immediate measures for the administration of medicaments for the pre - trial detainees under medication, by only providing them with the daily doses separated by physician's recommendation and always under the supervision of the duty shift assistant physician that is to assist them until the time of complete consumption of the medicine.

5.15. Durrës Penitentiary Institution - Dated 29.09.2014 / Doc. No. 201401740

Preliminary remarks

Durres Penitentiary Institution is an institution with an official maximum capacity of 300 persons, which has a special care unit with a capacity of 50 persons, where people with mental health problems are detained. On the day of the inspection, 384 persons were found at the

premises of the institution. Overcrowding was an evident problem with a number of 84 pre – trial detainees above the official capacity.

In accordance with the monitoring procedure, the inspection team initially met with the Director of the institution, who expressed his willingness to cooperate in fulfilling the purpose of inspection. During the meeting, the inspection team initially requested information on the rights and treatment of prisoners, and on how the issues raised during previous inspection visits at this institution had been addressed.

The institutional managers made the experts aware of the fact that the Durres Penitentiary Institution, in its special care sector housed 29 inmates with mental health problems on the first floor and 21 pre - trial detainees on the second floor, who were housed in this sector due to overcrowding.

There were no separate sections for juveniles, or for pre - trial detainees within the age group of 18-21 years old, regardless of the fact that at the time of inspection 52 pre - trial detainees belonging to this category were found at the institution. The managers of the institution also informed the inspection team about the outstanding issues of amortization of the whole building, supply of running water that continued to be restricted and lack of funding in this regard, for this area.

Observation /seclusion rooms located on the first floor of the building were in very bad conditions. They were a total of 4 observation/seclusion rooms, two of which had been transformed into toilets due to overcrowding. On the day of inspection one secluded person with a disciplinary measure was found. The observation of the records of disciplinary action showed that disciplinary measures had been issued for 3 pre – trial detainees on the same day, 29/9/2014, but none of them had been provided with a copy of the disciplinary measure decision.

The institution employed 21 pre – trial detainees as cleaners, food distributors, librarians etc.

Treatment

The objective of the monitoring group was to collect information regarding the treatment of pre - trial detainees in identifying cases of the use of physical force beyond the limits as defined in regulations or psychological pressure on this category, as well as cases of disciplinary measure decisions. From the received information, the group and private conversations with the prisoners, the Monitoring Team did not identify any flagrant cases of torture or excessive use of force.

At the time of inspection, at the Durres Penitentiary Institution there were complaints by prisoners related to high prices in the institution store, especially phone card prices and the lack of medication. There were also complaints on food, both in terms of quality of cooking and diversity of meals and cleanliness during food distribution.

Safeguards

The Admission Committee functioned normally. Data was recorded in a specific register. The physician was part of the Reception Committee. She was also part of the Disciplinary Commission as an observer with no voting right.

During the inspection of the internal areas of the regime, it was found that there was a special facility for visitation meetings of pre - trial detainees with family members, who had 7 glass cubicles to house parties to the meeting. There were also two food control reception desks. Even in this Penitentiary Institution, the Monitoring Team observed the issue of the lack of a special place for meetings with juveniles. Meetings with family members were held once a week.

There was a system for requests/complaints and the relevant boxes for posting them, in place. Despite the latter, the pre - trial detainees submitted the requests/complaints to the education employees who forwarded them to the security chiefs. The latter submitted them to the Director of the institution, who distributed them. The Inspection Team was informed by the Director of the Institution that the requests/complaints of pre - trial detainees were generally found a solution within 24 hours. The Inspection team noted that such a system does not meet the criteria stipulated in the GDP Order, which clearly provided for management of boxes to be done by the education sector.

All the pre - trial detainees interviewed confirmed they could talk to their relatives on the phone as often as they wanted using the card phones found within the regime premises, but the price for the latter was much higher than the price outside the institution.

Regarding security, the Durres Penitentiary Institution had CCTV coverage in the internal and external premises, including in the hallways and observation/seclusion rooms.

Material conditions

As confirmed by the Head of the Institution and as found in previous inspections, premises in the regime were dilapidated and damp.

Residential rooms housed 4, 6 or 7 people each, but not all rooms respected the standard of vital living space per person. Rooms, mostly on the first floor, housed around 6 people each, 3 of whom slept in beds and 3 others on the floor as a consequence of overcrowding, which was clearly observed on the first floor of the regime, where almost all joint activity rooms, including the Christian chapel, counselling rooms, etc., were being used a residential premises. Consequently, they had no indoor toilets and pre - trial detainees used shared toilets, including the two improvised toilets of the observation/seclusion rooms. In general, the rooms were adequately naturally lit and were equipped with the necessary furniture, albeit not in every room. The lack of windows in some of the rooms in regime created a substantial problem, especially once into the winter season. The presence of insects was found in the residential premises and in the areas outside the observation/seclusion areas and the inspection team faced the presence of rodents.

Shared toilets were out of every standard and in very bad hygienic – sanitary condition, which was noticed by the heavy smell across the first floor hallway. There were only two toilets for the whole first floor and they had no showers or washbasins and no running water either and there were only two WCs in very poor condition with no accessories serving water dischargers.

The observation/seclusion rooms lacked windows and there was no running water for personal needs.

In general, during all the interviews conducted, the inspection team faced claims that bedding had been provided by family members and for those cases when they belonged to the institution, they were very old and shabby. The Inspection Team found that there were serious shortages in the supply of pre - trial detainees with bedding garments, with other means of personal and shared hygiene and that the pre - trial detainees received supplies by family members.

Durres Penitentiary Institution also had a special section for the treatment of persons with mental health problems. The sector with the capacity of 50 persons was extended on two floors. On the first floor there were 8 rooms where, on the day of inspection, 29 pre – trial detainees with mental health problems were housed, while on the second floor there were 11 rooms, which housed 21 pre - trial detainees without health problems. The rooms of this sector were all equipped with toilets, while the showers were shared: 7 on the first floor, of which 7 were functional and 7 on the second floor of which 4 were functional. No overcrowding situation or lack of hygienic-sanitary conditions was observed in this sector. These facilities were in striking contrast with the other premises in the regime in terms of maintenance, ventilation, lighting, or overcrowding.

The running water supply was restricted. Despite the fact that the head of the institution informed the inspection team that there were water tanks they needed maintenance and as observed at the regime supply of running water was an outstanding problem. Equally problematic was the issue of drinking water, which the pre – trial detainees continued to buy as the washbasin water was not drinkable. There were 2 showers on the first floor, which boilers posed life – threatening danger to the lives of pre - trial detainees, because the electrical installations in their panels were completely exposed. All 7 other shower heads, which were fully operational, had dampness. A major factor for concern was the lack of hot water in rooms or in the shared showers. For this reason, the pre - trial detainees were forced to heat the water with primitive electrical appliances.

There was no central heating system. Consequently, during the winter, the pre - trial detainees used primitive tools to get warm.

The monitoring group found that there was an external facility used for airing. As aforementioned, above, the common premises on the first floor had been converted into living areas, and as a result the training courses and other activities were not taking place.

The library was located on the first floor of the building. It was a small room, relatively clean, with a poor number of titles. According to psycho-social staff around 97 pre - trial detainees of whom 20 were of the age group 18-21 years visited the library and facing it was another room

which served as a counselling room, but was also used to deliver English and Italian language courses.

The Inspection Team noted that the kitchen of the Durres Penitentiary Institution was relatively clean and tidy. The daily menu was posted and the posted quantities were in accordance with the regulation. However, the inspection team drew the attention to the preservation of food samples that were not being refrigerated. There were pre – trial detainees employed at the kitchen and they did cleaning chores and distributed food. They did not use gloves for the latter.

The Inspection Team found that the service for orders and purchases of items allowed in the Penitentiary Institution was in place, and the lists of related products with prices were displayed. The shop had a variety of products.

Regime and activities

The schedule of activities, including wake – up times, cleaning of rooms and shared facilities, educational and professional work etc., was posted on the educational room and included activities until 0500 hrs. From conversations with the pre - trial detainees, mainly of the first floor, the inspection team was informed that there were differentiations regarding airing. They claimed that they were allowed to go out on airing only for an hour in the afternoons. The activities area in the Durres Penitentiary Institution, for the first floor sector in particular was problematic, due to the voiced fact of the transformation of shared facilities designated for activities into residential rooms. Consequently, pre - trial detainees expressed complaints about the lack of activities and socio-cultural activities.

According to information received by psycho-social staff, 16 pre - trial detainees would resume the school program for the elementary levels of education. The institution was also in preparation of the football championship among institutions. Pre - trial detainees were doing art work, such as painting and also writing and poetry. The only training courses that inspection team found that were being delivered were the foreign languages courses, namely English and Italian. Gym attendance was not possible due to the fact that some pre - trial detainees had had conflicts with other pre – trial detainees.

The library room was functional and had a number of titles. Taking books from the library and returning them was based on marking relevant data in a personal file of the pre - trial detainee. Psycho-social staff informed the inspection team that going to the library was an activity of interest to pre - trial detainees.

There was a unique facility on the first floor of the regime for offering religious services for the Muslim community, which was actually clean and tidy. Christian religious services were offered at one of the security specialist offices, as rooms previously used for this purpose had been transformed into residential rooms.

According to the approved organizational chart for the psycho-social care sector, it consisted of a chief of sector and 10 specialists, 2 of whom with a psychology educational background, 2 with

an educational background in "social work", one in "sociology" and the rest did not meet the education level criteria for the post.

The review of the psycho-social staff documentation, such as monthly reports on the activities of the sector, psycho-social files and individual treatment programs showed that they were being held regularly and in locked places. The individual treatment programs were divided according to vulnerability groups, namely the mentally ill, persons with drug addiction and prisoners between 18-21 years old.

Health care service

The organisational chart of the health sector consisted of the chief of the sector, which was also psychiatrist of the institution, two general physicians, a dentist, a pharmacist, 10 assistant physicians, and three sanitary workers.

Inspection Teams examined the physician room, the pharmacy and the infirmary and concluded that they were equipped with dilapidated furniture completely out of standards.

The dentist room was also dilapidated and not in compliance with the standards. It was equipped with a unit, which was completely out of order and was missing the autoclave and dental materials, thus neither filling nor extractions could be performed by the dentist. He could only treat with aesthetic drugs, where the latter was provided privately.

The Pharmacy was also very poor with medications. The nursing room, likewise, was equipped with an old cabinet which lacked basic emergency medications. At the time of the visit, the only medicine found were a small amount of Prednisilone, Analgin, Furosemide and a small amount of physiological solution of glucose calcium.

During the monitoring visit to the institution, it was noticed that there was good regad for the health care service in general, by pre - trial detainees in all sectors. They stated that the medical staff showed willingness in reacting to their requests and complaints regarding their health and as a result no cases went untreated or unconsulted in the institution. Such a thing was well – reflected in the health sector documentation, as well. However, numerous complaints were received in terms of dental services, where the pre - trial detainees claimed they did not admit any kind of service at all. According to the dentist, apart from emergency treatments, he could not provide any other interventions and such services were provided by private dental practices.

With regard to the special care sector that housed pre - trial detainees that were treated for mental health problems, they stated that the psychiatrist was present in the sector every day and was responding to all patients’ requests and complaints about their health concerns.

Another identified issue, not only for the special care sector, was the clear lack of medicines. People with mental health problems held in this sector included 22 pre - trial detainees diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, anxiety disorder and even personality disorders. Whereas 27 other pre - trial detainees were placed in other sectors and

suffered from chronic diseases, such as diabetes mellitus, HTA, posttraumatic epilepsy, bronchial asthma etc.

The information received from the psycho-social and health care sectors, this Penitentiary Institution had 12 people with drugs abuse issues that were treated with Methadone.

The institution had no ambulance.

The examination of the medical staff documentation, in particular the physician's documentation, identified the existence of a fundamental register of visits with the general physician and one for the chronic patients. All medical examination forms were kept in order. 24 hours Information Registers were regularly kept by assistant physicians. Medical files were completed correctly, but were not kept locked away. All the pre – trial detainees in the institution were provided with health booklets. The rest, who had just been housed in this institution, were awaiting completion of the relevant documents to continue with the procedure of having health booklets issued. Medicine reimbursement scheme was fully operational for the chronic patients, whereas for acute illness cases this scheme did not work.

On all of the above, it is recommended:

1. Taking immediate measures to reduce overcrowding in the regime, especially on the first floor and in respect of personal space.
2. Taking immediate measures regarding hygiene and sanitary conditions in all the premises within the regime, especially for the first floor.
3. Taking immediate measures to appropriately equip the two observation/seclusion rooms – turned – into – toilets to function as such.
4. Taking measures for the proper furnishing, adaptation and creation of living conditions according to the standards of the General Regulation of Prisons in the observation/seclusion rooms.
5. Taking immediate measures for the disinfection of residential rooms and outdoor premises.
6. The education sector to take measures to rigorously implement the order of the GDP on the process of handling complaints/requests.
7. Taking measures to separate pre - trial detainees between 18-21 years old to a particular sector.
9. Taking measures to organize various social activities and for all pre – trial detainees to use the gym by all pre - trial detainees according to a defined schedule.
10. Taking measures to verify the prices in the shop of the institution in order to address the concerns of the pre - trial detainees regarding high prices.
11. Taking measures to address the issue of the phone card price per credit.
12. Taking measures to increase staff in the organisational chart by one psychiatrist.
13. Taking immediate measures to supply the institution with an ambulance.
14. Taking urgent measures for supplying the pharmacy room with emergency medications, and with the appropriate furniture to store them.
15. Taking immediate measures to implement the medicine reimbursement scheme for patients with acute illnesses.

16. Taking measures to equip the dentist room with an autoclave, to make the unit operational and to supply with dental materials.

5.16. Fushë Krujë Penitentiary Institution - Dated 01.10.2014 / Doc. No. 201401904

Preliminary remarks

Fushë-Krujë Penitentiary Institution was established in July 2008. By Order No. 329, dated 15/01/2009, "On the classification of penitentiary institutions" and subsequent changes, "the Fushe-Kruje Penitentiary Institution was classified as a high-security prison, with an ordinary security section and a custody section". The official maximum capacity of this Penitentiary Institution is 312 persons. At the time of the visit it had 420 people (one of whom had been sent to the Special Health Institute of Prisons), with an overpopulation of 107 people over capacity. Breakdown by sector at the time of the inspection was: 140 pre - trial detainees, 100 in high-security and 180 in normal security. Section for pre - trial detainees with a capacity of 30 people, appears to be divided into two sectors, namely sector 3 with ten rooms, and sector 4 with 7 rooms.

In the absence of the Director of the institution, the Monitoring Team was received by the chief of the legal section. The monitoring visit at the Fushe-Kruje Penitentiary Institution was held in a spirit of mutual cooperation, with provision of access according to the rules and without difficulties in all premises monitored by the experts. The main objective of this monitoring visit was the conditions and the treatment of prisoners and pre - trial detainees.

At the time of the visit the institution held 8 pre - trial detainees between 18-21 years old. The pre - trial detainees were mainly housed in double rooms, but due to overcrowding, in some cases double rooms housed 4-5 people. 18-21 year old pre – trial detainees were not arranged in a separate section, but instead they were housed in rooms together with adult pre – trial detainees.

The institution held 4 foreign citizens, Macedonians and Bulgarians who presented no communication problems because they all spoke Albanian.

Separate categories in the Fushe Kruje Penitentiary Institution included 7 mentally ill persons and 5 that were receiving treatment with methadone.

Treatment

The objective of the monitoring group visit regarded the collection of information regarding the treatment of prisoners and pre - trial detainees in the identification of cases of torture, degrading and discriminatory treatment, the use of physical force beyond the limits specified in regulations or psychological pressure against the category, as well as cases of taking disciplinary measures of seclusion from the joint activities. Regarding this fact, from the information obtained by group and private conversations with the prisoners and pre - trial detainees themselves, the Monitoring

Team did not identify any cases of torture, excessive use of force or physical violence exercised by the staff of the Penitentiary Institution on prisoners and pre - trial detainees.

Rooms within the regions housed from 1 to 9 persons, according to sectors. The institution currently had 420 pre - trial detainees and prisoners per only 312 beds; thus not pre - trial detainees had a bed and a part of them slept on mattresses on the floor. At the time of monitoring, at the institution rooms foreseen to house two persons held 3 or 4. This was in violation of the living surface standard per person (25.3 m2 4 m2, as provided by law). It was also found that, the third or fourth person in the room was sleeping on the floor, such as was the case for sector 3, rooms 4, 5, 10; sector 4, room 7. In addition, there were 9 people in s room with 25m² area, of which 3 people slept on mattresses on the floor in room 5, sector 2. In most rooms with a 25m² area in sectors 1 and 2 there were 8 people sleeping: 6 in beds and 2 others on mattresses on the ground.

Apart from issues with the structural degradation and deterioration of services provided to persons deprived of liberty, such data on the overcrowding of detention facilities in the Fushe-Kruje Penitentiary Institution raise concerns among national and international institutions working in the field of respecting human rights in a democratic country. The fact of a significant number of pre - trial detainees sleeping with mattresses on the floor is considered to be a degrading and inhuman treatment.

Safeguards

Experts received information on the admission of prisoners/pre - trial detainees at the institution and on the operation of the Admission Committee, as well as on completing records and personal files. From the conversations with the Head of the Institution and file verifications, the Monitoring Team found that admission procedure was incorrectly applied in the institution.

Not only had the age group of 18-21 year old pre - trial detainees not arranged in a separate section, but they lived in rooms together with adult pre – trial detainees and carried out joint activities together with the adult age group. Contact with the 18-21 year old category of pre – trial detainees themselves suggested to the experts that co living with adults was based on their personal choice, in most cases due to the friendly relationships they had with their roommates and due to lack of other alternatives that came as a result of the overcrowding in the institution.

The verification and inspection of documents showed that everything was recorded in the relevant register and that it was protocol led. Records were kept by the Department of Education. Pre - trial detainees in this Penitentiary Institution, when they filled out a request/complaint form, they submitted it to an educator, either enclosed in an envelope or not. The latter submitted it to the protocol office. After the protocol, they were submitted to the Director of the institution, who in turn either replied in writing or met with the prisoners. The requests/complaints not addressed to the Director were mailed to destination. This procedure does not guarantee confidentiality and privacy of the writing or material on paper. Replies to requests/complaints were generally submitted within 24 hours, but not all had received such a fast reply. According to the information that was gathered at interviews, there had been cases when complaints had not been addressed or they had been addressed very late.

In terms of disciplinary measures at the time of inspection and visits at the isolation/ seclusion sector, there was a discrepancy between the persons actually found in these facilities and measures issued according to verification of records. The measure issued for persons found in the isolation/seclusion room had not been reflected in the register of disciplinary measures in accordance with Article 53 of Law No. 40/2014 on "Rights and Treatment of Prisoners and pre – trial detainees"

The phones were working at all times and the interviewed prisoners confirmed that they could talk to their relatives whenever they wanted, using phone cards that were found in the regime premises. What the prisoners complained about regarded the high price per credit for the cards provided by Abcom service provider, whereas Albtelecom services had been terminated without any reason. Pre - trial detainees and prisoners complained because according to them Abcom service costs more than the one provided by Albtelecom.

In terms of employment, this Penitentiary Institution employed 1 pre – trial detainee and 33 prisoners, mainly as cleaners, sanitary workers and in food distribution. Interviews with then identified that some of them had not been given the work dynamics, even though they had requested such a thing. There were complaints of abuses with working days recorded under the names of people who had not worked. A convict who had been working for a month and which was recognized by the staff as such, complained because he had no information on whether he was recorded as an employee in the employee chart. Verifications showed he was not recorded in the prisoners' employee organization chart for September 2014.

Meetings with family environments were common in both sectors. There were 8 glass cubicles and 2 food control reception desks in the visitation room. Inmates could meet with their families once a week. There were no particular facilities or room for the pre - trial detainees who have small children or elderly to meet with them freely and without restrictions.

Material conditions

The Fushe Kruje Institution had no ventilation system in place. Ventilation in the institution was accomplished naturally, through windows, with measures within the requirements of the standard. Another problem identified by the monitoring group was the lack of heating in winter, an outstanding problem in this institution. The institution had a heating plant installed, but it was not yet activated for this year.

The Monitoring Team observed the internal regime premises. The residential rooms, which were of standard layout and had toilets and washbasins, had approximately these dimensions: 4.5mx 2.5mx 2.8M and the larger rooms were: 5 x 5 x 2.8M.

Bedding was provided by the institution. During a visit to the residential premises we found that the situation was hygienically okay. Rooms were lacking chairs and clothes closets and the pre – trial detainees would keep their clothes in plastic bags or sacks, mainly under the beds.

The visits at the prisoners / pre - trial detainees' rooms identified that running water supply still followed a schedule with these running hours: 6:30 to 07:30; 9:30 to 10:30; 14:30 to 15:30;

18:30 to 20:30. This fact can serve as grounds for breach of personal hygiene of pre - trial detainees, which therefore does not meet the Minimum Rules for the Treatment of Prisoners, as well as the requirements of the European Rules for Prisons. A disturbing factor was the lack of hot water in the rooms and in the common showers. For this reason, the pre - trial detainees were forced to heat the water in the primitive devices that are very dangerous to life.

The Monitoring Team observed shared showers on site. Although the shower facilities and equipment were almost new, from conversations with pre - trial detainees, as well as from the on – site observations of the monitoring group, and even during the conversation with the Director of the institution, the conclusion that they were not functioning properly was reached.

The laundry room was functional, but pre - trial detainees did not have access to it. They wash their clothes themselves or had them washed by their families.

The institution did not meet the obligation of providing pre - trial detainees with common and personal hygiene products and detergents, garbage bags, shampoo and other items completely and systematically. Pre - trial detainees are provided with these items mostly by family members.

Inspection showed that the conditions in the 10 seclusion/isolation rooms were not good. The rooms had toilets and furniture such as chair, table and bed, despite their poor conditions, but some of the rooms were missing some of them. Hygiene was not to the appropriate standards and it was a very humid environment. Each isolation/seclusion room had its personal airing facility separate from that of other rooms. Showers were shared, but at the time of inspection it did not function as such because it was missing every kind of accessory that would make it function normally.

Observation premises consisted of 5 rooms, 2 of which had toilets and 3 others with shared toilets. On the day of inspection there were 11 persons under observation. Although the maximum number of days a person can stay under observation is for up to ten days, the conversations showed that there were prisoners who had had over 15 days, even months of stay within the observation premises. Apart from dampness, hygiene was visibly noticed missing. For rooms that had no toilets in the room, there was a shared toilet in very poor conditions, which lacked accessories for normal showering and for water usage.

Detention section was divided into normal security and high-security detention which was located on the first floor of their respective buildings. In high-security detention the number of pre - trial detainees varied from 3 to 4 people per room. This section had four sectors with seven to ten rooms each. The rooms had toilets. In the normal security section there were also four sectors with five to six rooms per sector. All rooms had a number of 7-9 the pre - trial detainees and in each of the rooms, 2 pre - trial detainees slept on mattresses on the ground. The rooms had inside bathrooms. The showers were shared, but most of them were not functional. Between sections were common activity rooms.

High-security sections and normal security sections were located on the second floors. Each section had two sectors. In the normal security section there were around six rooms for the sector

with 4-6 persons. The rooms had inside toilets and showers were shared but were non – functional and in poor condition.

The visits in the institution and its observation/seclusion, observation sectors, visits to the visitation rooms used for meeting with family members, kitchen, and discussions with the pre - trial detainees and prisoners on room conditions and activities offered identified that what was notable since the first moment in this institution was the outstanding presence of high level of dampness and dampness. This had been one of the main concerns throughout the years and it continued to be a problem. Almost all the rooms had damp beyond any allowed norms.

During the visit to Fushe Kruje Penitentiary Institution, the Monitoring Team observed that the kitchen was clean and tidy. Quality and quantity of food cooked n the day of the visit were within standards. Cooks, assistant cooks and 7 persons serving their sentence at this institution worked there. The daily menu was displayed. Samples of food cooked the day before were stored in the refrigerator. Most of the pre - trial detainees did have the food cooked at the institution, but would receive it from their family members. There were numerous complaints by pre - trial detainees about its quality and the cooking itself. Complaints mainly regarded the fact that food was not cooked well, lack of variety, and the fact that service was not delivered in the proper sanitary conditions. In terms of milk, the allowances were distributed once a week, but according to the pre - trial detainees and prisoners, it did not meet the quality requirements.

Regime and activities

The Monitoring Team was briefed on respecting the rights of prisoners/pre – trial detainees to have contact with family members and observed the visitation rooms. The latter were in conformity with the required parameters. Visitation room was separated by glass and the family members and prisoners could communicate freely while sitting on benches, the whole time under the distant observation of the police employees. Privacy was respected. The meeting lasted about 30 minutes. Conversation with prisoners on the subject did not identify any complaints.

There were no concerns from prisoners in terms of the number of calls that they could make during a month.

The institution had a library and reading room and prisoners / pre - trial detainees had the opportunity to take books away to read in their rooms. There were a considerable number of books, but they did not meet all the needs. There were about 17 pre - trial detainees and 203 prisoners who were recorded and through their personal library card could take boos away to read and then bring it back, as required.

The right to religion was respected and there was a separate room to exercise religion, which was performed on certain days. The Albanian Muslim and Christian Associations of Albanian Prisoners organised religious activities with cultural topics.

In terms of sports activities, apart from table games, football games were organised twice a week for the interested prisoners / pre - trial detainees. A new football field with high standards was constructed with the help of the Albanian Football Federation. During the day of inspection,

there was ongoing training at the institution in preparation of Tournament with the teams of other institutions.

The social care service sector continued to have the same number of staff: ten employees.

During the inspection of all common facilities it was observed that the activity rooms, like the educational room, the counselling rooms etc. were empty. Regardless of the schedule of activities, no one was noticed or contacted among the social care sector staff that should have been inside the regime, in the activity rooms, providing individual programs or counselling. In terms of the schedule of activities, it remained the same throughout the sectors, regardless of the security levels.

There had been no complaints in terms of airing during the summer months, but most of the pre – trial detainees and prisoners were concerned and not happy with the new reduced airing times during winter time. Many of the interviewees in the rooms were asked about the activities or programs they participate in and they replied they only played football, went out to airing and did religious activities. Clearly, this institution did not organise any other integrating social, cultural activity or anything in the direction of professional training. According to the chief of the institution, the pre – trial detainees and the prisoners would sign up to attend a number of activities but did not always attend. The English language training course had been interrupted and was expected to resume soon; the teaching process, even though it was already too late, was expected to restart soon. The education process would start for 11 pre – trial detainees with the elementary school (9-year mandatory education) level.

Pre – trial detainees and prisoners' psycho-social files included individual training programs and information on joint activities with the detained, mainly consisting of group discussions on social topics and sports activities. Psycho-social support were well completed, including summaries of recent meetings with prisoners, individual and group training programs, quarterly assessments and other supporting documentation.

Health care service

Staffing in this Penitentiary Institution with regard to the healthcare sector was in line with the organisational chart, employing 1 chief of health sector (physician), 1 specialized physician, 1 dentist, five assistant physicians and one pharmacist.

The institution had no ambulance.

There was a building that served as the hospital of the Penitentiary Institution. On the first floor of this building, there was a dentist room, a physician's room used for visitations and a pharmacy. The second floor was a ward with beds in bad sanitary and hygienic conditions, it was very damp, there was no heating, and the toilets had showers that were completely out of standard with no hot water boilers. There were two telephone in the hallway and at the moment of the visit they were in working order

The physician's room was clean, well – kept and had a patient bed, a cabinet to store the emergency medicine and another one, where the medical files were locked in.

The dentist room was also tidy and had a functional unit and autoclave, as well as dental instruments and material supply.

The Pharmacy in this institution was poor in medicaments.

According to the information received from the chief of the health sector, there were 7 people with mental health disorders; 3 of which were diagnosed with schizophrenia, 2 with personality disorder and 1 with bipolar disorder and an unspecified psychotic disorder, in this institution. From prisoners / pre - trial detainees that were drug abusers, 5 were being treated with Methadone. There were also persons suffering from chronic diseases, of which 6 were with Diabetes Mellitus, 13 with HTA, 2 with bronchial asthma, 4 with Epilepsy, etc.

The visit to this Penitentiary Institution and the interviews with the pre - trial detainees identified different issues regarding provision of health care in this institution. They were mostly related to medication, which was often covered with medicine brought from family members. There were also allegations regarding the untimely response to the requests of the prisoners for medical examination depending on the problems they demonstrated. There were patients suffering from Diabetes Mellitus, who took their medication, but for whom there was no care from the healthcare staff to check levels of glycaemia, and according the diabetic diets were not reflected in their medical files.

Numerous complaints were received during the interviews, all regarding out – of – institution consultation sessions, especially in cases of a necessary surgery for which consultations were needed at the frequency of once a month, according to the recommendations of the specialized doctors. There were complaints about the dental service, for lack of service regarding medication, extractions and fillings thereof. Dentists claimed that the people who had complained had received service, but the review of documentation proved that the people who had complained about the lack of service had no records of them having received dental service.

The review of the medical staff documentation with special regard to the documentation of the two physicians identified the presence of: visitation books, the fundamental prisoner register, the serious incidents register, the medicine discharge book, the book on medicine provided by the families and the 24 hour nurses' information books. Medical files were well – kept and were stored in a locked cabinet. The issue identified was that of the two patients with Diabetes Mellitus, whose respective diets were not reflected in their medical cards.

The medicine reimbursement scheme was functional for 277 prisoners/pre - trial detainees who had been provided with health booklets.

On all of the above, it is recommended:

1. Taking immediate measures to address the overcrowding situation in respect of Article 24 of Law No. 8328 dated16.04.1998 "On the Rights and Treatment of Prisoners and Pre - trial detainees", as amended, which provided a separate bed and the standard to a set of convenient bedding as well as a cell that provides a minimum 4m2 vital space per person for each prisoner.
2. Taking immediate measures to ensure provision of chairs and room cabinets for each prisoner.
3. Taking immediate measures to separate adults from 18-21 year olds, thus avoiding the situation of adults sharing rooms with 18-21 year olds (within the detention sector) and to organize shared airing.
4. Taking immediate measures to fix and put the central heating system into use during the colder winter months.
5. Taking measures to establish an environment that is suitable for visitation meetings of the prisoners/pre – trial detainees with their minor family members.
6. Taking measures to keep the educational and professional training courses running.
7. Taking measures to increase the number of social – cultural and reintegrating activities in general and for 18-21 year olds specifically.
8. The responsible staff to take the necessary measures for the provision of individual and group counselling in rooms designed for counselling purposes.
9. Taking measures to supply detergents with the aim of periodical hygienization of residential rooms, outdoor facilities, the kitchen and the food warehouse.
10. Taking immediate measures to improve hygiene and sanitary conditions and the current situation with the dampness and lack of heating in the hospital premises.
11. Taking immediate measures to improve the conditions of toilets and showers within the hospital premises as well as to provide running water.
12. Taking measures to offer the services of a psychiatrist from the area to conduct psychiatrist assessments and to take patients to the hospital for more frequent consultations, in the absence of a prison psychiatrist.
13. The health sector staff to take measures to respond to the prisoners' requests regarding medical visits and specialized consultation visits at the hospital centres on time.
14. Taking measures for providing an efficient dentist service providing the appropriate intervention, filling or extraction services, given the fact that the dentist room had no lacking of dental instruments and materials.

5.17. Burrel Penitentiary Institution - Date 06.10.2014 / No. Doc. 201401905

Preliminary remarks

The monitoring visit in this institution was developed in cooperative grounds. In the absence of the Director, chief of security sector and the services office of the institution gave an opportunity to the monitoring group to have access within the rules and without any hardships to all facilities and meet all persons subject to monitoring.

Based on the Order of the Minister of Justice no. 329, date 15/ 01/ 2009, “On Classification of Penitentiary Institutions”, changed, the Penitentiary Institution of Burrel is classified as “High Security Prison, it has a section of ordinary security and pre-trial detention facility”. Actual capacity of the institution is 198 persons.
On 6.10.2014 there were 211 persons in this institution with an overpopulation of 13 prisoners. The sectors were divided in: 76 in pre-trial detention, 28 high security and 107 prisoners in the ordinary security sector. There were 3 facilities in the institution used as seclusion / observation rooms. In the Penitentiary Institution of Burrel there was no dedicated sector for juveniles aged 18-21 years old, even if there were 8 prisoners of this age group. Other specific categories in this institution were 6 mentally ill persons and 1 drug addict.
During the introductory meeting, heads of sections admitted that the infrastructure of the institution is old and worn-out material wise, despite their efforts to refurbish it. There were limited opportunities to do something about it due to the lack of funds. As a response to that, monitoring group clarified that the Ombudsman’s opinion expressed in the last recommendation was for the GDP to consider designing and approving a project to build a new institution.
Lack of toilets in the cells of high security and showers in the sector has been identified during continuous visits in the institution. The conditions of premises in general were not good and could not be spacious enough for social-cultural activities. It was identified the lack of an efficient heating system for winter and ventilation system. Electrical installments and hydro – sanitary installments were damaged.

Treatment

Based on the information received, both from management of the institution and private and group conversations with persons in pre-trial detention, monitoring group didn’t find any cases of torture, excessive use of force or psychological violence towards prisoners / pre-trial detainees from the personnel of Penitentiary Institution of Burrel.
Complaints raised during inspection were related to limited space of rooms, quality of food, lack of showers in the sector and respectively in the high security sector, lack of medicine and activities. There were also complaints about lack of heating during winter time and lack of cleaning detergents.

What was observed during this monitoring visit was lack of a special section for 18 – 21 year old juveniles, which was also admitted in the meeting with the staff of the institution. They were accommodated in cells with pre – trial detainees or prisoners closer to their age and with similar interests.

Prisoners and pre – trial detainees also complained about fresh air facilities, which were empty and with concrete and inappropriate for either summer or winter.

Safeguards

When checking and inspecting documentations related to requests/complaints system it showed that all data were entered and had been given protocol number in the relevant registers. Registers were stored in the secretary office of the institution. All pre – trial detainees and prisoners filled a form for complaint / request and submitted it to the staff of psycho-social sector. The employee

would then send it to the secretariat of the institution and protocol it and then submitted to the Director of the Institution who would reply in written or meet prisoners in person. However, according to the interviews there claims about cases when they had made a complaint and never received a reply or the reply were sent too late.

In relation to disciplinary measures at time of the inspection in the seclusion – isolation sector there were no prisoners / pre – trial detainees subject to seclusion.

Telephones were working all the time and the persons interviewed admitted that they could talk any time they wanted to their relatives via telephone with prepaid cards, which were in the internal facilities. What the prisoners / pre-trial detainees complained about was the high price of credit.

There were no complaints from prisoners / pre –trial detainees about non respecting number of meetings with family members, but there were many complaints from prisoners about the way food was checked from the staff of the institution.

There was no separated facility or a room for pre – trial detainees / prisoners who had young children or old people to see and where they could meet without any obstacles or restrictions and where minors would be in a friendly environment.

In the Penitentiary Institution of Burrel there were 18 prisoners working, mainly as cleaners, sanitary, in food delivery, etc. and they were paid 90 ALL/ months, but would not benefit reduction of their conviction like in the other institutions. There was a complaint from the convict P.R. who had been working for 7 months and a half and was never paid. According to chief of finance sector that happened because of the insignificant amount, she had collected some months and deposited the money in the bank.

Material conditions

The building of this Penitentiary Institution, a premise inherited from dictatorial times, in addition to being very old, didn’t meet hygienic and sanitary conditions to accommodate prisoners according to European prisons. The walls were considerably humid and despite the efforts to paint them often, there were molds on the wall, which proved the fact that this was not a healthy environment. In many cases it was noticed that plugs and electrical wirings were unprotected and not in compliance with technical security parameters, in particular installments of shower boilers in the common facilities of the regime.

During the inspection it was noticed that observation / seclusion room had three rooms. At the moment of the inspection there were 6 prisoners punished with observation measures and no one in seclusion. In both sectors, rooms had toilets inside, whereas showers were common, in humidity and not maintained. In the high security section, toilets were common, with inappropriate conditions and equipments, old doors and not functional, without sinks and taps. An issue in this section remained the location of common showers outside the sector. In particular in winter times, prisoners had to go through the cold or rain out in a yard to reach the shower in the common facilities.

Despite the minor overpopulation, there were no prisoners sleeping with mattresses on the floor. Rooms were of different sizes and however the overpopulation didn't seem a primary issue in this institution. In general there were concerns about living spaces which according to legal standards must be 4 m2 per person in room. There was artificial lighting, but the windows in the sectors were fairly small and didn't allow for sun light and fresh air.

Despite the fact that heating appliances or equipments existing in the ordinary security sector visited by the group of experts, from communication with prisoners it was admitted by the latter that they were not turned on regularly and enough in winter time so heating was mainly provided though blankets, clothes or any personal heating equipment provided by prisoners themselves. In high security cells heating system and heating equipments in general were lacking.

Cells were in general furnished with necessary equipments such as tables, chairs and closets, but there were complaints from some of pre-trial detainees that they were not allowed to bring in second used equipments from their relative such as TV or refrigerator and on the other hand they could not buy new ones because of financial problems. According to them, the problem was Order of Director General of Prisons no. 3895, date 09.04.2013, which allows only new equipments provided by the institution through a special commission.

During visits in corridors, meeting rooms, joint facilities, kitchen, etc., it was noticed a good hygiene, because from inspection team it was found that the institution was just recently cleaned. From interviews, it was found that in many rooms were complaints about lack of detergents. No insects were identified, because the institution had taken measures for the disinfection of the entire building.

Kitchen was clean and tidy. Food items cooked the previous day were stored in refrigerator. Prisoners complained about bread quality and asked for sliced bread by the supplier and based on verifications, the bread was provided unsliced and prisoners broke it into pieces using their hands. Most of the detainees admitted they would rather receive the food by their families as the quality of the food was not satisfactory.

There were no complaints about the showers as the showers issue mentioned above was resolved by the prisoners by taking warm water from the common showers and washing themselves in the rooms.

With regards to the washing of linens: sheets, pillows and blankets in this institution continued to be washed by families in most cases as there was no laundry room yet to provide this service.

Regime and activities

During the check it was noted that there were no common activities organized in education spaces. During the inspection in the internal regime, meetings were held with psycho-social sector staff that was in contact with prisoners/detainees.
No problems were noticed with airing space, but most detainees and prisoners were concerned about the time in the open air and did not agree with that because it was very limited. Many of

the interviewees in the rooms asked for more common sportive or education activities and sport equipment. The institution did not have an agreement yet with the Directorate of Education for the continuation of education process in elementary and secondary education for the six prisoners/pre-trial detainees.
The right to keep contacts with families and friends was generally followed according to the Regulation. Meetings were organized roughly 4 times a month, in accordance with the General Regulation of Prisons. Meeting with family lasted about 20 minutes. Prisoners had no complaints regarding phone calls which were allowed even after 14:00, which is a more suitable time to find families available at home. Prisoners had limited opportunities to use the library, table games and other creative activities due to inappropriate common facilities.
Outdoor facilities were in continues use but rather than being used for fresh air, they were systematically used for playing football based on a preapproved schedule. The surface for the fresh air was within accepted standards.
There was not an appropriate room for practicing religions, which prisoners/detainees had many complaints about. In Penitentiary Institution of Burrel the library room was currently used for this purpose, despite that was very poor in number of various books. In this room there were generally practiced religious activities offered by the Albanian Muslim Community.
Opportunity for vocational trainings was limited considering that extra services offered by NGOs in this area were inexistent.
There were no educational courses for illiterate persons. The institution showed no initiative regarding vocational training and training of prisoners in general.
Regarding psycho-social support prisoners received, more frequent contacts of the prisoners/detainees with respective staff of social care were noticed. However, lack of suitable environments for individual counseling limited the inclusion in the rehab process. More attention is needed regarding individual processing of files, psychological assessment or intervention offered by them and for efforts to build communication with families of persons missing these contacts.

Health Care Service

The structure of medical staff in this institution consisted of one full time doctor, 3 assistant doctors, 1 dentist and 1 pharmacist. During the visit in this Penitentiary Institution and from the interviews with prisoners, the major number of issues stated in this institution with regards to health service, were mainly related to medications, which were often covered by families considering that the institution itself had serious lack of medications.
Dental service showed deficiencies and offered only minor treatments and removing teeth.
Prisoners gave positive feedback about the doctor of this institution who paid regular visits in the regime, responded on time any detainee/convict’s request and organized specialized consults outside the institution when needed.
Based on the information received by the health service supervisor, there were 7 prisoners suffering from mental health disorder: 3 of whom diagnosed with Schizophrenia, 2 with personality disorder, 1 with bipolar disorder and 1 with unspecified psychic disorder. None of prisoners/detainees using narcotic substances were treated with Methadone. There were also other persons suffering from chronic diseases: 6 from Diabetes Mellitus, 13 from HTA, 2 from bronchial asthma, 4 from Epilepsy etc. The institution did not own an ambulance for emergency services or other health services.

Doctor's room was clean and tidy, well maintained and equipped with an exam table, a cabinet for emergency medicines and another one where medical records were kept locked.
Dentist's room was also tidy, equipped with autoclave unit and amortized, but functional dental instruments, whereas dental materials were individually provided by the dentist.
Nursing room located within the regime in B1 sector was used for doctor's visits. The room was equipped with two beds and a table, whereas emergency medications were kept in a bag which served for other sectors as well considering that the latter had no nursing room.
Pharmacy of this institution was tidy and equipped with medications for chronic diseases, but the ones for acute diseases were missing.
From the check of medical staff documentation, of the doctor's in particular it was stated that there was a visits register, basic register of prisoners/detainees and 24 hours information registers of nurses, while the register of serious violence cases was missing. Medical records were filled out correctly, but there were those of persons with mental disorder and narcotic substance abuse in particular, which continued to be treated with the same therapy of sedative-hypnotic or antidepressants for a long time without making a re-examination of the diagnosis or medication.
Health booklets were provided only to prisoners, while pre – trial detainees did not have these booklets due to the delay in the completion of personal file documentation. Moreover, the medicine reimbursement scheme was functional only for chronic diseases and it did not apply to acute diseases as according to the doctor of the institution this was not provided by ISKSH. (Social and Health Contribution Institute)

As per the above it was recommended:

1. Immediate measures to be taken for repair, maintenance, elimination of mold and painting of prisoners' rooms.
2. Immediate measures to be taken for the improvement of joint living environments making necessary refurbishments of common bathrooms in the sector, reparation of pipes and broken hydro-sanitary equipment, lights and electrical wirings according to technical security standards.
3. Immediate measures to be taken for respecting personal space of $4m^2$ in the rooms.
4. Immediate measures to ensure all prisoners are equipped with necessary quantity of basic products of personal hygiene (including toothpaste, toothbrush, shampoo, etc) as well as with necessary materials to clean their cells.
5. Measures to be taken for providing heating in all sectors according to the standards stipulated in the regulation of prisons.
6. Measures to be taken for application of the existing regulation between Penitentiary Institution Burrel and DAR (*Regional Education Directorate*) for obligatory education of illiterate persons and those who have not finished obligatory education.
7. Immediate measures to be taken for application of medication reimbursement scheme for all prisoners/pre-trial detainees and for acute diseases.
8. Taking measures for more frequent consultations with prisoners with mental health problems so that diagnosis and respective treatment is re-examined and specified.
9. Measures for offering a full and adequate dental service.

10. Measures for ensuring and using a facility to practice religion.
11. Measures for improving family meetings rooms and establishment of a separate and appropriate room for meetings of prisoners with young children.
12. Measures for separation and establishment of a separate sector for 18-21 years old juveniles.
13. Measures to improve the airing facility to fit with climatic conditions and need for green plants.
14. Measures to find a solution for the institution to offer laundry service for prisoners' personal clothes and linens.
15. Measures for adding activities and meetings with prisoners for rehab, counseling, reintegration and socio-cultural-sport activities
16. Measures for unification of pre-trial detainees/prisoners treatment employed throughout the system and improve their payment situation

5.18. Penitentiary Institution Berat - Dated 14.10.2014 / Doc. No. 201401923

Preliminary remarks

Penitentiary Institution Berat has a maximum capacity of 37 persons and 46 beds. On the inspection day, there were 75 detained persons in the premises of the institution. Overpopulation was consequently the issue, with almost twice above the official capacity of people.

Based on the agreement between the Ministry of Defense and Ministry of Justice, dated in 2012, "On temporary retention and treatment of the arrestees/detainees in police stations of Berat, Sarande and Tropoje within the Penitentiary Institution of the Ministry of Justice", within the Penitentiary Institution there were 2 security rooms of Police Station Berat. On the inspection day, there were 7 people in these rooms. Also, there were 4 persons diagnosed with mental health problems in the Penitentiary Institution of Berat.

In accordance with the monitoring development procedure, the inspection group had meetings with the head of the institution who was very willing to cooperate for fulfilling the inspection's goal. The head of the institution informed the experts that Penitentiary Institution Berat is an institution of custody, which has no separate sections for the detainees aged 18-21 years old. However, in the moment of the inspection there were 10 detainees aged 18-21 years old in the institution. He informed also that the issue of the amortization of the building as well as the lack of funds for this purpose was still present.

In the monitoring time, the observation/isolation rooms were turned into living spaces due to overpopulation. Consequently, these cells had lost their legal scope and were violating the standard of the living spaces and cubature surface per person.

Treatment

From the information received, group and private conversations with detainees, the monitoring group did not state any flagrant torture cases or excessive use of force.
In the moment of inspection in the Penitentiary Institution Berat there were complaints regarding the quality of food, the quality of cooking as well as variety of meals and overextension of trials, overpopulation in the rooms and lack of medication.

Safeguards

Reception Commission operated as normally. Data was registered in a special register.
There was an observation/isolation room in regime, but because of the overpopulation it had lost its legal scope and had turned into a living space.
There was a request/complaint system. Detainees filled out a complaint/request form and handed it over to the psychologist who would send it to the protocol. After being registered in the protocol, the Director of the Institution would answer the same day or within 3 days.
All interviewed detainees admitted they could phone their relatives using pre-paid phone cards from the phones located in the regime facilities according to the legislation in force.
Regarding the security matter, there were security cameras in the regime.

Material conditions

As it was confirmed by the Head of the Institution and as stated by previous inspections, the regime environment consisting of one floor with 22 rooms, 2 of which used by the Police Commissariat Berat, based on the aforementioned agreement between MoI and MoJ, is still too amortized and contains mold.
Cells consisted of 2, 6 or 8 people, but not all of them followed the living space standard per person, considering the overpopulation fact as well. The inspection group stated that due to overpopulation most prisoners slept on the floors.
It was also stated that not all rooms had tables, chairs or appliances. Cells did not have internal toilets. All regime had 2 common toilets which were too amortized and with poor hygiene and sanitary conditions. Regardless of the presence of running and hot water, people had showers according to a schedule in the 2 common showers where mold was extreme.
On the inspection day it was also noticed one detainee with mental health problems who did not have a bed and slept on the floor on a mattress totally out of the standards, in a space where detainee's legs were under the bed of another person. This was a discriminatory, degrading and inhuman treatment.
The inspection group stated that natural and artificial light in the rooms was very poor, because the windows were too small and covered with wires which stopped natural light and airing into the room.
During the inspection of the regime's internal environment, in Penitentiary Institution Berat, there were 2 rooms used for family meeting, meeting with lawyers and for interrogation of citizens by the prosecution, which had two iron bars and wire windows making visual and normal communication with family impossible. The inspection group stated that meetings with family were carried out with family members standing in the external part of the institution and detainees standing on the internal one. The same environment was used for children too. The

head of the institution informed the inspection group that an order was given for meetings of detainees with children up to 10 years old to be carried out in the corridor separated by a grill. Rather than for the above, this environment was used for manipulations or medical examinations considering that doctor's room was missing.
There was no central heating system in the institution. The inspection group was informed by the head of the institution and by detainees themselves during the interviews that due to small size of the rooms to accommodate the big number of the detainees, during summer hot months doors of the regime were kept open and hours in the open air were prolonged.
Penitentiary Institution hall was too amortized and electrical wires were exposed which was very risky.
It is worth mentioning the fact that there were no rooms for counseling, religious, cultural, sport activities etc. Library consisted only in a few shelves in the outer hall of the institution.
The inspection group stated that there was an outer environment used for airing, where detainees went out in the open air from 9:00 to 13:00 and from 15:00 to 17:00. From the interviews within the regime it was stated that detainees were allowed to have their hours in the open air and no problems were stated regarding this matter.
While personal hygiene items for detainees such as soaps, detergents, toothpastes and toothbrushes etc. were insufficient and almost inexistent. Regardless of the above, the inspection group did not notice any presence of insects or rats.
Kitchen was too small and amortized, with poor hygiene-sanitary conditions. Equipments were too amortized including camping ovens and food samples were stored in a locked and chained camping refrigerator. One cook and one assistant cook worked in the kitchen. The daily menu was displayed. From the interviews with the detainees, it was stated that the major part of the detainees did not consume the food of the institution but they cooked or receive the food by their families.

Regime and activity

The schedule of actions, including waking, cleaning of rooms and common environment, education and professional work etc. was displayed. From the conversations with detainees, the inspection group received the information that hours in the open air were carried out according to the standards. Under the chart, hours in the open air were carried out from 9:00 to 13:00 and from 15:00 to 17:00. The latter was added during summer months or in cases of overpopulation like in the moment of inspection.
Considering the lack of suitable environments in the regime, Penitentiary Institution Berat could not organize any cultural, educational, religious activity including professional courses.
From meetings with social workers of the sector and interviews conducted with detainees, the inspection group noticed a very good communication and interaction among detainees. Some of the files were in order including minutes from the last meetings with detainees, with individual and group programs, quarterly assessments and other supporting documents, while in some others there were yet elements to be completed.
In the moment of inspection there were 3 detainees employed in the institution as housekeepers and food distributors.

Health Care service

Medical staff in this institution consisted of one part-time doctor and three assistant doctors.
During the inspection in this Penitentiary Institution and also from the interviewees with detainees, problems were stated regarding health service in this institution. They were mainly related with medications which in most cases were covered by medications provided by families. Many problems were also faced with the consults outside the institution. The inspection group stated that all actions, visits and medical interventions by the medical staff were conducted in a totally inappropriate environment, out of the standard, under inhuman and degrading conditions.
Many complaints were also stated about the dental service which according to the interviewed persons was offered only privately, regardless of the contract with the Dental Center, Berat. This was due to the lack of a dentist in the organizational chart of the institution. According to the information received by the doctor of the institution, cases with dental problems were treated with antibiotics for dental infection followed by respective treatments in the Dental Center, Berat.
Under the statistics of September in this Penitentiary Institution, there were 22 detainees suffering from chronic diseases such as cardiac, neurologic, oculist, hematologic diseases etc. 4 detainees of these were diagnosed with mental health problems and 5 were known as narcotic substance users.
There was no doctor's, pharmacy or infirmary room in this institution. Family meeting room was used for this purpose breaching all standards of medical treatment for persons in this institution. There were also many deficiencies of emergency medications as well as for chronic illnesses.
From the check of medical staff documentation, particularly the doctor's one, it was stated that there was a register of doctor's visits, nurses registers of 24 hours information and medical records which were kept in order.
On the inspection day only one detainee had the health booklet. Therefore, the medication reimbursement scheme did not work for any person in this institution.
At the end of the inspection, the inspection group was accompanied by the head of the institution to the new environments of Penitentiary Institution funded by EU, which fulfilled all standards under the legislation in force. The inspection group was informed by the Director of Penitentiary Institution Berat that this building was to be taken over soon.

As for the above, it was recommended:

1. Immediate measures to be taken for taking over the new building of Penitentiary Institution, Berat which would fulfill all living standards for detainees.
2. Measures to be taken for bringing down the overpopulation in the existing building of Penitentiary Institution, Berat.
3. Measures to be taken regarding the hygiene-sanitary conditions and mold in toilets and showers.
4. Measures to be taken regarding the exposed electrical installation in the hall of the regime considered as too dangerous
5. Measures to be taken for conducting psychosocial counseling and other activities in this focus, within the regime in a suitable environment for this matter.

6. Measures to be taken for supply, adaption and establishment of living standards under the General Regulation of Prisons standards on living environments.
7. Measures to be taken for creating suitable conditions for meetings of detainees with families, lawyers and especially children.
8. Measures to be taken with regards to fill out of psycho-social files yet to be filled out.
9. Immediate measures to be taken for employing a full time doctor in this institution.
10. Immediate measures to be taken for the possibility to establish a suitable room within this institution for the doctor, pharmacy and infirmary so that health service is offered with dignity to all detainees in there.
11. Immediate measures to be taken for creating more adequate living and hygiene-sanitary standards to persons diagnosed with chronic diseases and especially to those diagnosed with mental health problems.
12. Immediate measures to be taken for the full functioning of medication reimbursement scheme and for provision of all detainees with health booklets.
13. Immediate measures to be taken for supplying the pharmacy with medications, mainly the emergency ones.

5.19. Penitentiary Institution "Mine Peza" 302 Tirane - Dated 17.10.2014 / Doc. No. 201401977

Preliminary remarks

Penitentiary Institution Mine Peza is an institution with maximum capacity of 170 persons, classified as a high security section and an ordinary security one. On the inspection day there were 237 detainees and 8 other persons in QSB in this institution. Consequently, the overpopulation was a very visible issue.
Under the monitoring procedure, the inspection group had a meeting first with the head of the institution who was willing to cooperate for the inspection.
Treatment
The monitoring group's objective was to collect information regarding the treatment of detainees, to identify cases of excessive physical violence stipulated by normative acts or psychological pressure against this category and also cases of disciplinary actions. From the information received and group and private conversations with detainees, the monitoring group claimed that violence was used. However, regardless the efforts of the inspection group they were not proved beyond any doubt.
In the priory meeting, the inspection group was informed that only two persons had received disciplinary measures and they were barred from the hours in the open air. While there were discrepancies between the disciplinary measures register and statements by the in section group surveys. The service report said that the detainee Y.J had broken the light bulb on the day he was on isolation, while according to the dates, this person should have been on isolation on the inspection day but he was not physically there. Also, due to concrete cases of claims for violence, or excess of competences by the staff of the institution, NMP asked to check the security cameras on the dates and times assumed by the detainees. Regardless the hesitations

from the head of the institution, with the intervention of the Deputy General Director of Prisons, with the assistance offered GDP (General Directorate of Prisons), NMP received full access into security cameras. From the check it was stated that immediately after the inspection group arrival into the institution, 3 persons were taken out of the isolation room.
Also, from the check made to security cameras, it was noted that during the change of shifts, appeal was made with the presence of rapid forces, which was not noticed in other institutions. Deputy General Director of Prisons put at the inspection group following the Order of GDoP no. 274 dated 14.10.2014 "On application of description of prisons' police duties and placement of services schemes in Penitentiary Institution "Mine Peza", where under point 7/3 appeal could be made on every shift under this procedure. Some of the detainees mentioned in their complaints the name of the guardian G.R for rough behavior and communication and also for use of violence, chaining, handcuffing mainly in lawyer's room and also in living rooms, stairs and precisely in spaces which were not monitored by surveillance cameras.
In the moment of inspection in Penitentiary Institution Mine Peza, there were also complaints regarding food quality for the quality of cooking as well as for the variety of meals and overextension of trials, overpopulation in rooms and lack of medications.

Safeguards

Reception Commission operated as normal. Data was registered in a special register.
There were observation/isolation rooms in the regime but they had poor hygiene-sanitary conditions.
There was a request/complaint system. Detainees in this Penitentiary Institution filled out a request/complaint form and then handed it over in an envelope or not to the educator. The later would send it to the protocol. After the protocol it would go to the Director of the Institution who would reply in written or meet the prisoners in person according to the legislation in force. However, according to the interviews, there had been cases when complaints were made and there had been no or much delayed reply.
All interviewed detainees admitted they could phone their relatives using phone cards from the phones located in the regime environments under the legislation in force. However, there were claims that priority was given to certain detainees. The group of experts noticed favors to some detainees who could move freely in the environments of the internal regime of Penitentiary Institution Mine Peza .
As for the security issue, there were functional security cameras inside the regime. Their problem consisted only in the storage of registration which could be kept only for two weeks in the server and then would be automatically deleted according to the information received by the responsible person for this matter in the General Directorate of Prisons.

Material conditions

The environment of the regime is still too amortized, molded and characterized by overpopulation.
Rooms are of different sizes but because of the overpopulation not all rooms follow the living space standard per person. The inspection group stated that because of the overpopulation not all detainees could sleep in beds, some of them would sleep on the floors. It was also stated that not

all rooms had tables, chairs or household supplies. There were also lackings in detergents, blankets, personal hygiene items etc.

All rooms were provided with indoor bathrooms, but in general they were in poor hygienic-sanitary conditions and there were insects everywhere. Some of the rooms were provided with windows so that natural light and fresh air penetrated, but there were also some rooms with very small windows or close to the toilets and therefore they were lacking fresh air.

There is no central heating at Mine Peza Penitentiary Institution and the inspection group found out that the pre-detainees were using appliances which they procured themselves for winter and summer.

As found out during the inspection, Mine Peza Penitentiary Institution has a visitation room for meetings with the families, provided with four areas separated by iron bars monitored by surveillance cameras. There is no separate unrestricted room where pre-detainees can meet their little children or senior relatives. There is also a specific room for meetings with attorneys which meets the respective standards.

Joint showers, which were used as per a defined schedule were located in the first sector of the first floor where also the rooms of the 18-21 years old pre-detainees were located.

The pre-detainees complained about the lack of activities in the institution, despite the existence of the volleyball field at the entrance of the institution, which was the only area for sports activities. The inspection group found out that there was a facility for counseling activities and a library, even though it has a few book titles. The same facility was used for religious, social and cultural events, celebrations for special holidays etc. There were 4 personal computers (PCs) at the library, for various uses, as well as a Ping-Pong table

The inspection group found out that there was an outdoor space used for airing for the pre-detainees who would spend two hours/day before noon in the open air. The airing space was not sheltered which prevented this activity to be held when it was raining.

The kitchen, located at the entrance of the regime, was clean and well-equipped for cooking. Food samples were properly preserved locked in the fridge. The inspection group found out that the same food was provided to diabetics, but it was being cooked in compliance with the respective diet. Daily menu was posted. The inspection group was informed during the interviews held with the pre-detainees that most of them do not eat the food provided by the institution because of the poor quality and lack of variety. The inspection group also had the chance to verify the truthfulness of the complaints about the bread which was too hard.

The shop of the institution was located at the entrance of the airing space. The shop was small and did not offer a variety of products. The pricing list was not posted.

Regime and activities

Daily schedule, to include time to wake up, making the beds, cleaning the rooms and the common space, educational and professional work etc. was posted. Nonetheless, the inspection group gathered from the conversations with the pre-detainees that no activities were organized, and that only the sport activities were held more frequently at the only field of the institution.

In the course of the interviews, the pre-detainees claimed that the joint educational or sports activities were rare and the opportunity to exploit or use the volleyball field located opposite the building was almost non-existent. According to them, there were huge deficiencies as far as the sports tools/equipment is concerned.

Regarding the 9-year elementary education, the inspection group was informed that the institution was about to start the educational system for 4 pre-detainees. Enrollment process for vocational training classes such as plumbing for 24 persons, 3 of which were 18-21 year old, English classes for 28 persons, 2 of which were 18-21 years old as well as cooking classes, had just started.

The inspection group found out that the library room was a multi-functional space, even though it had a limited number of book titles and at the time of the inspection it was being used for a religious activity organized by SHKBSH. The latter held its activities every Friday, while Muslim religion activities were held every Wednesday. This room was used for individual counseling, religious activities and professional classes. Another area which was used for individual counseling and literacy classes was located in the first floor and it was furnished with a long table, six chairs a closet with some magazines and some paintings hanged on the walls.

The psycho-educational files were provided with individual treatment programs and joint activities, mainly group discussions for social topics and sports activities. The psycho-social files were properly filled, there were summaries of the latest meetings held with the prisoners, individual and group programs and the quarterly assessments and all support documents.

At the time of the inspection, 15 pre-detainees were employed by the institution as cleaning persons, food deliverers etc.

Healthcare service

The organizational structure of the health sector was composed of the chief of sector who was also the physician of the institution, a dentist, a pharmacist and four assistant physicians.

During the inspection in this institution and in the course of interviews held with the pre-detainees, they claimed that they were not provided with an efficient health system, especially they complained about the dentist who according to the interviewed pre-detainees could not perform any other service but tooth extraction. The pre-detainees complained that their requests for visits, medical examinations and lab tests were not taken into consideration or there were delays in the services that the health sector should offer. Also, there were numerous complaints for shortage of medicine for emergency and for chronic diseases, and as a result they had to have

the medicine provided by the respective families. Another issue claimed by the interviewed pre-detainees were the delays in medical visits, lab tests and consultations in specialized medical centers.

The data provided by the healthcare sector show that 5 pre-detainees were under treatment for mental health issues, 2 were diagnosed with Epilepsy, 10 were diagnosed with Diabetes Mellitus, 13 with other cardiac or pulmonary pathologies and one diagnosed with HIV/ AIDS. 5 abusers of narcotic substances, who were under treatment with Methadone were detained in this institution too.

The institution was provided with an auto-ambulance which facilitated the transport of the pre-detainees to specialized medical centers.

The examination of the medical staff documentation, in particular of the physician, showed the existence of a fundamental register and a confidential register for visits. All medical check forms were in order. The medical files were properly filled in and kept in a locker. Despite difficulties due to internal and/or external reasons of the institution, the consultation and the examinations in hospital specialized centers were carried out giving priorities to emergency cases and to senior citizens, keeping records in the respective files. 190 pre-detainees were provided with healthcare booklets. The other pre-detainees, accommodated in the institution were expecting to be provided with the relevant documents, so that they could carry out the procedure to be provided with healthcare booklets. The medical reimbursement scheme was fully operational for chronic and acute disease medicine. An exemption to this were the cases of pre-detainees who upon their/or their families requests were provided the medicine from outside the institution.

As for the above, the following was recommended:

1. Taking immediate measures to analyze the cases of alleged violence and the respective administrative sanctions imposed against the responsible persons.
2. Taking immediate measures to change point 7/ 3 of the order no. 274 of the GDP, dated 14.10.2014 “On the implementation of the description of duties for prison police and the deployment of police services for “Mine Peza” penitentiary institution, which gives the opportunity to call the roll at any shift, because this procedure leaves room for doubts and allegations for physical violence and psychological pressure.
3. Taking measure to keep accurate records of the disciplinary measures in the register, by specifying the measure given and the duration for each breach committed by the pre-detainees, according to article 53 of the Law no. 40/ 2014 “On the rights and treatment of the prisoners and pre-detainees”, as amended.
4. Taking immediate measures to tackle overcrowding in this institution.
5. Taking measures to equip, adapt and provide living conditions in accordance with the standards set forth by the General Prisons Regulation.
6. Taking measures to create appropriate conditions for the pre-detainees meetings with their families, especially their children.
7. Taking measures to adapt and create conditions in accordance with the standards set forth by the General Prisons Regulation for the solitary rooms.

8. Taking measures to improve hygienic-sanitary conditions and humidity at toilets and showers
9. Taking measures to organize more activities, especially sports activities.
10. Taking measures to cover a part of the airing space so that it can be used even when it rains.
11. Taking measures to have more frequent medical visits held by the physician inside the regime.
12. Taking measures to provide an efficient healthcare system enabling the pre-detainees to have examinations and consultations in specialized hospital centers depending on the needs for such specialized consultations.
13. Taking measures to provide a complete and efficient stomatologic service by the dentist.
14. Taking measures to provide the dentist's room with dental equipment and material.
15. The managing staff of the institution to take measures to ensure the supply of the pharmacist's room with medicine for acute and chronic disease by implementing more efficiently the medical reimbursement scheme.

5.20. Drenovë Penitentiary Institution, Korçe - Dated 29.10.2014 / No. Doc. 201402002

Preliminary remarks

This was the periodical monitoring visit of the Ombudsman in "Drenovë" penitentiary institution, for 2014. The institution has a maximum capacity of 312 persons divided in 4 sections, concretely the high security section, ordinary security section, pre-detention section and pre-detention section for juveniles.

In compliance with the monitoring procedure the inspection group first met with the Director of the Institution, who was willing to cooperate to reach the goal of the inspection, by providing access in accordance with the rules to all persons and the facilities that should be monitored. The inspection group first requested information on the current situation regarding the rights and treatment of the prisoners, and on the way the institution addressed the issues identified by the previous inspection of this institution.

The Director of the Institution presented the situation and emphasized that the main problem is overcrowding, which had brought about deterioration of the living conditions and difficulties in the provision of qualitative services. At the time of the inspection, there were 452 persons in the institution (140 persons over the capacity), 11 aged 18-21 years old, 3 minors, 11 persons with mental health issues and 9 drug addicts. There was a special section for juveniles and persons with mental health issues.

According to the director, the staff had managed to prevent some serious events such as suicide attempts.
Based on the information obtained and confirmed with the official list of the employees, 30 prisoners were employed by the institution at the time of the monitoring.

The staff was not complete. The revision of the documents and the interviews conducted with the staff and the prisoners showed shortage in staff. Concretely, the legal sector was short of a lawyer, the psycho-social sector was short of a psychologist (who was on maternity leave), and the health sector had only a part time psychiatrist and was short of a physician (whereas the organogram foresees two full time physicians).

Treatment

The objective of the monitoring group was gathering information regarding the treatment of the pre-detainees, identification of cases of use of torture, degrading and discriminating treatment, use of force beyond the limits provided for by normative acts or psychological pressure against this category and cases of disciplinary sanction of “solitary confinement from joint activities”. With regards to the above, during the inspection in the high security sector, the monitoring group of NPM ran into the denunciation of some of the prisoners of this sector who alleged that their inmate S.S. had been subject of physical violence used by the security personnel on 25.10.2014 during a check for forbidden item in his room and that S. S., was sent to the solitary room because he was also imposed a sanction of 20 days in isolation. In order to investigate the complaint of prisoner S.S alleging that he had been subject of physical violence exercised by the security personnel, the Ombudsman established an ad-hoc group, which administered the records of questioning of the citizens who were aware of the event. Findings are presented below.

S.S. room was located in the High Security sector and there was only one person in the room. According to the complainant, the violence was ordered by the Chief of B.K., as a punishment for the personal issues carried with them from the Prison of Peqin, from which both the prisoner and the Chief of Security B.K had been transferred to Drenovë penitentiary institution. The experts, bases on complainants declarations, managed to identify two witnesses who had information about the event and who provided their testimonies. The records of the questioning of the two witnesses were administered in compliance with the investigation procedures. One of them claimed that he had heard but had not seen anything because he was in the adjacent room on the right, while the other one declared that he had seen the security personnel exercising violence against S.S while handcuffing him to take him to the solitary room.

The investigative group questioned and administered the records kept by the two policemen, members of the security personnel who were present at the time of the inspection, who declared that they had escorted the complainant from his room to the solitary room, but that S.S had been handcuffed already by their colleagues when they entered the room and was ready to be escorted to the solitary room. According to their declarations, their colleagues had not violated the prisoner to handcuff him, but they had use proportionate force in compliance with the regulations for insubordination, offence and resistance showed by the complainant against the control of the room for forbidden items.

At the end of the investigation, the NPM experts based on the testimonies and the bruises on the body of prisoner S.S from the use of truncheon came to the reasonable doubt that there has been a use of excessive force from the security personnel. Such practices are unacceptable and persons who engage in physical mistreatment of the pre-detainees or excessive use of force must be held responsible. The directors of the institution must undertake concrete measures to

eradicate cases of physical ill-treatment of the prisoners from the security staff, by improving the management and supervising mechanisms. Fast and effective investigations, which enable the identification and disciplinary sanctions against the persons responsible for the ill-treatment of the prisoners are imperative in order to stop torture, degrading, inhuman and punitive treatment in our prisons.

In the course of the visit, during group and confidential conversations, the prisoners and the pre-detainees, complained about treatment, overcrowding, problems with the good conduct allowance and special leaves, lack of heating during winter, lack of airing because the pre-detention sector was overlapping with the observation section, the conditions of the rooms, especially in the observation section, airing space, lack of activities, expensive prices of the shop and lack of cleaning detergents.

At the day of the inspection, the persons deprived of freedom had no heating appliances and according to the GDP instruction the heating system would be turned on 15 November until 31 December, but only for 4 hours a day, which for the climatic conditions where the institution is located is not sufficient. When it rains and snows, the airing space is filled and lack of shelter and drainage system prevents it from being used, until water dries from natural causes.

A difference was noticed in the conditions of the rooms in different sectors. The monitoring of the sector A showed that some of the beds were empty, whereas the observation rooms were overpopulated with persons sleeping with their mattresses on the floor for months in a row, in very inadequate conditions and who, as a consequence, had health issues. Showering in this sector was possible only once a week, airing and activities were non-existent. The expectation was that the persons under observation would be soon accommodated in the facilities of the other sectors.

With regards to the treatment of juveniles in this institution, it was found out that they were not provided with school classes and according to the educational staff this was supposed to prevent them from mingling with the adult prisoners. There were no vocational classes for them. Airing time for this category was the same as for the adults, and it was offered only for 2 hours a day in separate spaces. They complained about lack of shower facilities, of water and especially hot water and absence of toilets in the rooms.

Monitoring and interviews carried out showed that 18-21 years old prisoners were distributed in various rooms. The schedule of activities was the same.

With regards to the persons with mental health issues, the monitoring group found out that the persons with mental health issues were distributed in various rooms. Many of them complained about poor treatment and failure of the physician to pay visits.

Many complaints were related to food. Most of the prisoners and pre-detainees confirmed during interviews that they were cooking themselves or they had food delivered by their families. Complaints were mainly related to food quality and lack of variety of the menu. Most problematic meal was dinner because they were always served beans.

Other complaints expressed during the interviews were related to the prices of some products and items of the shop, and the monitoring group verified that the prices were more expensive when compared to the commercial units outside the institution.

Safeguards

The verification and inspection of the documentation showed that everything was recorded in the respective register and was given a protocol number. The Educational Sector was in charge of keeping the registers. The pre-detainees/prisoners of this institution, filled in a form request/complaint and submitted it to the educational staff member. The latter submitted it to protocol office. Afterwards the protocol office would submit it to the Director of the Institution who would provide either a written reply or would meet with the prisoner, in compliance with the legislation in force. Nonetheless, according to the information provided during the interviews, there were cases when they had submitted a complaint and there had been no reply or it had been delayed.

Regarding disciplinary sanction, at the time of the inspection, there were 4 persons under disciplinary sanctions at the solitary-isolation sector. None of them had been given a copy of the disciplinary sanction, but they had been communicated the sanction verbally. The review of the disciplinary sanctions did not show any inconsistency.

With regards to good conduct allowance and special leave, the prisoners reported that the institution was very rigid in granting them and even though many of the prisoners met the foreseen criteria, the institution did not approve their requests.

Telephones were operational all the time and the interviewed prisoners confirmed that they could speak whenever they wanted with their relatives via the public payphones which were located in the regime facility. What they complained of, regarding phone calls, was the expensive price per telephone impulse.

The prisoners/pre-detainees were satisfied with the number of visits with the families, but many of them complained about the checks carried out by the staff of the institution on children, women and food. The prisoners of ordinary security and the pre-detainees were meeting their children and parents at the same facilities that were used for the prisoners of high security sector. There were no physical restrictions in the visitation room, nonetheless it did not provide a warm and welcoming climate for the children, appropriate for their age.

With regards to the employment in this institution, 30 prisoners were employed and they were subtracted 3.9 days from their sentenced imprisonment. At the time of the inspection, they complained that one person, although he was working (and the other persons of the sector and the security staff admitted this) his name was not reflected in the structure, and this was verified with the respective documents. They requested the opening of new job positions for the pre-detainees, following the example of other penitentiary institutions.

Material conditions

Drenovë penitentiary institution was established in 2008. Almost all sections, like the ordinary security section and the high security one are fully equipped, with the exception of the pre-detention section and the observation section rooms which were turned into living rooms for the pre-detainees. Not all rooms were provided with TV sets and refrigerators. The families provided the prisoners and pre-detainees of all sectors with linen and blankets, because the institution did not provide them with linen but only blankets which were very shabby. They could be washed in the laundry room.

A main issue remained and most of the complaints were related to the supply with detergents for personal hygiene and to clean the rooms and the toilets. According to the interviewed prisoners, the institution had not provided them with detergents for nine months and many persons could not afford to buy them. Some of the pre-detainees and the prisoners whose families would not pay them a visit were lacking detergents for personal hygiene and bed linen.

Showers were located in every section, apart from the observation section. Shower facilities were provided with sinks and four or five showers. The level of humidity was high. These facilities were not lacking any equipment but there was no water at the time of the monitoring visit. Most of the time, considering that a central heating was not in place, showers were being used to provide hot water according to a defined timetable. During the interviews held at all sectors, the monitoring group was informed that sometimes they could shower only once in ten days.

As far as light and air are concerned, despite the fact that most of the rooms were small, they were not lacking air and natural light.

Two wells were providing water at given times, because there was no connection with the water supply system. Most of the interviewed prisoners confirmed that they bought potable water because tap water was not good.

There was a building in the territory of the institution which served as a hospital. The dentist's room, the physician's room and the pharmacist's room were located in the first floor of the building. The second floor was composed of a hospital ward with 8 rooms, where one of the rooms that was for contagious diseases was turned into a residential room for juveniles (room no. 6). The room had a bunk bed and one single bed for 3 juveniles, and two mattresses which were used by persons 18-21 years old to sleep on the floor. Generally speaking, the conditions in the ward, where the minors were accommodated, were not good. The building was provided with bathrooms with two toilets and one shower out of standard and hot water was absent. Apart from the physician's room, dentist's room and pharmacist's room the hygienic-sanitary conditions were very bad, cold and damp.

The building where the meetings with family members were held, was separated from all the rest and only served to that purpose. There were two high security visitation rooms in this building, which were monitored with cameras and were furnished with a table and chairs in good conditions. Visits for ordinary security prisoners and pre-detainees were held in a common space, divided in 7 cubicles with glass barriers and in good conditions.

The common security section was located in Building B. This building was composed of two floors with four sectors for each floor. Three to six persons were accommodated in every room, but there were also cases with one prisoner per room.

The high security section was located in Sector A. This section was divided into 4 sectors for the high security prisoners and 4 sectors for the high security pre-detainees. Prisoners in the first floor were distributed in rooms with one person/room. Rooms were provided with toilets. The second floor of this pre-detention sector was overcrowded. 3-4 persons were accommodated in every room and in most of the cases 2 persons were sleeping with a mattress on the floor.

The observation section was composed of 10 rooms, but at the time of the inspection the section was serving as a pre-detention facility as a result of the general overcrowding of the institution. But overcrowding was beyond the acceptable norm even in this sector. For example, room no. 9 had no beds, table and chairs and at the time of the inspection 9 persons were accommodated in the room and they all slept on the floor with a sponge mattress. At the monitoring day, 56 persons were accommodated in this section. Rooms were not provided with indoor toilets. Some of the rooms did not meet any living standard, they were damp and mouldy, and the windows could not be opened. There were two common toilets in the sector for all the rooms. A big concern were the outdoor showers. As mentioned above, there was no airing space.

The solitary section was serving for observation purposes and prisoners were kept under observation for 5 days. There were also 10 rooms provided with indoor toilets. Some of the rooms were lacking tables and chairs. This section had an airing space.

The institution had a gym, classrooms and counseling rooms. Even though they existed as classrooms and common areas, most of them were empty. There was one PC room and all PCs were in order. Gyms did not offer any possibility for sports activities and they had completely lost their role. Sports activities consisted mainly in soccer and table games. Classrooms were empty and lacking minimum equipment such as chairs, tables, extra promotional material etc.

Payphones and request/complaints boxes were in the sectors.

There was a library room in the institution with 1929 articles and a cult room used for religious purposes.

The kitchen of the institution was big and modern, satisfactorily clean but the personnel did not wear gloves. Cooking measurement and the daily menu were posted in the kitchen, and food samples cooked one day ago were properly preserved in the fridge. There was no special menu for the diabetics. 5 prisoners were working in the kitchen.

Regime and activities

At the time of the inspection the educational and social staff were not present, even though inspection was carried out during working hours. When inquired about this, they responded that there was an overload because one educational staff must cover 4 sectors and this is unrealistic since the working hours end at 1300.

The schedule of the activities was the same for all sectors, despite the level of security and according to the interviewed prisoners the list of activities was very poor. Even though they had facilities where they could hold social-cultural activities, they were organized very rarely. The main activities consisted in showing movies or having parties for special days.

1929 articled of the library inventory were distributed to the prisoners/pre-detainees to read, based on their requests. There was no library specialist, so the other employees were also in charge of the administration of the library.

Muslim religion practitioners would gather in the cult room from 12:00-13:00 hours and would practice their religious rituals under the direction of a prisoner. Whereas catholic religion practitioners would gather every Tuesday, Thursday and Saturday, under the direction of an envoy from Korca church.

PC room was used mainly by juveniles and for various purposes.

At the time of the inspection, no vocational class was provided and the last one had ended in September 2014.

Two teachers in the institution were in charge of the educational process and 47 prisoners were attending the classes. None of the juveniles was part of the process, with the justification that they must not mingle with the adults.

The group of experts found out that airing as of 20 October was provided for two hours a day, for the minimum period of time foreseen from 09:00-11:00 and 11:00-13:00. Before this date, according to the prisoners/pre-detainees the airing time was in the afternoon from 15:00-18:00. Regarding the conditions of the airing space: it is completely open, there is no sheltered area which would be useful when it rains and snows, or for sun protection in summer.

The doors of the rooms in the institution were closed 20 hrs/day, therefore two hours spent in airing, soccer included in the airing time and activities organized on holidays, classes for the enrolled prisoners and the religious activities were insufficient to meet the needs of the pre-detainees and the prisoners in this IEVP.

The examination of the psycho-social files of the pre-detainees/prisoners showed that drug addicts were suggested to attend individual and group counseling and occupational therapy. The counseling sessions were not taking place according to the pre-detainees/prisoners, even though there were reflected in the files. Group counseling consisted in discussing topics, individual counseling consisted in meetings with the staff in the rooms, while the occupational therapy was seen as connected with employment. Persons who had committed suicidal attempts were suggested accommodation in rooms with other inmates and also counseling sessions in order to emotionally afford the situation.

The examination of the psycho-social files showed that the assessment of the treatment plan reports was done periodically every 3 months. Whereas the assessment report of behavior in the

institution was carried out in a monthly, but the descriptions were mainly standardized. Reports of individual treatment programs as well as the organization of joint activities were part of the psycho-social files, even though they were almost non-existent.

Healthcare service

The medical staff of the institution was composed of the chief of sector who was an assistant physician, a part-time psychiatrist (it was foreseen as a full time physician), 6 assistant physicians, 1 dentist and 1 pharmacists. There was no physician even though he was foreseen in the organogram. The absence of the physician in the structure was certified by the claims of the prisoners and the pre-detainees, who declared that they did not know the physician of the institution and that the physician was not conducting any visits. The chief of sector was playing the role of the physician.

The monitoring group identified many flaws in the health service in the course of the monitoring visit and from the interviews with the prisoners. They were mainly related to medical cure, for which they were very often using the medicine provided by the families. There were also allegations regarding the response in time to the demands of the prisoners for medical visits depending on the problems that they manifested.

The also complained about stomatological service, which was falling short off in medicine, tooth filling and extraction, and even during the visit there were cases that needed dentist's urgent intervention.

Some patients were suffering from Diabetes Mellitus, and they were preparing food for themselves because the kitchen did not prepare food according to their dietary needs.

The dentist's room, infirmary room, pharmacists room, ward with 8 rooms and bathrooms with two toilets and one shower facility out of every standards were located in the hospital of the institution. They were not provided with any heating system and the level of humidity was high. The hygienic-sanitary conditions of the ward were inappropriate.

The infirmary room, where the medical visits, injections and perfusions took place, was clean, neat, and well-maintained and equipped with a bed, a closet for emergency medicine and a locker for the medical certificates.

Dentist's room also was neat, equipped with a unit, an operational autoclave as well as dental equipment and material.

Pharmacist's room was also well-maintained and supplied with a variety of medicine. Emergency medicine were provided with the funds of the institution, whereas medicine for chronic diseases were provided by the medical reimbursement scheme. A challenge for the institution was the procurement of medicine for acute diseases.

According to the information provided by the chief of health sector, 11 mentally disturbed persons were sentenced with imprisonment in this institution. Only 1 from 9 drug abusers

prisoners/pre-detainees was treated with Methadone. Some other persons were suffering from chronic diseases: 6 with Diabetes Mellitus, 8 with cardiac pathologies, 8 with gastro-hepatologies, 5 urologic pathologies, 4 with oncologic pathologies, 2 with neurologic pathologies, etc.
The institution did not possess and auto-ambulance.

In the course of the examination of the medical staff documentation, and especially the documentation of the physician, we found a register for medical visits, which was filled in by the psychiatrist, a fundamental register for all prisoners and a medical visit request form, which was filled in by the shift nurse, a book to record the medicine provided by the family and the registers of 24 hours information filled in by the nurses. All medical files were in order and kept in a locker.

The reimbursement scheme was working for 200 prisoners, who were provided with healthcare booklets, while the implementation of such scheme for pre-detainees was difficult. Because of the delays in the completion of the pre-detainees with the documentation of the personal files, it was impossible for the pre-detainees to benefit their medicaments from the medical reimbursement scheme.

As for the above, the following was recommended:

1. Taking immediate measures to analyze the situation of use of excessive force from the security personnel against prisoner S.S, and the conclusions about the liabilities and the disciplinary sanctions against the responsible persons to be communicated to the Ombudsman within the legal timeframe.
2. The Director of the Institution to take immediate measures to eliminate cases of ill-treatment of prisoners by the security staff, by improving the management and supervising mechanisms which hold responsible the persons who engage in physical ill-treatment or excessive use of force against the prisoners.
3. Taking urgent measures to complete the structure as planned.
4. Taking immediate measures to address the overcrowding in compliance with article 24 of the Law no. 8328 dated 16.04.1998 " On the rights and treatment of the prisoners and pre-detainees", as amended, which foresees that every prisoner is provided with a separate bed, a bedding set and that the living standard every cell should meet is 4 m2 area for every person.
5. Taking immediate measures to provide the prisoners and the pre-detainees with bedding sets, chairs, closets and personal hygiene products.
6. Taking measures to address the overcrowding issue in the observation section which serves currently as pre-detention sector. This sector did not provide any of the services such as airing, activities and showers inside the building, because of lack of space within the sector.
7. Taking measures to provide a solution to the issue of showers and water supply in the observation and health sector where juvenile pre-detainees are accommodated.
8. Taking immediate measures to improve hygiene-sanitary conditions of the hospital facilities, in order to provide a human and dignitary treatment to all persons sentenced with imprisonment in this institution.

9. Taking measures for the physician/assistant physician to conduct more frequent visits in the regime and to provide a more efficient healthcare service.
10. Taking measures to provide all necessary stomatological services.
11. Taking measure to make sure the kitchen of the institution provides the prisoners diagnosed with Diabetes Mellitus with diabetic dietary food.
12. Taking measures to include acute diseases medicine in the medical reimbursement scheme.
13. Taking into consideration establishing a special sector for persons with mental health issues.
14. Taking measures to improve the quality of services provided by the psycho-social staff, to increase the number of contacts and the re-integrating and social-cultural activities in general and in particular for juveniles and 18-21 years old prisoners.
15. Taking measures to resume school classes and vocational training classes for minors.
16. Taking measures to increase the number of employees, to include not only prisoners but also pre-detainees.
17. Taking measures to verify the prices and quality of products in the shop of the institution and increase the variety of products.
18. Taking measures to ensure heating for more than 4 hours a day, taking into account the climate of the area where the institution is located.
19. Taking measures to ensure drainage for airing space and covering parts of the airing space to guarantee that such activity is not prevented by rain or snowfall.
20. Taking measures to carefully asses the award of good conduct allowances and special leaves, by making a clear and adequate verification of the assessment and the credibility of the person who claims he is entitled to the leave and it has been denied.

5.21. Penitentiary institution Tepelene - Dated10.11.2014 / No. Doc. 201402365

Preliminary remarks

The official capacity of the penitentiary institution is 86 pre-detainees and prisoners, but during the visit we found out 160 persons, out of which 32 prisoners and 128 pre-detainees. There were 4 persons with mental health issues, but there was no special facility for their treatment. The other categories present in the institution were: 8 persons 18-21 years old, 4 drug abusers and 3 alcoholic. 11 prisoners were employed by the penitentiary institution.

At the beginning of the visit, the experts met with the Director of the Institution. The monitoring visit was carried out in a good spirit of cooperation. The director of the institution offered the monitoring group the opportunity to have access according to the rules without obstacles to meet all persons and at all facilities under monitoring. During the meeting the Director presented the situation of the institution identifying as the biggest issue of the institution the overcrowding. The director informed us that there have not been any serious events in the institution. The disciplinary sanctions, which mainly consisted in solitary confinement from joint activities, were used against the prisoners who breached the regulations of the institution. These measures were enforced in their rooms because the solitary/isolation rooms were turned into living rooms thus

losing their role as rooms for disciplinary sanctions, and this because of the overcrowding in the institution.

The organization structure of the institution was partly completed, because there was shortage of medical staff and psycho-educational staff. Such shortage was challenging, considering the overcrowding situation.

The previous visit identified issues related to overcrowding, infrastructure, personal and common hygiene etc. These flaws identified by the previous monitoring and the measures taken to reduce or improve them, were also part of the preliminary discussion.

In the aspect of infrastructure, Tepelena institution was completely depreciated in spite of the modest efforts of the director of the institution to adapt, repair or adjust the current building in order to achieve its goal in respect of the standards.

The activities and the education treatment in the institution could not be organized as a consequence of the extreme overcrowding and lack of facilities.

Treatment

In the frame of monitoring the rights of the prisoners/pre-detainees, the monitoring group organized a monitoring visit in the internal facilities of the institution and communicated in private with the prisoners/pre-detainees. During the private meetings and conversation with the prisoners/pre-detainees, the monitoring group asked questions regarding cases of use of physical and psychological violence, or manifestation of offensive behavior by the employees of the institution towards them. In general the prisoners/pre-detainees reported that there was a good relationship between the prisoners/pre-detainees and the employees of the institution.

The monitoring group was informed of a case of violence and use of excessive force from the security personnel of DAP. Pre-detainee K.T reported this to the experts. The pre-detainee in September 2014 had been subject of excessive use of force, violence, hit with a truncheon while being handcuffed. The reason for this was an information (which at the end was not true) for the existence of a cell phone in his room, which pushed the DAP personnel to conduct a thorough check. During the checks, pre-detainee K.T was beaten with a truncheon, was handcuffed and turned with his head against the wall until the thorough check of his room was over. After the checks, the pre-detainee had been subject of psychological pressure in order to tell where the cell phone was hidden. DAP staff continued to beat him with a truncheon even when he was being escorted to his room once his handcuffs were removed. This fact, confirmed by other pre-detainees and eye witnesses, was referred to the Director of the Penitentiary Institution of Tepelena, reminding him that he is the only one responsible for the order and security in the institution and that the security personnel of DPB are merely supporting the joint operation of security of the penitentiary institution and must be coordinated and supervised by the director of the institution.

Other complaints related to treatment mainly referred to the quality of food, overcrowding in the rooms, lack or bad quality of mattresses, lack of medicaments and stomatological services, as

well as new airing schedule which deprived them from airing in the afternoon. Another concern raised during the interviews was lack of heating and malfunction of central heating boilers during winter time.

The prisoners and the pre-detainees complained for the airing space which was uncovered, there no shelter to save them from the rain or the sun, and because the location where the institution is situated has a cold and humid climate throughout the year, airing at all seasons was almost impossible.

Joint premises where school classes, vocational training classes, activities to develop individual skills, social-cultural activities could be organized were completely missing. The need to turn these premises into living areas hindered the organization of integrating activities and the quality of services provided decreased.

Safeguards

The adult and 18-21 years old pre-detainees in Tepelena institution were not separated in sections. Because of the overcrowding in pre-detention, separation in section for group age 18-21 years old was not possible, therefore this category was holding joint activities and airing together with other adult prisoners.

In the internal regime, on the second floor, in separate rooms other pre-detainees and prisoners were accommodated. They carried out activities separately.

The monitoring group was informed that the temporary seclusion facilities, mainly for solitary confinement from joint activities, were turned into living rooms thus losing their role as facilities where disciplinary sanctions are enforced.

Verification and inspection of documentation did not show any irregularity. Everything was recorded in the relevant register and was given a protocol number. The education sector was in charge of the registers. Regarding the functioning of the complaint/request system, the pre-detainees and the prisoners would fill in a complaint/request form which they submitted to the educator in an envelope or in person. The latter submitted the complaints to the protocol office. The protocol office submitted them to the Director of the Institution who would provide a written reply, or would meet the prisoners in person, in accordance with the legislation in power.

Telephones were operational and the interviewed prisoners admitted they could speak any time they wanted with their relatives via public payphones located in the regime facility. They complained about the expensive price of telephone impulses.

The two sectors shared the visitation facilities. There were three cubicles separated with glass barriers and iron bar gates. Pre-detainees/prisoners could meet with their family members once a week. There was no specific premise or room for pre-detainees with toddlers. A little room located at the entrance of the building was mainly used for meetings with old family members, children and pregnant women, but this in fact did not meet any condition to be considered as a

visitation room, even though this was the only solution provided by the institution considering overcrowding and shortage of additional space.

All security cameras were out of order as a result of a lightning causing an electrical discharge. Regarding this issue, the Director of the institution told us that they had requested a special fund from the General Directorate of Prisons to repair the camera surveillance system.

Material conditions

The focus of the experts of the monitoring group was also respect of normal living standards. In this frame we visited and discussed with the prisoners/pre-detainees about the respect of such standards and we surveyed in field the quality and observation of these standards.

According to the information obtained from the prisoners/pre-detainees, they spent most of the times in their rooms. This was also because according to them, the institution did not organize joint activities. Rooms were provided with separate bathrooms (WC and sinks) with doors. The monitoring group visited most of the living rooms.

Natural lighting was in compliance with the standards. Natural light and ventilation was secured by the windows which met the required standards.

According to the information of the prisoners/pre-detainees, they were supplied, not in a regular manner, with products to maintain their hygiene, mainly with soap bars, cleaning detergents and equipment to clean the joint facilities. The institution would not supply them with products of personal hygiene such as: hair shampoo, toothpaste and toothbrush, which were provided by their families or those who could afford it, would buy them from the prison shop.

The prisoners/pre-detainees complained that the shop would not satisfy their personal requests for purchases, because of the malfunction of the shop and the expensive prices it applied, compared to the market.

The monitoring group visited the joint shower facilities. Out of 3 shower posts, only one of them was functional, but without a showerhead. The monitoring group also found out an exposed electrical connection not meeting the technical security conditions in the shower facilities. Nonetheless, the shower facilities were used twice a week, in accordance with a schedule. According to the testimonies of the pre-detainees, they were not sufficient for the number of the prisoners/pre-detainees in the institution and the only allowed solution was to take hot water in buckets and shower in their rooms. Even though the shower schedule (twice a week) was in compliance with the law, the group of experts came to the conclusion that practically the only shower available for the entire rooms of the first floor was not sufficient.

Electricity and water supply was uninterrupted.

The monitoring group noticed that the equipment was somehow in place in the rooms subject of inspection, but some rooms, due to overcrowding, did not meet the necessary living standards. In many rooms the pre-detainees slept with a mattress on the floor, because there were no beds.

In room no. 24, measuring 4 m x 6 m for a surface area of 24 m², 12 persons were accommodated and 4 of them were sleeping with a mattress on the floor. In room no. 16 me 5m x 5m for a surface area of 25m², 12 persons were accommodated and 4 of them were sleeping with a mattress on the floor. In room no. 14 measuring 2.50mx4m for a total surface area of 10 m², 5 persons were accommodated and 1 of them was sleeping with a mattress on the floor. Most of the rooms had this surface area and were overcrowded, there was lack of sufficient living space, and people were sleeping with a mattress on the floor. The data of the extreme overcrowding of the facilities of Tepelena Penitentiary institution, apart from the issues of structural deprecation of the buildings and deterioration of the services provided to the freedom deprived persons, raise the concern of national and international institutions regarding respect of human rights in a democratic country.

The situation of overcrowding in Tepelena penitentiary institution with approximately 100% more persons than the official capacity brings about the violation of a series of rights of prisoners/pre-detainees, because as a result of the overcrowding not only there is less living space for every prisoner, but also less services are provided, which, due to a pre-defined number of staff are less qualitative. Therefore, movement in the room and joint premises was limited, there was discontent regarding educational and rehabilitation programs which under the overcrowding conditions and use of classrooms as living rooms were inexistent.

During the visits of the halls, joint showers and the rooms, we noticed the poor hygienic conditions, mainly due to lack of personal detergents and chemicals for showers and toilets. Most of the cases the detergents and other chemicals were procured by the pre-detainees and the prisoners themselves.

Food was served in 3 meals, according to a defined schedule. In general prisoners/pre-detainees complained about the quality of food. We verified the kitchen, which was found in order. It had been refurbished recently, but the kitchen equipment did not meet the standards of social food cooking. Regarding the requests to prepare and provide for food, we found out that the legal requirements were observed. Food was prepared in compliance with a pre-approved list and the food samples were preserved in the fridge. Prisoners/pre-detainees remarked about the quantity and especially the quality of food.

The family members continued to help the prisoners with washing their clothes and linen since there was no laundry room available to provide for this service.

Regime and activities

The meeting with the psycho-social staff gave us the impression that their team spirit was high. An obstacle to their work was lack of joint facilities and classrooms which hindered the work of the educational experts. Whenever there was a need of counseling or conversation, it was held in the improvised room for meetings with the attorney.

The monitoring group was informed of the activities and programs implemented by the institution and examined selected files of the pre-detainees and prisoners, files of the 18-21 years old, as well as the files of mentally ill persons. Notes regarding individual treatment and

organization of joint activities were found in the files, although most of them were merely formal, because absence of adequate facilities and classrooms made it impossible to organize them. Notes mainly claimed provision of group discussion for social topics and sports activities in the airing space. The psycho-social files were complete, provided with summaries of the latest meetings with the prisoners, individual and group programs, quarterly assessments and all support documents.

There was no library and there was no facility to be used for this purpose. The few books inherited in the institution were preserved in the offices of the institution and were distributed based on requests of the prisoners and pre-detainees, but in fact during the interviews with the prisoners/pre-detainees, they reported that the institution did not provide them with books, rather they had to rely on their families for this.

Time in the open air is the only activity the prisoners could hold altogether due to shortage of space. Time in open air in winter time was hold for two hours before noon. The institution provided two airing spaces for different categories: for 18-21 year old persons, for persons with health issues, for specific situation in cases of conflicts and misunderstanding between different groups. The prisoners of two floors were spending time in open separately. The situation of both airing spaces was not good, because the airing spaces were uncovered and as such were not appropriate for airing when it rains, snows or when it is very sunny.

Regarding employment at the penitentiary institution, 11 prisoners were hired as cleaning persons, food deliverers etc. The interviews conducted with some of them revealed no issues with their employment.

Healthcare services

The organogram of the healthcare service of the institution was composed of a part time physician, an assistant physician-pharmacist, four assistant physician and a dentist.

The visit of the monitoring group and interviews held with the prisoners identified various issues related to the health service in this institution. They were mainly related to the presence of the physician in the regime and the delays to respond to the requests of the prisoners for medical visits depending on the issues they presented.

Additionally many complaints were related to the consultations and examination in the hospital centers based on the needs of the prisoners/pre-detainees who suffered from chronic diseases, which required reassessment of the situation and of the medical cure provided.

Another issue identified in this institution related to healthcare service was the medicine, which in most of the cases were provided by the families.

During the interviews we encountered more complaints related to stomatological service, in respect of medication, tooth filling or extraction, end even though the visit of the working group was carried out during the official working hours, the dentist of the institution was not present.

The institution did not have an ambulance to provide the prisoners/pre-detainees with consultations, examinations and specialized tests in hospital centers.

Infirmary room, which was located inside the regime, was used to carry out medical visits, injections or perfusions in accordance with the needs. It was provided with a bed, one table and three stools that were old and extremely depreciated, thus not meeting any standards. There was also a medicine box there, where emergency medicaments should be preserved, but at the time of the inspection it was empty.

Pharmacist's room was nonexistent in this institution because such a facility was missing. All medicaments were kept at the physician's room, outside the regime, in the administration's office, but the inspection group found out that most of the medicaments were missing, to include emergency and chronic diseases ones.

The medical files were locked in the physician's room, but the inspection group did not manage to have access, because the physician was absent during the inspection. Another issue was the fact that the assistant physician did not have access to the documentation preserved by the physician.

The inspection group did not manage to verify the dentist's room because the dentist was not in the institution and no one else had access to the room.

The medical reimbursement scheme was not working at all in this institution; therefore there was a lot of shortage in medicine. The managing staff confirmed that the majority of the prisoners/pre-detainees were not provided with healthcare booklets, therefore the reimbursement scheme was not effective.

As for the above, the following was recommended:

1. Taking immediate measures to limit the overcrowding of Tepelena Penitentiary institution, with the objective that every cell provides at least 4m2 living space/person.
2. Taking immediate measures to address the situation of overcrowding in respect of article 24 of the law no. 8328 dated 16.04.1998 "On the rights and treatment of the Prisoners and Pre-detainees", where it is provided that every prisoner is entitled to a separate bed and a suitable bedding set.
3. Taking immediate measures to provide Tepelena Penitentiary Institution with equipment and financial funds to enable the organization of educational, social and cultural activities.
4. Taking immediate measures to improve the performance of the social care sector with the purpose of enabling counseling and discussion of social topics and to enable increase of cooperation with the institutions, with the ultimate goal of rehabilitating the prisoners/pre-detainees.
5. Taking measures to complete the structure with a psychologist.
6. Taking immediate measures to ensure a facility dedicated to the psycho-therapeutic treatment of the prisoners.

7. Taking immediate measures to supply the pre-detainees with necessary hygienic-sanitary products.
8. Taking necessary measures to repair and make the showers fully operational, while respecting the technical security parameters for electrical connections.
9. Taking immediate measures to put the prisoners of 18-21 years of age in a separate sector in order to avoid joint activities with adult pre-detainees.
10. Analyzing and reporting to the GDP the cases of use of violence by the security personnel of DAP in September 2014 against pre-detainee K.T.
11. Taking immediate measures to prevent the excessive use of force and use of tools like truncheon or handcuffs during the routine checks of rooms for forbidden items. In this respect, the directorate of the institution must be more attentive and to lead the security operations whenever joint operations with DAP personnel are organized.
12. Taking immediate measures to complete the structure of the health sector with a full time doctor.
13. Taking immediate measures to make sure regular visits are conducted by the physician of the institution, thus ensuring an adequate health service.
14. Taking immediate measures to provide the institution with an auto-ambulance.
15. Taking immediate measures to provide all prisoners/pre-detainees with healthcare booklets.
16. Taking immediate measures to implement the medical reimbursement scheme, to make sure that the supply with medicine for acute and chronic diseases falls under this scheme.
17. Taking immediate measures so that the Director of the Institution raises funds for emergency medicine.
18. Taking immediate measures to provide an appropriate facility which meets all the standards for a visitation room within the regime.
19. Taking immediate measures to make sure the dentist of the institution provides the complete spectrum of stomatological services.
20. Taking immediate measures to repair all security cameras of the institution.

5.22. Penitentiary institution Sarande - Dated 12.11.2014 / No. Doc. 201402313

Preliminary remarks

Saranda penitentiary institution is a pre-detention facility institution that has a maximum capacity of 31 persons. In compliance with the monitoring procedure, in the absence of the director of the institution, the inspection group first met with the chief of legal sector who was willing to cooperate in order to reach the goal of the inspection. There was a good spirit of cooperation throughout the inspection visit. The management staff of the institution offered to the experts of the inspection group the opportunity to have access and no restrictions in meeting all persons and at all facilities they needed to monitor.

During the meeting, the inspection group first requested information related to the rights and treatment of the pre-detainees, as well as the way the institution tackled the problems found out during the previous inspection of this institution. The Director of the Institution met with the

monitoring group in the course of the visit and he was present in the last meeting when the findings of the monitoring were presented.

There were 58 persons in the institution on the inspection day. The overcrowding was an issue. There were 27 pre-detainees, approximately two times more than the official capacity. As a result of the overcrowding, there were pre-detainees who slept on the floor, in an inhuman and degrading condition. Some of the rooms were so small that the pre-detainees who slept on the floor with a mattress would lie them under the bed or close to the door. The fact that some of the cells were used for the treatment of the detained/arrested persons of the Police Commissariats of Saranda, based on the Bilateral Agreement of 2012 between the Ministry of Justice and the Ministry of the Interior "On holding and treatment of the detained/arrested persons" of the Police Commissariat of Saranda, Berat and Tropoja in the facilities of the penitentiary institutions.

According to the information provided by the chief of legal sector, there have not been any serious cases in the penitentiary institution of Saranda.

During the visit, the inspection group found out that half of the building where the pre-detainees were accommodated was underground and therefore had a high level of humidity.

The institution did not have separate sections. At the time of the inspection there were no pre-detainees of the category 18-21 years old.

There were no drug abusers in the institution. There were some prisoners suffering from chronic diseases who, at the time of the inspection were at the Special Health Institution for Prisons.

The observation/solitary room was located at the end of the hall. It did not meet any standards, the hygienic-sanitary conditions were poor, it had no light and the ventilation was provided by a very small window.

The structure was not complete as the dentist and the pharmacist were missing.

Two pre-detainees were employed as food deliverers.

Treatment

The objective of the monitoring group was gathering information about the treatment of the pre-detainees, identification of cases of excessive use of force, beyond the limits provided for by normative acts or psychological pressure exercised on this category, as well as cases when disciplinary measures are taken. The information provided through group and in private conversation with the pre-detainees did not specify any case of use of physical force, psychological violence and pressure, any flagrant case of torture or excessive use of force.

In Saranda Penitentiary institution, at the time of the inspection, there were complaints about overcrowding of rooms, food quality, lack of hot water, hygienic-sanitary conditions of the showers and toilets, lack of heating, non-functioning of the heating boilers during winter, and

lack of joint activities. They also complained about lack of medicine and stomatological service and the airing space which was inadequate for such purposes.

Airing in this institution was hold in a facility measuring 6 m2, with a ceiling and only 3 walls, an iron-bar door on the other side, which did not meet the standards and was inappropriate for sports activities for the pre-detainees. The situation was even more concerning for the fact that fresh air and natural light were almost missing because the pre-detainee's rooms were very small and half of the building that was underground.

Joint facilities where education, vocational training, development of individual capacities, social activities, sport's activities, individual and group activities were supposed to be held, were completely missing. Lack of these facilities hindered the organization of integrating and psycho-social activities

The shop where the prisoners could purchase products based on their needs was missing. As a result, the family members would provide them with these products, which would first undergo the checks as foreseen in the regulations and then would be delivered to the relevant person.

Safeguards

The Admission Commission functioned normally. Data was registered in a special register. The physician was part of the Admission Commission as an observer with no voting right, as provided for by the standards.

There was a register for serious events and disciplinary sanctions, and the last sanction registered dated 04.08.2014. All the documentation of the legal sector, the register of the disciplinary sanction and the personal files of the pre-detainees were administered by the chief of psycho-social care.

The monitoring system of the institution was composed of six indoor and outdoor cameras, which were all in order.

During the inspection of the internal premises of the regimes, it was found out that there was a specific facility for the meetings of the pre-detainees with their family members, which was separated with an iron-bar door and it was under camera surveillance. The monitoring group emphasized the issue of lack of a specific visitation room for minors. Meetings with family members were hold once a week.

There was a request/complaint system in place, but the pre-detainees submitted the requests/complaints to the education employee, who forwarded them to the chief of security. The latter submitted them to the Director of the Institution, who was in charge of their delivery. The Director of the Institution informed the Inspection group that pre-detainees' requests/complaints, in general were provided with a solution within 24 hours, although there were some delays for some of the complaints. We need to emphasize that such a system does not meet the criteria of the GDP order, where it is provided clearly that requests/complaints must

be submitted first in closed boxes and that the educational sector is in charge with their administration.

All interviewed pre-detainees confirmed that they could speak with their relatives anytime they wanted via the public payphones located in the regime facility, but they complained that the phone calls were more expensive than outside the penitentiary institution.

With regards to the security, Saranda Penitentiary institution was provided with six security cameras located both indoors and outdoors, to include the hallways.

Material conditions

As confirmed by the managing staff of the Institution and as found out by the previous inspections, the facility of the institution continues to be depreciated and damp.

At the second floor, where the offices of the administration were located, we found out some facilities that were subordinated to Saranda Commissariat. As mentioned in the Preliminary remarks section, the bilateral agreement between the Ministry of Justice and Ministry of the Interior. "On the temporary holding and treatment of the arrested/detained persons of the Police Commissariats of Saranda, Berat, Tropoja at the facilities of the penitentiary institution constituted a big issue regarding the administration and management of these facilities. The commissariat's offices located within the territory administered by the penitentiary institution were mainly composed of warehouses containing overalls and other materials for the commissariat. According to the Director of the Institution, if the agreement would be dissolved and the administration of the two floors would be transferred to the directorate, this would make possible the changes in the infrastructure, concretely the reorganization and establishment of new facilities appropriate for airing, turning the warehouses and the depots into visiting rooms for children, activity rooms and joint facilities for various social, education and/or religious activities.

At the time of the inspection, the institution was comprised of 12 residential rooms where 4, 6 or even 10 persons were accommodated and none of the rooms meet the living space per person standard. A warehouse and the attorney's rooms were transformed in residential rooms due to overcrowding. Some of the pre-detainees were sleeping on the floor, in inhuman and degrading conditions as a result of overcrowding.

Another issue were the windows of the rooms which were very small, and as a result light and ventilation were not sufficient, therefore the level of humidity was very high in almost every room. Some of the rooms were provided with ventilators, to ensure air circulation. Due to overcrowding and very small areas of the living rooms where the pre-detainees were accommodated, furniture like tables chairs or stools were missing.

Additionally, many rooms were short of equipment such as fridge, TV set, closets etc., because according to the order of the General Director of Prisons no. 3895 dated 09/ 04/ 2013 they must be purchased by the Institution via a special commission, but the pre-detainees could not financially afford this. In general, the inspection group was told during the interviews that the

pre-detainees were provided with linen and blankets by their families and when they belonged to the institution they were too old and shabby.

The inspection group found out extreme shortage in the supply of the pre-detainees with products of personal and common hygiene, such as soaps, shampoo, cleaning detergents etc., and that most of the time families were providing for these products.

Supply with running water was as problematic as the issue of potable water that the pre-detainees continued to buy themselves. The toilets and shower facilities were shared, and in total there were only two toilets and one shower facility in the institution. The pre-detainees claimed that these facilities were also used to wash dishes and food, and this constituted a huge issue in terms of hygienic-sanitary conditions.

They could only shower twice a week and in confidence they reported that very often there was no hot water.

A washing machine placed at the entrance of the institution served as a laundry room. It was functional every 15 days only to launder blankets and linen, but the pre-detainees claimed that this process took too long, therefore they preferred to have this service provided by their families.

There was no central heating system in the institution. Therefore, during winter heating was provided by the equipment procured by the pre-detainees.

The observation/seclusion room was located at the end of the hallway, in very bad conditions, with a very small window which hindered ventilation and natural lighting. Even the artificial lighting was very poor.

The examination of the physician's room, which was located at the regime, revealed that it was depreciated, provided with old equipment and a first aid box which was old. Whereas the waiting room was transformed into a meeting room with the attorney, which was used in special cases for meetings with the minor family members.

The kitchen of Saranda penitentiary institution which was located in a very small facility close to the administration offices, was very clean and neat, but it was short of some basic equipment such as aspirator and boiler. As a result, there was no hot water in the kitchen. Daily menu and cooking measurement were posted in accordance with the regulation. Nonetheless, the inspection group commented on the preservation of food samples, which were not preserved in the refrigerator, because according to the sector employees it was out of order. There were no persons with special needs in terms of food in the institution.

Regime and activities

According to the approved organogram, the psycho-social sector was composed of a chief of sector who acted as a social care specialist. Daily schedule, to include time to wake up, time to

arrange and clean the rooms and common areas, time for educational and professional work etc., was posted.

Social activities were completely absent in Saranda penitentiary institution, due to lack of common facilities where they could take place. There was no library in this institution.

The examination of the psycho-social documentation, such as monthly reports on the activity of the sector, psycho-social files and the individual treatment program were in place and kept in a locker, although their content was formal, because lack of common facilities made it impossible for them to be organized.

There were two pre-detainees working in the kitchen in Saranda penitentiary institution.

Healthcare service

The structure of the healthcare sector was not complete. It was composed of a chief of sector, a part time physician, and three assistant physicians but there were no pharmacists and dentist.

During the visit in the institution, we noticed many complaints about the healthcare service. All the pre-detainees claimed that the physician did not respond in time to their requests for medical visits, there was shortage of medicine for chronic and acute diseases, and therefore medicine were mainly provided by their families. Additionally, many complaints were related to the stomatological service, which according to the managing staff of the institution was provided by a school dentist, in compliance with a contract concluded between the Director of the Institution with the State Stomatological Service. However, according to the claims of the pre-detainees, they were not provided with this service at all. During the visit we ran into cases that needed intervention since a month and they were provided with none.

The institution did not have an auto-ambulance.

The examination of the healthcare documentation, specifically physician's documentation, showed that there was a register of files and a register of hospitalization at the town hospital, but we did not manage to examine the register of the physician's visit which according to the staff was located at the archive but the archive specialist was not in the institution. This is contrary to the standards, because the medical visits register must be administered and filled in only by the physician of the institution. None of the registers examined was secured confidentiality. Whereas the medical files that were not locked, were photocopied because the institution was not provided with the forms by the GDP. We did not find any medical checks forms in the institution, whereas the nurses' 24 hour information registers were in order.

Only 36 pre-detainees were provided with healthcare booklets. The rest who were just accommodated in the institution awaited the completion of the relevant documents in order to be provided with healthcare booklets.

The medical reimbursement scheme was not operational and almost all cases under medication, were prescribed a report and the medicaments were provided by the families. There was an extreme shortage of emergency medicine.

As for the above, the following was recommended:

1. Taking measures to address the issue of the premises made available to the District Commissariat of Saranda, in compliance with the agreement between the Minister of Justice and the Minister of the Interior. Under the conditions of overcrowding and shortage of premises which hinders the provision of necessary services to the pre-detainees, the exclusion of this penitentiary institution from this agreement would be the right solution and it would enable the complete refurbishment of Saranda Penitentiary Institution with the purpose of meeting the requirement and standards posed by the legislation in force and the European Convention on Human Rights.
2. Taking immediate measures to address the overcrowding situation, in respect of article 24 of Law no. 8328, "On the rights and treatment of the Prisoners and Pre-detainees", as amended, which provides that every convict is entitled to a separate bed and an appropriate bedding set.
3. Taking measures to make sure every room provides at least 4m2 living space per person, and to improve the hygienic-sanitary and humidity conditions of the institution facilities.
4. Taking measures to equip, adapt and create living conditions in the observation/solitary room, in accordance with the standards set forth by the legal framework in force and the General Prison Regulations.
5. Taking immediate measures related to administration and management of the registers of disciplinary measures and pre-detainees' personal files by the legal sector and not by the psycho-social one. .
6. Taking measures to make sure the education sector observes rigorously the order of the GDP regarding the process of complaint/requests handling.
7. Taking immediate measures to provide the kitchen with refrigerator, aspirator and boilers and to preserve food samples in the fridge.
8. Taking immediate measures to provide the pre-detainees with personal hygiene products and detergents.
9. Taking immediate measures to fully repair the showers and toilets, and to improve their hygienic-sanitary conditions.
10. Taking measures to provide the pre-detainees with a shop where they can purchase products based on their needs.
11. Taking measures to arrange for common facilities where the psycho-social care staff can organize religious, cultural and sports activities for the pre-detainees.
12. Taking measures to add to the structure a full time physician, in order to provide an efficient healthcare service.
13. Taking measures to add a dentist and a pharmacist to the structure in order to provide for an adequate dental service and an efficient healthcare service in general. .
14. Taking measures to provide the Institution with an auto-ambulance.
15. Taking immediate measures to make the medical reimbursement scheme operational.
16. Taking immediate measures to provide the pharmacy with emergency medicaments and medicaments for chronic diseases.

17. Taking measures to make sure only the physician/assistant physician are responsible to administer and fill in the medical checks registers.
18. Taking immediate measures to ensure secrecy of the registers administered by the healthcare sector.

5.23. Vlora penitentiary institution - Dated 13.11.2014 / Doc. No. 201402366

Preliminary remarks

The monitoring visit of NPM staff took place in a spirit of cooperation. The Director of the Institution facilitated the external and internal inspection of the institution in compliance with the general Human Rights Standards, the regulations and without posing any obstacles to meet all persons and visit all premises. The main objective of the monitoring visit was the assessment of the conditions and the treatment of the prisoners/pre-detainees.

Based on order no. 329, dated 15/ 01/ 2009, "On the categorization of the enforcement institutions of criminal sentences" as amended, the Penitentiary Institution of Vlora is categorized as a "pre-detention institution, with a pre-detention section for juveniles and an ordinary security section". The maximum capacity of this penitentiary institution is 115 persons. At the time of the inspection, the institution was housing 197 prisoners/pre-detainees, marking an overcrowding of 82 persons.

The monitoring group met first with the Director of the Institution who presented the current situation of the institution. The Director noted as one of the main issues of this institution the overcrowding. At the time of the inspection, the prisoners divided in categories were as it follows: 28 juveniles and 169 adults, among which 14 were 18-21 years old, 2 persons with mental health issues and 8 persons suffering from chronic diseases. Vlora penitentiary institution offered employment opportunities to 21 pre-detainees.

At the time of the inspection in the institution there were persons under disciplinary sanctions. Five of them were juveniles and they were accused of possession of forbidden items and two adults were accused of insubordination against the security personnel of the penitentiary institution. According to the Director, one of the most concerning issues apart from the overcrowding were the juveniles, most of which were recidivists.

Treatment

In respect of the Human Rights for Dignity and Prevention of Torture, the monitoring group met and contacted the pre-detained juveniles, the 18-21 years old pre-detainees and the adult pre-detainees. The juvenile pre-detainees were accommodated in a section detached from the other pre-detainees. They carried out airing and joint activities separated from other adult pre-detainees. Whereas the 18-21 years old pre-detainees were grouped in separate rooms but in the same sector with the adults and they would carry out joint activities together.

The interviewed juveniles complained about sporadic cases of use of physical and psychological violence against them by the security personnel of the institution. According to them violence was not premeditated, but it was a punishment for disciplinary breach or fight amongst minors. Also, they complained during the conversations and confidential interviews, that they were given frequently long disciplinary sanction which were executed in the solitary rooms located in the first floor of the building. Juveniles felt threatened and under psychological pressure by the psycho-social staff: in case they misbehaved or broke the silence in the institution they were punished with up to 20 days of confinement in the solitary room.

Juveniles complained that in special occasions they were taken to locations with no camera coverage where the security personnel exercised psychological pressure and physical violence against them. The alleged facilities were the meeting room with the attorney, the column and the stairs on the way out from the institution. The monitoring group verified and indeed found that there was no camera surveillance of these locations.

At the time of the inspection, juveniles were found physically divided into two groups/sections and they were collectively punished with expulsion from the foreseen 3 hours a day time in the open air (according to the legal provision). Airing was provided for only 30 minutes a day to each group because the personnel and the psycho-social staff claimed that the two groups of juveniles were in a conflict with each-other and it was not possible to hold joint activities for security reasons. The conversation held with the juveniles and then with the psycho-social staff showed that the conflicting situation between the two groups and the police staff started a month ago as a result of a fight attempt and an intervention of the police to stop it. Following this situation, the police conducted searches and found forbidden items in the rooms of the juveniles. As a preventive measure it was ordered physical separation of the juveniles in two groups and also disciplinary sanctions were imposed.

The monitoring visit conducted in the other 3 sections of the pre-detention facility and the confidential interviews with the adult pre-detainees in their rooms, showed many problems. During the monitoring of the solitary/observation rooms, the monitoring group found out a case of use of restriction tools (handcuffs) and use of the truncheon in the seclusion room. The interviews conducted with the security personnel and the secluded persons showed that pre-detained K. Xh and L. Z were physically violated by the members of the security personnel when they were being escorted to the solitary rooms following a verbal conflict with a security staff. NPM experts noticed two truncheon marks on the left shoulder of pre-detainee L.Z which were confirmed also by the expertise of the institution's physician.

Security staff A.K confirmed seclusion and handcuffing of the pre-detainees. He reported in the interview record that: "the above mentioned persons once handcuffed were escorted from the airing space to the seclusion rooms and we left them handcuffed because they continued to manifest aggression as they continued to curse the police employees".

NPM considers that handcuffing the pre-detainees inside the solitary room is unacceptable and can be considered as a degrading and inhuman treatment, given that it is implemented in a high

security facility with trained personnel that is all the time present. This behavior is considered by international standards as punitive and non-proportional practice.[13]

Regarding the findings of the monitoring group about the excessive use of physical force and use of truncheon against the pre-detainees K. Xh and L. Z, leaving them with visible marks, on 13.11.2014 around 12.00 hours, while they were escorted to the solitary rooms we notice that: Such practices are unacceptable and people who engage in practices of physical ill-treatment of or use of excessive force against the pre-detainees must be hold responsible. Management of the institution must undertake concrete steps to eradicate cases of physical mistreatment of the prisoners by the security staff by improving the management and supervising mechanisms. Quick and effective investigation which identify and enable disciplinary sanctions against persons responsible for ill-treatment of the prisoners, are essential in giving a real value to the principle and legal requirements to prevent torture, degrading and inhuman and punitive treatment in our prisons.

The conditions of the solitary/isolation rooms, where the pre-detainees were kept under disciplinary sanction, were very poor and did not meet any standard for the human and dignified treatment of the pre-detainees. Two of the isolation rooms, where some persons were accommodated, were not provided with stools or mattresses. Pre-detainee F.R., was given the disciplinary sanction of 20 days of solitary confinement due to an offence against the medical staff. According to the information provided by the physician of the institution, the pre-detainee displayed issues of mental health, therefore keeping him in such conditions for such a long period of time, was a breach of human rights and fundamental freedoms. The conditions of the room where he was kept were very poor. He was not allowed to shower, even though he had been in seclusion for 6 days. Food was served in the room in very undignified and non-hygienic conditions.

Safeguards

At the time of the monitoring visit, Vlora penitentiary institution was overcrowded. The Director of the Institution confirmed that the overcrowding was even higher on the days prior to the monitoring visit. Pre-detainees of Vlora Penitentiary institution were divided in sections for juveniles and adults. Due to overcrowding, there was no separate section for group age 18-21 years old. They were sharing the same sector with the adults, but in separate rooms, with exceptions, as explained above. Juveniles carried out airing and other joint activities separated from other age-groups.

The experts were informed about the admission of the pre-detainees/prisoners at the institution, the functioning of the Admission Commission, and the registers and personal files. The discussion with the Director of the Institution and the verification of the files showed that the admission procedure was carried out in a proper manner.

Regarding disciplinary sanctions at the time of the inspection, the visit carried out at the juveniles' sector showed an inconsistency between the persons found in the rooms and the sanctions imposed according to the records of the registers. There was a special room in the

[13] Hungary: CPT Visit 2009[par.57]

juveniles' regime which was used as a solitary room for juveniles with bad behavior or juveniles subject to disciplinary sanctions. The disciplinary sanctions such as seclusion/isolation, as provided for in article 53 of the Law no. 40/2014 "On the rights and treatment of Prisoners and Pre-detainees", imposed to juveniles were not always reflected in the register of disciplinary sanctions.

In this regard, NPM is concerned about the juveniles put in seclusion for 20 days, because this may compromise their physical and/or mental integrity. NMP notes that these measures are to be considered exceptional and they must be given for the shortest term possible and that the minors must be always guaranteed human contact, access to reading and airing every day. Council of Europe Committee for the Prevention of Torture (CPT) 14 recommends the Albanian authorities in the report of 2010 that the disciplinary sanction such as a solitary confinement regime is a measure which can easily compromise their physical and/or mental integrity; consequently, resort to such a sanction should be regarded as an exceptional measure which should be used only for very short periods (preferably, for a period not exceeding three days15.

All disciplinary procedures against juveniles must be followed by official guarantees and be recorded in the respective registers. In particular, juveniles must be given the right to be heard for the offence they allegedly have committed and to appeal to a higher body against such sanctions; full details of the sanctions must be recorded in a special register of the penitentiary institution. Juveniles must be informed in writing about the offences and charges against them, and must be systematically provided with a copy of the disciplinary commission decision, which must include information about the legal remedies in a higher instance. Regarding the educational measure and its termination time, the legal procedures which embody an educational role must be observed.

In this regard, Vlora penitentiary institution must take into consideration the recommendations of the GDP for the implementation of the good European practices in the area of juvenile justice, on the implementation of alternative disciplinary sanctions instead of the "solitary confinement regime". In the course of the inspection it was found out that the new disciplinary educational measures were not taken into consideration by the educational staff and were not implemented in accordance with the disciplinary educational policies for juveniles, as set forth in the administrative guidelines of the GDP. The educational measures, due to their pedagogical role must be used more frequently and possibly to substitute the other disciplinary measures foreseen for adults. Additionally, these measures must be given in a fair, just and unbiased manner. The procedure must be transparent and the juvenile must be heard and must be given the opportunity to explain his reason and actions. The procedure must be simple and easy to understand by the juvenile:

a. Suspension/expulsion from the educational activity from 10-15 minutes up to 25-30 minutes in case the juvenile has not reflected. (This measure is imposed by the educational personnel).

[14] Albania: Visit 2010 [par. 98]

[15] 18th General Report of CPT (CPT/ Inf(2008)25), para 26.

b. Expulsion from any of the favorite activities of the juvenile for no more than 50-60 minutes (The educational personnel upon the approval of the Chief of Social Care sector may impose such measure).
c. Expulsion from daily group activities and staying in the room during the day. In such a case, time spent in the room cannot be longer than 15 hours (this measure can be given by the Director of the Institution based on the written report of the Chief of the Social Care Sector).

The verification and the inspection of the documentation showed that everything was registered and given a protocol number. The Sector of Education was in charge of the registers. The pre-detainees filled in a complaint/request form which they submitted to the educational staff in an envelope. The latter submitted it to the protocol office. Afterwards the complaints were submitted to the Director of the Institution who provided a written answer or met with the prisoners.

Telephones were operational all the time and the interviewed prisoners confirmed that they could speak anytime they wanted with their relatives via the public payphones located in the regime facilities.

Material conditions

The monitoring group gathered information and monitored various aspects of the material conditions of the pre-detainees in the institution with the main focus on: overcrowding, living conditions, food, lighting, ventilation, personal hygiene, sanitary conditions, clothing etc.

The infrastructure of Vlora penitentiary institution was relatively new. The institution was provided with a functional ventilation and aspiration system. Nonetheless, the experts were informed that even though the ventilation and aspiration system are functional, they are used only for limited periods of time.

Given the relatively new infrastructure of the institution, the living rooms were provided with indoor toilets (WC and sink) whereas the shower facilities were shared. Regarding water supply in the living rooms, the directorate informed the experts that this issue had been taken care of by installing water tanks. The pre-detainees did not express any concern in this respect.

The pre-detainees complained about the difficulties to take shower especially during winter season (there was no heating in the shower facilities). The monitoring group verified the showers and according to the verification some of them were not operational as they were missing tap-heads and shower heads.

Visits of the residential rooms of the juvenile sector showed that the toilets, furniture and hygiene were far from being satisfactory. Mattresses were in very bad shape, and linen, blankets, towels and detergents for juveniles were provided by the family members. The poor conditions of the rooms did not contribute to their path towards rehabilitation. The toilet doors were damaged and in some rooms they were missing, therefore they were replaced with sheets or old covers. Plastic stools were damaged most of the time. Juveniles mainly complained about

the poor room conditions, mattresses, shortage of personal hygiene products and detergents to clean the rooms and toilets. Issues in the living rooms were also the absence of electric plug covers, exposed electricity wires which posed a threat to the life of the juveniles because they were not meeting any technical security standards.

Very few of the juvenile rooms were provided with TV sets. Juveniles claimed they were delivered by the staff of the institution, but only some of the rooms benefited from the distribution.

The equipment of rooms inspected in the adults sector was somehow in place, but there were some rooms, which due to overcrowding did not provide adequate living conditions. In most of the rooms, at least one pre-detainee was sleeping with a mattress on the floor due to lack of beds.

Findings related to extreme overcrowding of Vlora Penitentiary Institution, apart from the issues of structural deprecation of the buildings and deterioration of the services provided to the freedom deprived persons, raise the concern of national and international institutions regarding respect of human rights in a democratic country.

The overcrowding situation of Vlora penitentiary institution with approximately 80% over the official capacity brings about the violation of a series of rights, because due to overcrowding not only there is less living space per prisoner, but also less services are provided. Under the conditions of a limited number of personnel, the services they provide are less qualitative. Therefore, moving around the room and in joint facilities was restricted and the pre-detainees were unsatisfied with the educational and rehabilitation programs which were very poor due to overcrowding.

Not all cells were provided with TV sets and refrigerators. Generally speaking all rooms were provided with tables but there were no stools for the pre-detainees. The conditions of the toilets and hygiene was very poor. Most of the toilets were missing their doors or the doors were damaged and they were replaced by the pre-detainees with old sheets.

The situation of the joint facilities was completely different: they were provided with all necessary equipment and the level of hygiene was satisfactory.

Food was served in 3 meals according to a defined schedule. Pre-detainees complained about the quality of food. The complaints were compared with the official kitchen documentation and the food quality was verified. The finding was that food meets the legal requirement. The kitchen met the required standards in terms of hygiene. Food was prepared as per daily planning and approved requests, cooking measurement and calories per person were posted. Food samples were properly preserved in the fridge, they were secured for 24 hours and afterwards were substituted with samples of the served food.

Regime and activities

The experts were informed by the pre-detainees that their right to have contacts and talk on the phone with their family members were properly observed. Phone calls upon request were hold every day. They lasted 5-20 minutes and were conducted from 08:00 to 14:00 hours.

The monitoring group visited also the visitation rooms, which separated with glass barriers the pre-detainee from the family members. Our observation showed that there was no visiting room equipped especially for meetings with children. Usually a facility that was a bit more open and that offered a bit more opportunity for physical contact was used, and in some special cases meetings were held in the attorney meeting room.

The experts monitored the placement of the request-complaint boxes and the respective box for the Ombudsman, and all was found in order.

Cultural and artistic activities for adults were very rare. Pre-detainees could attend the gym on a pre-determined schedule and they could play football twice a week.

The right of religion was respected and there were two rooms in the institution for religious practices (church and mosque). There was also a cinema room located in the juvenile's sector, but it was not always operational due to technical flaws of the equipment.

The monitoring group found that the educational sector was really committed to implement their educational plans in the juveniles sector. Juveniles declared that they attend regularly various activities and vocational training classes for electricians, IT and English language classes. Their division into two groups affected the quality of the activities because classes were repeated for both groups. At the time of the inspection, they were preparing the next cycle of the classes; the persons to attend were already identified and two more classes were added: barber and cook.

Additionally, apart from time in the air that was reduced to only 30 minutes a day, juveniles were involved in other activities that they tried to attend regularly. These activities were group discussions, watching movies, IT lab in the PC room and various games such as: ping pong, soccer etc.

Another important activity taking place in this Penitentiary institution is the compulsory 9 year education. There were classes provided with the adequate equipment to carry out this activity. Teaching was provided by two teachers who followed with the approved program. Teaching hours were from 08:30-11:30 and 18 juveniles attended the classes.

In the course of the meeting with the psycho-social care sector staff, we noticed a good communication and cooperation spirit among them. The inspection group was informed about the activities and programs implemented in the institution, and a few selected psycho social files belonging to all three categories: juveniles, pre-detainees and 18-21 years old were examined. Individual treatment programs and notes about joint activities were found in the psycho-social files. Periodical appraisals were filled in properly.

When asked about the situation of the juveniles' sector the staff responded that they were aware that the sector had been divided in two groups by the security personnel to avoid potential conflicts. Whereas exemption of all juveniles from the ordinary airing of 3 hours a day had been considered as a temporary measure to avoid conflicts and they were working on organizing group meetings and joint activities in order to increase group cohesion and mitigate conflicts among juveniles. The organization of discussions in groups and movies in groups were the immediate initiatives that this staff would undertake to help the juveniles.

Health Care services

The organisational set-up of this sector had vacancies. It consisted of 1 part-time physician, 4 ass/physicians, 1 dentist and 1 pharmacist.

From the inspection visit in this IECD and interviews with prisoners, the inspection team noted many complaints about the health service - involving mainly treatment - that was covered with medicaments supplied by their families. There were also claims about delayed response to the requests by prisoners / pre-trial detainees for medical visits – particularly in the section of minors – but this was justified by the staff with the fact that the physician was employed on a part-time basis. The prisoners / pre-trial detainees complained also about the stomatology service, claiming that it was deficient. The dentist there dealt only with emergency treatments, whereas dental filling and more specific therapies were missing. This was attributed to the significant shortage in dental materials.

As for the alleged violence mentioned above, the physician saw the violence marks on the body of L.Z. and followed the procedure to fill out the relevant documentation, both the medical check form and the registry of violence cases, a copy of which was obtained by the NPM expert group.

In this IECD, there was a 4-room building used as hospital. Rooms had good-quality furniture, an examination bed each and good hygiene and sanitary conditions. There was no prisoner / pre-trial detainee hospitalised there at the moment of the inspection.

The inspection team found the physician's room, dentist's room and the pharmacy. The physician's room had an examination bed, table, chair and a locker where medical files were kept under lock. The dentist's room was tidy and equipped with a couch, a functional unit, but lacked an autoclave and basic dental materials. Also, the pharmacy was tidy, but a small share of medicaments was obtained from the General Directorate of Prisons, whereas the rest had to be obtained through the reimbursement scheme which had stalled in this institution. As regards the complaints of those interviewed about full coverage with medicaments from the institution, the pharmacist claimed that prisoners / pre-trial detainees opted for "more expensive and better" medicaments, and consequently they were obtained through their families.

It should be noted that the physician had paid particular attention to mentally-ill patients, with frequent consultations and time-to-time assessment of diagnosis and treatments, covered by the psychiatrists of Vlora district.

The institution did not have an ambulance.

Examination of the documentation of the medical staff in general, and the physician in particular, the inspection team saw a registry for medical visits, a registry of treatments, a registry for specialised examination in Vlora Regional Hospital, a registry for mentally-ill persons and abusers of narcotics / alcohol, a registry of persons refusing therapy, a registry of 24-hour information for nurses, which were all coded and kept in order. Medical files were also kept in order and inside a locked locker.

A problem in this institution was the lack of medical cards for prisoners / pre-trial detainees, with only 20 of them having such completed cards. The others were incomplete, due to the lack of ID documents or delayed transfer from institutions where they previously served their time. Consequently, the reimbursement scheme is not applicable and this led to difficulties in obtaining medicaments through this scheme.

As for the above, the recommendations included:

1. Take immediate measures to reduce overcrowding in Vlora IECD, aiming for each cell to have at least $4m^2$ living space per person.
2. Take immediate measures to address the overcrowding issue, in respect of Article 24, Law No 8328, dated 16.04.1998 "*On the rights and treatment of prisoners and pre-trial detainees", as amended,* and ensure that each has an individual bed and appropriate sleeping uniform.
3. Take immediate measures by the Head of Institution to dismantle cases of physical maltreatment by the security staff, by improving management and oversight mechanisms which ensure that persons who physically maltreat pre-trial detainees or use excessive force are brought before justice.
4. Take immediate measures to put an end to the use of handcuffs inside the confinement premises as an unacceptable practice that can be considered degrading and inhumane treatment of prisoners.
5. Take immediate measures to stop collective punishment of minors, consisting in the reduction of the yard time from 3 hours to 30 minutes per day.
6. Take measures to prevent the practice of placing minors in conditions that are similar to solitary confinement up to 20 days, as it may compromise their physical and/or mental integrity.
7. Consider taking disciplinary measures for confinement of minors as rare cases, and use the shortest periods possible (no longer than 3 days, preferably).
8. Take measures on the introduction of educational programmes for minors, valuable for their pedagogic function, which should possible replace disciplinary measures foreseen for adults.
9. Take immediate measures to ensure that disciplinary procedures applied for minors are accompanied by official procedures and recorded in the relevant registries, will the full details of such sanctions recorded in a dedicated registry.
10. Take immediate measures to organise group activities for minors that foster their group cohesion and dialogue, in order to promote reconciliation and generate socially solidarity situations, as well as intended to prevent conflicts and incidents in the yard-time and common premises.

11. Take measures to use and keep open the TV room for minors who lack a TV in their rooms, not only during the morning hours, but also during the evening activities.
12. Take immediate measures to improve living conditions of minors' rooms, repair toilets and improve hygiene in rooms.
13. Take immediate measures to provide basic hygiene kit and detergents to minors and adult pre-trial detainees.
14. Take immediate measures to clean confinement rooms and furbish them with tables and stools, in order to enable humane feeding and basic living conditions.
15. Take immediate measures to install surveillance camera in the corridor to the entrance of Building "A".
16. Take immediate measures to fill the vacancies of the health services sector with one full-time physician, at least.
17. Take measures so that the physician establishes more frequent contacts with prisoners / pre-trial detainees, particularly with minors as a vulnerable group serving time in this IECD and given the needs they manifest, as well as for timely response to their needs for medical visits
18. Take measures to supply the dentist's cabinet with an autoclave and dental materials, and provide an adequate stomatology service that intervenes in time.
19. Take measures to secure an ambulance.
20. Take immediate measures to supply all prisoners / pre-trial detainees with health cards.
21. Take immediate measures to introduce the medicament reimbursement scheme and ensure regular supply of such medicaments.

5.24. Tirana Special Penitentiary Health Institution - Dated 09.12.2014 / Doc. No. 201500083

Preliminary remarks

As stipulated in the inspection procedure, the expert team authorised by the Ombudsman initially met the Head of the institution, who expressed his availability to cooperate in accomplishing the purpose of the inspection. The Head provided access to the expert team, in line with rules and free of any impediments, to meet all the persons and inspect all premises required.

The Head noted that pursuant to Order no 3187/2, dated 13.06.2011, the name of this institutions was changed from "Penitentiary Hospital Centre" to "Special Penitentiary Health Institution", and a copy of such order was taken as evidence by the NPM team. Also, a section for "collaborators of justice" was added pursuant to this Order.

The Special Penitentiary Health Institution has an official capacity of 99 persons. On the inspection day, there were 97 patients, two of whom for specialised visits: one on the Trauma Hospital Centre and the other at the University Hospital "Shefqet Ndroqi". There was no overcrowding in this institution.

The Special Penitentiary Health Institution treated prisoners with security measures *compulsory treatment* or *temporary hospitalisation* delivered by the respective courts, witnesses of ongoing trials and prisoners waiting to perform forensic examination. The rest of prisoners / pre-trial

detainees present at this institutions had been brought there for more specialised treatment for various pathologies manifested in their IECDs. The main service provided in this Centre is health care and psychosocial care.

The inspection team found 51 mentally-ill patients in this Institution, of whom 19 were under *compulsory treatment* and 23 under *temporary hospitalisation.*

This Institution lacked a particular section for minor or 18-21 year old persons. There were not prisoners / pre-trial detainees of this category at the day of inspection.

The Special Penitentiary Health Institution had no division in the sector for pre-trial detainees or prisoners; rather, the division was made by their condition, i.e. in three wards: Pathology, Psychiatry and Infective Diseases.

The Pathology ward had 15 patients hospitalised and 3 patients in the observation room used for more serious cases needing continuous monitoring by the medical staff.

The Infective Diseases ward had 15 patients. It also had a special sector with 6 rooms, serving for the hospitalisation of women patients. At the day of inspection, there were 5 women under *compulsory treatment*

The Psychiatry ward had 34 patients. It had 10 rooms.

The organisational set-up had no vacancies, and the Director noted that it is necessary to add the security staff for escorting and transportation of patients under security conditions to the other sections of QSUT, according to the need for specialised visits for these patients. The medical sector was complete with physicians of various profiles, while the Director said that more nurses and wardens are needed.

From the information obtained from the Head, there had been no serious occurrences in this Institution.

The inspection team found that the building where patients were kept was quite dilapidated, with a high level of dampness in all its premises and lacking any heating systems.

Treatment

The inspection team's objective was to collect information on treatment of patients (prisoners / pre-trial detainees), identify cases of psychological pressure or use of excessive force in violation of legal provisions. The information obtained from group and private discussions with them, the inspection team did not find any case of psychological pressure, excessive use of force or flagrant case of torture.

In the Tirana Special Penitentiary Health Institution, the inspection team received complaints about the hygiene conditions in rooms and toilets, and about the lack of a .

Two uncovered premises of 10-12m^2 served for yard time in this institution.

Common premises that are supposed to provide for development of individual skills, social and sports events, individual and group counselling were lacking.

This institution lacked a shop where prisoners / pre-trial detainees could buy grocery items as per their needs. Consequently, such items where provided by their families, after being subject to control as stipulated in the regulation.

It had a dedicated premise for patient-family meetings, situated at the entry of the regime. There was a room for such meetings, unsuitable because of the lack of tables and chairs. Persons had to stand on foot during the meetings, on both side of the barred door.

Safeguards

The Reception Commission functioned normally. Data were recorded in a dedicated registry. Specialised physicians played the main role in the reception and admission of persons in this Institution, because one of the primary principle here is provision of specialised health care service.

As regards security, IECD Tirana had camera surveillance in the outdoor and indoor premises, including corridors.

Meetings with families took place 4 times per month, in a particular premise designated for this purpose. The room did not meet the specific conditions for meetings with minors.

There was an applications / complaints system managed by the Psychosocial Sector, which forwarded them to the Director of the Institution. The latter reviews them and issues a verbal or written reply within 24 hours, through the social workers or educators. There were no complaints about the time of reply by the Head. The whole procedure followed by the Education Sector was documented in an applications / complaints registry properly maintained by this staff.

Physical restraint means included some leather straps used very rarely and in extreme cases under the recommendation of the psychiatrist, as the staff said.

Patients treated in this institutions were allowed 8 phone calls per month.

A problem across the wards was the lack of electronic bells in the patients’ rooms, which hampered normal communication of patients with staff, in case of their urgent need for assistance.

Material conditions

As confirmed by the Head of the Institution and by previous inspections, the premises under regime continued to be extremely dilapidated and significantly damp.

The building was constructed many years ago and investments for its reconstruction were rare. The Head informed that recent investments focused on the renovation of the management premises and the external repair & waterproofing of the building, while he had frequently asked for funds for complete renovation.

It lacked a central heating system, as the inspection team immediately found. Although temperatures in the external premises were tolerable, there was a significant change of temperature at the hospital entry, because patients were not allowed to use other heating appliances in their rooms. For this issue, the Head said that there is an agreement between the Ministry of Health and the Ministry of Justice, according to which QSUT "Nënë Tereza" had the obligation to provide heat to the Special Penitentiary Health Institution. Repeated requests by the Head to QSUT calling for observance of the agreement had proven futile. Heating was missing in all the premises of this Institution.

The Pathology word was on the first floor of the internal regime. It consisted of 8 rooms with *en suite* toilets whose hygiene and sanitary conditions left much to be desired. There was a person with disability in room 2, diagnosed with multiple sclerosis. It should be noted that facilitated conditions were provided to him, for personal needs in the room and, through the corridors leading to the yard.

There were four showers at the end of the corridor, with only one having a shower head. They could shower several times per week without any schedule, but patients in confidential interviews complained about frequent lack of warm water.

Nearby, there was a premise with 4 functional phones. In addition, there was the counselling room of the Education Sector where individual counselling and social topics for small groups of patients took place. This part of the ward included also a yard-time premise.

The Infective Diseases ward had 8 rooms, one serving as observation room. Hygiene and sanitary conditions in these rooms were inadequate, cramped and damped. Toilets and showers were extremely worn. The showers had a bathtub and two posts, with only one being functional. This ward included a site for yard-time, with similar surface area and conditions as that in the Pathology ward.

The Psychiatry ward had 10 rooms with many lacking tables and chairs. Sheets and mattresses were too old and damaged. The staff informed the inspection team that this was a common problem in this ward, because the patients themselves did the damage. However, such claim cannot justify the fact that these patients are kept in degrading and inhumane conditions.

Another ward was in the second floor, where mentally-ill patients were kept in one wing, and patients with internal diseases were kept in the other; conditions in both wings fell short of the standards.

Rooms, toilets and showers were extremely worn. However, rooms had toilets, albeit most lacked accessories.

Natural light in patients' rooms was insufficient due to small windows. Equally insufficient was the artificial light in each room, provided by a small lamp placed over the door.

There were no problems with the provision of running water in this institution, while drinking water was bought by patients' families.

From private talks with patients, the inspection team found that provision of patients with items of personal hygiene as soap, shampoo, etc. was sometimes missing.

The kitchen was clean and tidy, but damp as all other premises of the institution. It served to distribute meals in wards, because food was catered through QSUT. Daily menu was posted and food samples were maintained in locked refrigeration.

The laundry room consisted of only two washing machines that were insufficient to cover all needs. For this reason, patient preferred to resort to their families.

The library did not exist in this institution. There were also no places of worship.

Rooms for medical visits inside the regime were divided per ward, with one serving as a forensic room and the other two as examination rooms. As all other premises, these rooms were extremely dilapidated, despite the staff's efforts to maintain them.

Infirmary rooms were also divided per ward. Two were in the Pathology and Psychiatry wards, whereas another served also for surgical procedures. These rooms were kept tidy, but were dilapidated and poorly equipped.

Meeting rooms were inadequate, due to high dampness, fallen plaster and lack of tables and chairs; it also fell short of the standards for meetings with minors.

Regime and activities

The Psychosocial Care Sector was fully staffed. It consisted of the Head of Sector and two education specialists.

Contacts with the Psychosocial Care Sectors and examination of the documentation in Tirana Penitentiary Special Health Institution led to the opinion that activities were scarce, due to the lack of appropriate premises, but also difficulties resulting from the patients' health condition and their chances of being active. However, this institution often collaborated with SHKBLSH (Printing House), the Muslim Community and QSHPLI (Centre for Integrated Legal Services and Practices), which the inspection team deems very useful for the patients of this hospital.

Twice a month, the psychosocial staff organised activities in small groups addressing social topics based on actual topics.

Group counselling was missing, while the staff tried to make individual counselling once a month, with each patient, in line with the working plan or upon the requests of patients themselves. Counselling was provided in the counselling room.

The psychosocial staff said that art therapy took place, based on individual interest and talent. There was also occupational therapy, in the external premises, on gardening, flower planting and watering, etc.

Psychosocial files that included individual treatment programmes were kept in order and locked, in general, albeit records in many were formal. Individual treatment plans were concentrated in persons who had committed attempted suicide and who had abused with narcotic substances.
In cases of mentally-ill patients, the psychosocial staff's intervention plans were not satisfactorily coordinated with the medical staff, this also due to the lack of proper conditions and premises. However, the employees of this Sector were present in the morning rounds/visits made by the medical staff in wards.

Health Care service

The Health Sector was fully staffed. It consisted of 8 specialised physicians, 1 chief nurse, 13 nurses, 1 lab radiologist, 1 pharmacist, 3 wardens and 11 janitors. The Head of this Institution said that it is imperative to have more nurses and wardens.

During the visit, the patients in all wards seemed satisfied with the degree of health care provided and the frequent contacts with the health care staff. This was reflected by requests from patients to stay longer in this institutions, even when their health situation did not allow it. Besides, according to private interviews with patients, consultations in the QSUT services were carried out whenever necessary and their needs were timely addressed.

Infirmary rooms were divided per ward. Two were in the Pathology and Psychiatry wards, whereas another served also for surgical procedures. These rooms were kept tidy, but were dilapidated and poorly equipped. Daily treatment and emergency medicaments were kept in these rooms.

Physicians do rounds in wards each morning, checking on the situation since the previous evening and providing case-by-case consultation and examination.

The pharmacy had significant shortage of medicaments. It had recently been supplied with a variety of medicaments, thanks to additional funds obtained by the Head, as confirmed by the specialised physicians working there. However, the Head noted the difficulties in treating persons with tumours, due to the high cost of tumour medicaments.

The Institution had a new ambulance obtained by the Head several months ago.

Stomatology service was covered by the dentist of IECD "Ali Demi" who conducted weekly visits. He performed his work in a room at this IECD.

Inspection of the documentation of the health care staff, particularly the physician's, the inspection team found that there existed a registry of files opened and a registry of medical visits, properly coded and kept in order. Files were filled out properly by the physicians, providing detailed information on the health condition and daily therapy of the patient. Nurses regularly filled out and updated the 24/7 information registry.

As for the above, the recommendations included:

1. Take urgent measures for complete renovation of Tirana Special Penitentiary Health Institution. Being that it provides primarily health services, conditions and health care treatment for patients must be adequate and in line with the legislation and the European Convention on Human Rights.
2. Take measures to allocate patients in designated sectors for pre-trial detainees and prisoners, as provided for by standards.
3. Take measures to provide adequate and standard-compliant premises for meetings of patients with their adult and minor family members.
4. Take measures to equip each internal-regime room with electronic bell, in order to facilitate patient-staff communication in case of emergency assistance.
5. Take immediate measures to provide heat in all premises, as stipulated in the agreement with QSUT Directorate.
6. Take measures to furbish patients' rooms with furniture, sheets, matrasses, tables and chairs, in order to provide appropriate living conditions, as envisaged in the legal framework in force and the General Regulation of Prisons.
7. Take immediate measures to provide patients with the basic personal hygiene kit.
8. Take measures to fully repair showers and toilets, as well as improve hygiene and sanitary conditions.
9. Take measures to open a grocery inside the institution, where patients may buy basic food items.
10. Take measures to provide common premises for religious, cultural and sports events delivered by the Psychosocial Care Sector.
11. Take measures to recruit additional medium-level medical staff, considering the particular category of persons treated in this Institution.
12. Take measures to recruit an additional dentist to ensure adequate dental service.
13. Take measures to raise a reserve fund for tumour-sick patients, whose treatment requires costly medicaments.
14. Take measures to recruit additional police staff, so that patients are escorted to other hospital centres within QSUT without infringing on the security.

5.25. Rrogozhina IECD - Dated 30.12.2014 / Doc. No. 201500038

Preliminary remarks

The inspection visit by the People’s Ombudsman and NPM staff flowed through a very collaborative spirit. The Director was available and facilitated the internal and external inspection in the Institution, following the rules and without hampering access to persons and premises to be inspected. The main objective of the inspection visit was to assess the conditions and treatment of prisoners / pre-trial detainees.

Pursuant to Minister of Justice’ Order No 329, dated 15.01.2009 “On the categorisation of institutions for execution of criminal decisions" as amended, Rrogozhina IECD is categorised as "...ordinary-security prison with a pre-detention section". With a maximum capacity of 345 persons, it accommodated 462 prisoners / pre-trial detainees at the moment of the inspection visit.

The inspection team first met with the Head of Security who made an overview of the actual situation in the Institution and noted that overcrowding is one of the key problems there. At the moment of inspection, there were 462 persons accommodated: 309 pre-trial detainees and 153 prisoners. Rrogozhina IECD offered employment opportunities to 8 pre-trial detainees and 44 prisoners. These worked mainly in kitchen, garden, cleaning, library, maintenance, etc. There were no complaints about recognition of working days and employment dynamics by interested persons.

There were 2 mentally-ill patients and 5 with chronic diseases who were transported to Tirana Special Penitentiary Health Institution for specialised medical treatment, as well as 20 persons of the group age 19-21 years-old.

There had been a serious occurrence on 28.12.2014; a pre-trial detainee named Qamil Zela had committed suicide at 3:00 A.M. For this case, a working group was sent by the People’s Ombudsman to Rrogozhina IECD on that day to inquire on the circumstances of this serious occurrence further elaborated below.

Treatment

The inspection team visited and contacted with prisoners / pre-trial detainees across all Rrogozhina IECD. They confirmed that their rights related to yard time, meetings with family, phone calls, regular quality food etc. were generally respected.

From the interviews, they complained for physical and psychological violence by the security staff against two pre-trial detainees, Sh.S. and E.G., placed for 30 days under confinement no. 7. They complained that they had been beaten and heavily offended by the IECD police staff on their first days here. They also claimed they were not allowed yard time and had not come out of the room during these 30 days of confinement. The room they had been placed in was only 2x4m, with a small window that did not allow proper aspiration or natural light as required by legal provisions. It had only two beds; no table, no stools and no cupboard for clothes. The pre-

trial detainee E.G. informed the inspection team that he attempted suicide by cutting his wrists two weeks ago, because of heavy psycho-emotional state caused by the conditions and the situation he found himself in.

The confinement section was used to keep prisoners / pre-trial detainees for long periods of time, because of overcrowding, while these are intended for short stays and placement there should follow a decision of the disciplinary commission.

In the confinement room no. 3 was the citizen S.F., sentenced in absentia with 60 days in prison. He had already stayed 7 days in these premises and complained that he had not been informed whether he would be transferred to any appropriate accommodation. Citizen G.H., charged with offences of low social danger (theft of electricity) had passed 40 days in these premises. The Institution's reply to his request for transfer to pre-trial detention regime was that there were no free places. Citizen F.K., 62 years-old, had been in these rooms for almost a month, without any hope of transfer to normal regime. Citizen A.Sh. had been imposed the disciplinary sentence of 20 days in confinement and exclusion from any common activities, but he had already stayed 30 days in confinement and still continued to be kept there.

NPM pays particular attention to persons detained, pre-detained or sentenced for any reason (for disciplinary reasons as a result of their "dangerous" or "concerning" behaviour for the interest of a criminal investigation or security reasons, or upon their own request) and kept in conditions similar to prolonged confinement. The principle of proportionality calls for a balance between the requirements of the case and application of the prolonged confinement regime; such decision can be very detrimental to the persons concerned. Prolonged confinement may result, in some cases, in degrading and inhumane treatment. As a rule, all forms of confinement must be as short as possible.

In case such regime is imposed or applied upon the prisoner's request, the physician's constant presence in the confinement premises is essential, as he/she makes sure that the medical staff regularly perform the medical examination of prisoners. Results of these examinations - including a description of the physical and mental situation and the foreseeable consequences of continuous confinement, must be regularly presented in writing in a statement signed by the physician, to the competent bodies for IECD regime and security issues.

Safeguards

There was overcrowding in Rrogozhina IECD at the moment of inspection; as confirmed by the executives, the number of prisoners / pre-trial detainees had been high all year long.

Pre-trial detainees were kept in a separate section from prisoners. The did yard-time and other common activities separately from prisoners. Due to overcrowding, there was no division for the 18-21 years old persons. They were placed in the same section with adults, but in separate rooms. They engaged in common activities together will adults.

The Reception Commission functioned normally. Data were recorded in a dedicated registry. Specialised physicians played the main role in the reception and admission of persons in this

Institution, because one of the primary principle here is provision of specialised health care service.

As regards security, IECD Tirana had camera surveillance in the outdoor and indoor premises, including corridors.

Meetings with families took place 4 times per month, in a particular premise designated for this purpose. The room did not meet the specific conditions for meetings with minors.

There was an applications / complaints system managed by the Psychosocial Sector, which forwarded them to the Director of the Institution. The latter reviews them and issues a verbal or written reply within 24 hours, through the social workers or educators. There were no complaints about the time of reply by the Head. The whole procedure followed by the Education Sector was documented in an applications / complaints registry properly maintained by this staff.

Physical restraint means included some leather straps used very rarely and in extreme cases under the recommendation of the psychiatrist, as the staff said.

Patients treated in this institution were allowed 8 phone calls per month.

A problem across the wards was the lack of electronic bells in the patients' rooms, which hampered normal communication of patients with staff, in case of their urgent need for assistance.

The experts obtained information about the reception of prisoners / pre-trial detainees in the institution and the functioning of the Reception Commission, as well as about the completion of registries and personal files. From the talk with the Head of Institution and verification of files, the inspection team concluded that the admission procedure in the institution was applied correctly. They also found that everything was recorded in the relevant registry and archived. The registries were maintained by the Education Sector. There were postal boxes inside the regime where you could put complaints / applications. Prisoners / pre-trial detainees could opt for submission of their complaints / applications to the Education staff, who forwarded them to the Head. If not intended for the Head, those were mailed. There were no complaints about replies by the institution, which were usually verbal and within the time-frame foreseen.

Telephones worked anytime and interviewed prisoners / pre-trial detainees said they could talk to their families anytime they wished until 19:00 hrs, through pre-paid phones available in the regime premises.

Meetings with families in Rrogozhina IECD took place regularly, in booths barred from one another. Family members talked to prisoners / pre-trial detainees without the chance of physical contact, as would be the case if meeting around a table in other conditions. The inspection team found that there was no designated place for meetings with elders or minors, who must not meet their imprisoned / detained family members through the bars, but rather in a friendlier environment.

Rrogozhina IECD had 24/7 surveillance camera that covered mainly the exiting corridor at the part of the column.

Interviews and confidential discussions with prisoners indicated that special and compensatory leaves were the cause of many complaints by them. Although many of them satisfied the requirements for leaves, they were hampered by the Instruction No. 103, dated 17.02.2014 of the Minister of Justice on the recognition and implementation of the Minister's Instruction "On disciplining some issues related to the procedure of granting compensatory and special leaves to persons sentenced to imprisonment", which was followed on 3 September 2014 by another Order issued by the General Director of Prisons who calls for strict application of the legal requirements stemming from Law No 8328, dated 16.04.1998 "On the rights and treatment of prisoners and pre-trial detainees", the General Regulation of Prisons, and the Instruction No 103, dated 14.02.2014 of the Minister of Justice asking for changes to the procedure of granting leaves to prisoners for the criminal offences under Articles 100 to 104, which stipulated that leaves require a preliminary approval – for security reasons - from the Police Commissariat which the prisoner meeting the requirements belongs to.

Material conditions

Inspection found that sections for prisoners / pre-trial detainees were furbished more or less, but some rooms did not offer the necessary living conditions due to overcrowding. In Rrogozhina IECD, material conditions in 7 rooms of the confinement section were problematic and not good at all, with a worn infrastructure, extremely damp and hygiene that left to be desired. These rooms were unpainted, unclean and lacked necessary furniture. Even showers in this section did not function normally. Prisoners / pre-trial detainees of rooms 3 and 4 of this section complained that they had not had shower with warm water for a long time, because there was a glitch with the showers 3 months ago and it had not been repaired yet.

The situation in the pre-trial detention sector was worse, particularly in the room 1 of the observation building 3, where there were 23 persons accommodated on the inspection day. This room was 6x7x2.5m big and had 6 beds: 5 persons slept on mattresses on the ground, 2 slept taking turns or in a single bed. Concerning these extreme conditions, the pre-trial detainees in the observation room said that the situation was quite aggravated, because they even ate in non-dignifying conditions, because there was no necessary space for tables and chairs. This case is a serious violation of the legal criteria of surface area and square meters of living space per person.[16] For a similar case of overcrowding in this observation room, NPM recommended on 4.02.2014 that immediate action is taken to address the overcrowding issue in this room, because such situation created the premises for fire in the building and put the life of pre-trial detainees in serious danger. Despite the recommendation, the situation had grown worse, instead of improving.

Findings about extreme overcrowding in the premises of Rrogozhina IECD not only indicate the building's structural degradation and worsening of services provided to persons deprived of freedom, but also sound the alarms of national and international bodies concerning the observance of human rights in a democratic country.

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[16] See Article 22(1) of Decision No. 303, dated 25.03.2009 "On the approval of the General Regulation of Prisons."

The European Committee for the Prevention of Torture (CPT), on the occasion of its visit to Albania in 1997, gave the following recommendations to the Albanian authorities: Prisoners / pre-trial detainees must be accommodated in rooms no less than 22m² in cases of 6 persons placed in one room, and no less than 10m² in cases of 2 persons in one room. Besides, rooms smaller than 6m² fail to meet minimum standards for a prison room and must be put out of service.

The situation in Rrogozhina IECD with around 35% overcrowding above the official capacity leads to the violation of several rights of prisoners / pre-trial detainees, because there is less living space per person and less services provided; in the case of fixed number of staff, there is also lower quality of such services. Consequently, Rrogozhina IECD had brewed the premises for serious incidents and dissatisfaction about the education, recreation and rehabilitation programmes, which, as the inspection also concluded, were vague and insufficient.

Other rooms in the Pre-detention Sector had big windows that allowed adequate natural light and airing. Some rooms were big, but with overcrowding, the space available was reduced and failed to comply with the standards of surface area and square meters per person. In most of the rooms, 2.3 or more persons slept in mattresses on the ground. Rooms had not toilets. There were only common toilets in poor hygiene and sanitary conditions. Each building had 2 rooms with a small corridor which served for cooking for the pre-trial detainees and to go out in the yard.

Prisoners' Sector consisted of 4 one-storey buildings that accommodated 153 prisoners. Each building had 6 rooms separated in two by two in the form of an apartment. There were common toilets for each 2-room apartment and an external corridor for services and cooking. The situation in this section looked somewhat better than in the pre-detention sector, for the simple fact that there were less prisoners than pre-trail detainees.

The inspection found different material conditions in rooms between the pre-detention sector and the prisoners' sector. Certain rooms had heating (even two heating appliances) and others did not have any, partially due to delays in procedures to get heaters inside the institution or because the prisoner cannot afford one. Some rooms had broken windows that allowed cold to get in.

Some rooms had appliances and some not, depending whether the prisoner / pre-trial detainee could afford it.

The inspection found problems with the electrical installations and grid, due to lack of technical safety. In many cases, distribution boxes, temporary installations and exposed electrical connections of shower boilers fell in short circuit and took fire, seriously endangering prisoners / pre-trial detainees. Such a problem was identified also during inspection. Despite frequent repairs, the power grid was extremely worn and overloaded by amateur provisional connections and could not bear the load in buildings.

Water quality was another matter of concern. Information received and on-the-spot inspection found that Rrogozhina IECD took water from wells. Often, the water came out with dirt and too

contaminated to drink. Prisoners / pre-trial detainees complained that water used for showering and washing clothes was too dirty.

Hygiene in corridors, meeting rooms, common premises and the kitchen was relatively satisfactory. On the contrary, toilets in all sections had hygiene conditions out of any standard. Particularly in the overpopulated pre-detention rooms, where there was only one toilet for 19 or more persons, hygiene left much to be desired.

There were only common toilets and showers in all regimes. Some pre-trial detainees complained for lack of warm water and shower accessories (often they showered using cans). Worse was the situation in the observation room, where 23 pre-trial detainees had only one toilet and had no warm water due to a glitch in the boiler. However, there were such complaints also in other pre-detention rooms. The institution allowed them to have a shower whenever they wished, but running and warm water were not always available.

Sheets, blankets and pillow cases of pre-trial detainees and prisoners were washed by their families in the majority of cases.

An essential problem was the presence of parasites, cockroaches and other insects. Although disinfected several times, this problem had not been addressed and the experts noted this during inspection.

From the visit in the IECD kitchen, the inspection team found that quality and weight of food cooked on the inspection day was satisfactory. The daily menu was posted and grams were accurate. Food samples were kept in refrigeration. However, most of the prisoners/detainees did not consume the prison food, but cooked it themselves or their family members brought it. A glance of the menu showed that items were the same each day and did not offer variety, which was raised as concern by prisoners/detainees.

Regime and activities

Rrogozhina IECD offered very few activities in the pre-trial detention section, due also to the lack of space and overcrowding. The library was very poor in title and number of books.

Prisoners/detainees did not have complaints about yard-time. They were satisfied with the yard-time hours which were in line with standards and regulations. Doors were kept open for air from 07:00 to 19:00. Yard-time premises were allowed to be used by detainees only for sports activities, which were allowed following an order and upon request.

Staff turnover made activities more difficult in this institution. The director, head of security, and the head of the health sector had been newly appointed (in December).

Actually, the social care staff was incomplete, because it had only social workers and no psychologist. At the moment of inspection, there were two persons identified with mental-health problems, but for them there were no tailor-made training programmes.

As regards educational and rehabilitation activities in this IECD, NPM experts found that the only activities prisoners/detainees could benefit from was watching TV, table games and football games, when possible. The pre-trial detention section lacked a room for worship, which the section of prisoners did have. There was no counselling room.

The meeting with the Social Care Sector highlighted a good communication and cooperation. They informed about the activities and programmes provided in the institution and enabled the assessment of psychosocial files of prisoner/detainees. Overall, the employees of the Social Care Sector had designed individual treatment programmes. Common activities took place mainly with prisoners, because the detention sector lacked the common promises for this purpose. These were organised in the corridor of each building, whereas counselling took place in the library premises, when it was necessary on an individual basis. Lack of privacy, as a key pre-condition for fruitful counselling, hampered and diminished the work of these employees.

The psychosocial files were filled out properly, with summaries of the last meetings with detainees and prisoners, with individual and in-group programmes, with quarterly performance assessments and other supporting documents.

Health Care services

This sector did not have vacancies. It consisted of 2 physicians, but only one was appointed just one week prior to the monitoring visit by NPM. It also included a part-time dentist, 1 pharmacist and 5 ass.physicians.

There were many complaints by prisoners and detainees about the health service, mainly for the long absences of a physician, which meant that their request for medical visits hardly got replied, albeit the efforts of ass.physicians to ensure visits or consultations outside the institution.

There were many complaints also for treatment of chronic diseases, with many obtaining medicaments from their families. This was mainly due to the non-application of the trilateral agreement among the Regional Directorate of Social Contributions, IECD and “Omega Farma” pharmaceutical depot. They also complained that the stomatology services was poor.

During the interviews at the pre-detention sector, the inspection team met a detainee with amputated right arm and the left door partially functional, as a result of an accident many years ago when he was free. Therefore, he benefited 1rst category invalidity pension. In these conditions, he should have been provided assistance by another person 24/7 for personal needs. During the whole time in Rrogozhina IECD, he was assisted only by his roommates, but still proving insufficient, which had significantly aggravated his condition.

This Institution did not have monthly statistics how many persons were treated for mental health, or for chronic, cardiac, neurological, nephrological, gastro-intestinal conditions etc. The absence of the physician for many years had been the cause of that. But, during the inspection, the newly appointed physician conducted psychiatric visits with 4 persons who, according to him, manifested mental problems.

The medical examination room was furbished, but it was equally worn-out as the rest of the building. The first-aid kit was empty.

The dentist's room was also worn-out. It had a unit and autoclave, while instruments and dental materials he tried to obtain through private channels. Consequently, intervention involved only emergency treatment and pulling teeth. Rarely were there filling or specific dental therapy.

The pharmacy was operational, but a small supply of medicaments were obtained from the General Directorate of Prisons (GDP), whereas the rest should have been provided through the trilateral agreement and the reimbursement scheme. Due to the absence of the physician, the Institution was not supplied with medicaments for chronic patients from over three months. In December, a supply of medicaments were obtained as relief from GDP.

The Institution had an operating ambulance.

Inspection of the documentation of the health care staff, particularly the physician's, the inspection team found that there existed a registry of medical visits, a registry for chronic patients, registry on distribution of medicaments, registry of medicaments supplied from families and the 24/7 information registry of nurses. These were coded and kept properly, except for the registry on medical visits outside the Institution, which was uncoded. Medical files were kept tidy, in order and locked in a locker.

There were no medical check forms.

A problem in this institution was provision of prisoners / pre-trial detainees with health cards. Only 13 persons had obtained them. The reimbursement scheme for medicaments was not functioning, partly because of the stalled trilateral agreement among the regional directorate of Social Contributions, IECDs and "Omega Farma" pharmaceutical depot, which made it difficult to obtain medicaments through this scheme.

Prevention of suicide is another issue within the sphere of competence of the health and social care at penitentiary institutions. These two services must ensure proper awareness-raisng across the hierarchy of the institution and apply their know-how to clearly define preventive procedures. In this context, medical check in the first moment of admission of pre-trial detainees is particularly important, because, if conducted properly, it may identify some of the persons at risk and alleviate somehow the anguish perceived by all newly admitted pre-trial detainees. The prison staff, irrelevant of their position, must be made aware and trained to recognise the symptoms of the suicide risk, particularly in the period immediately before and after adjudication. Besides, the prison staff must be trained to tackle situations of mentally-ill persons that constitute added risk of suicide.

About the death of pre-trial detainee Q.Z. at Rrogozhina IECD on 28 December 2014, the inspection team found that the Psychosocial Sector had spotted signs of aggravated psycho-emotional state since 11 December 2014. So, records were entered in his file, which stated that he had been treated for psycho-emotional problems also in his free life. Also, it was written that the this Sector had kept him under observation on 22 December 2014 because of his unstable

emotional state. The file also indicated that he was under therapy due to the continuous emotivism he manifested.

The Health Sector had treated him with Diazepam for serious psychological problems, but his clinical file did not contain notes about diagnosis, medical visit or a treatment plan and medical observation recommended in such cases. Also, there was no communication and preventive interaction between the psychosocial, health and security sectors concerning this high-risk case identified by one of the sectors.

A person identified as at suicide risk must be kept under observation in medical premises, as long as necessary. Beside, he/she must not be given easy access to instruments that may help in a suicide act (window bars, broken glass, lace, belt, etc.)[17]
Measures must be taken to ensure proper circulation of information in the institution, particularly between the Psychosocial and Security sectors concerning persons identified as potential suicide risk.

As for the above, the recommendations included:

1. Take immediate measures to reduce overcrowding in Rrogozhina IECD, aiming for each cell to have at least 4m² living space per person.
2. Take immediate measures to address the overcrowding issue, in respect of Article 24, Law No 8328, dated 16.04.1998 "*On the rights and treatment of prisoners and pre-trial detainees", as amended,* and ensure that each has an individual bed and appropriate sleeping uniform.
3. Take immediate measures by the Head of Institution to assess and hold persons accountable for lack of coordination between the security and health care & psychosocial sectors on prevention of suicide occurred on 28.12.2014.
4. Take immediate measures to stop using confinement premises for prisoners / pre-trial detainees beyond the time sanctioned by the Disciplinary Commission, and to stop placing in these premises persons who are not subject of disciplinary measures.
5. Take immediate measures to improve living conditions in the rooms of per-trial detainees, repair toilets and improve hygiene in rooms.
6. Take immediate measures to provide confinement rooms with tables and cupboards for clothes, in order to ensure proper feeding and basic standards for dignified and human living conditions.
7. Take immediate measures to repair boilers and provide warm washing water in the confinement and observation premises, and in the other premises where they are dysfunctional.
8. Take measures to repair electrical installations and discipline exposed temporary electrical connections in line with the requirements of technical safety.
9. Take immediate measures for efficient disinfection of accommodation premises of prisoners / pre-trial detainees.
10. Take immediate measures to fill the vacancy of the Health Sector with one physician.

[17] General Report III of the Committee for Prevention of Torture (1992 [par.59]

11. Take measures so that the medical staff establishes more frequent contacts with prisoners / pre-trial detainees and timely response to their requests for medical visits, both for identifying new cases and for following chronic patients.
12. Take immediate measures to transfer any first-category person with disability to the Special Penitentiary Health Institution, where he can get more specialised treatment and continue serving his time.
13. Take measures to supply the dentist's cabinet with dental instruments and materials, and provide an adequate stomatological service that intervenes in time.
14. Take immediate measures to supply all prisoners / pre-trial detainees with health cards.
15. Take immediate measures to ensure application of the trilateral agreement between DRSKSH, IECD and "Omega Farma" pharmaceutical depot, so that the medicament reimbursement scheme becomes fully functional both for chronic and emergency cases, thus ensuring a regular supply of this Institution with medicaments.
16. Take immediate measures to supply the Institution with medicaments, particularly with emergency ones.
17. Take necessary measures, by the competent personnel, to enable individual and group counselling in designated rooms, and to increase the number of social / cultural / sports activities involving prisoners, for rehabilitation, counselling and re-integration purposes.
18. Take measures to equip the meeting premises with the necessary accessories and provide a warm and friendly climate for meetings between prisoners / pre-trial detainees and minor children and elders.
19. Take measures to unify the practice of giving compensatory and special leaves, as provided in Law No. 8328, dated 16.04.1998 "On the rights and treatment of prisoners and pre-trial detainees", as amended, and the General Regulation of Prisons.
20. Take measures to stop the practice of giving compensatory leaves upon satisfaction of a set of criteria and preliminary approval by the Commissariat which the detainee belongs to, as a practice unforeseen in the Law No. 8328, dated 16.04.1998 "On the rights and treatment of prisoners and pre-trial detainees", as amended.

5.26. Recommendation on the overcrowding situation in IECD - Dated 06.01.2014 / Doc. No. 201402452

The National Mechanism for Prevention of Torture has conducted inspection in all penitentiary institutions in Albania, in line with its legal rights and obligation to conduct inspections in penitentiary institutions, and in line with its 2014 work plan.

Inspections identified the number of pre-detained / sentenced persons and the factual situation against the official capacity of penitentiary institutions[18], specifically:

Nr.	IECD	Official capacity (persons)	Number of prisoners / pre-trial detainees at the moment of inspection
1.	IECD Zahari, Krujë	196	189
2.	Minors Correctional Faclity, Kavaja	40	26
3.	IECD Ali Demi (325)	80	91

[18] According to the official letter Prot. No. 9812/ 1, dated 14.10.2014 of the General Directorate of Prisons.

Nr.	IECD	Official capacity (persons)	Number of prisoners / pre-trial detainees at the moment of inspection
4.	IECD Vaqarr	146	164
5.	IECD Kosovë, Lushnjë	189	221
6.	IECD Peqin	685	750
7.	IECD Shën Koll, Lezhë	703	753
8.	IECD Kukës	36	27
9.	IECD Tropojë	25	4
10.	IECD Elbasan	120	212
11.	IECD Jordan Misja (313)	320	543
12.	IECD Durrës	300	384
13.	IECD Fushë-Krujë	312	419
14.	IECD Burrel	198	211
15.	IECD Berat	37	75
16.	IECD Mine Peza (302)	170	237
17.	IECD Drenovë	312	452
18.	IECD Tepelenë	70	160
19.	IECD Sarandë	31	58
20.	IECD Vlorë	125	197
21.	IVSHB Tiranë	99	95
22.	IECD Rrogozhinë	343	462

As the table shows, at the moment of inspection, all penitentiary institutions were beyond their capacity, except for the ones in Zahari, Krujë, the Minors Coorrectional Facility in Kavaja, Kukës, Tropoja. Furthermore, pre-trial detention were all operating heavily over their official capacity.

For each penitentiary institution inspected, NPM elaborated recommendations where the overcrowding issue was included. An overview of the most problematic IECDs in observing the minimum space standards is provided below:

- **"Jordan Misja" Pre-trial detention** had 543 detainees while its official capacity was 320. As a result of this overcrowding, living space for most detainees was less than 3m2 per person. Some rooms 8.8.m2 that accommodated 4 persons, the living space per person went even to 2.2m2. Sleeping on mattresses on the ground was almost the norm in each room.
- **Fushë-Kruja IECD** had an overcrowding of 107 persons, disproportional by section: living space was observed in the high-security and ordinary sectors, whereas in the pre-trial detention there were 8-9 persons staying in rooms intended for 6, of whom 2-3 slept in mattresses on the ground.
- **Rrogozhina IECD** was visited by NPM on 04.02.2014 in order to inquire on causes that led to the fire that put in danger the lives of pre-trial detainees there. Its capacity was 115 persons. But, on 31.01.2014 when the fire started at 20:00 hrs, there were 217 persons accommodated in pre-trial detention. The inspection team found that the room where the fire fell (room 1, building 3) was 6x7x2.50m and had been occupied by 21 persons for several months. In this room, 14 persons slept in 7 bunk beds, 5 other slept on mattresses on the ground, and 2 slept by shifts or two sharing a bed. This extreme overcrowding,

combined with reduced living area and space per person, as well as degradation of services and material conditions at these premises were the main causes of the accidental fire in Rrogozhina IECD.

- **Elbasani pre-trial detention** was opened in 2012 with an initial capacity of 120. Actually, beds were added in rooms to accommodate 143 detainees. On the date of inspection, there were 212 detainees, 69 of which slept on mattresses on the ground. Most of the rooms 3x4m intended for two persons with two beds were occupied by 4 persons, with 50% of them sleeping on mattresses on the ground.

- **Berati pre-trial detention** with a capacity of 37 persons, accommodated 75 at the moment of inspection, with the number even up to 90 some days earlier. Here, the issue of overcrowding was quite concerning, due to total lack of psychosocial activities, adequate yard-time premises and degrading restriction of living space for persons in the living rooms.

- **Drenova IECD** accommodated 140 persons overs its official capacity of 312. Observation rooms and common premises for activities were turned into rooms for detainees, who had been sleeping in mattresses on the ground for many months, in rooms without any furniture (table, chair, or cupboard to put clothes, etc.). 9 persons were staying from 10 months in a recreational room 5x5, and they slept on mattresses on the ground. Whereas the 8 observation rooms with size 2.50x3.50m intended for the accommodation of 2 persons, accommodated 4-6 persons, most of whom without a bed. Due to overcrowding, detainees were deprived of all common activities, including outdoor yard-time as provided by law.

- **Peqin IECD** had around 100 persons over capacity during all 2014, with significant overcrowding in the pre-trial detention sectors. Transfer of 78 detainees from Rrogozhina pre-trial detention to Peqini IECD increased the number of persons deprived from liberty to 861.

- **Durrësi pre-detention** had an overcrowding of 84 persons at the moment of inspection. Rooms accommodated 4, 6 or 7 persons, and most rooms did not comply with the standard of living space per person. On the first floor, many rooms were occupied by 6 persons, 3 sleeping on beds and 3 on the ground, as a result of overcrowding. On the first ground, all the recreational rooms, such as the one for Christian rites, the counselling room, etc. had been turned into living rooms; consequently, they did not have toilets and detainees were forced to use common toilets, including the improvised two of the observation/confinement rooms. Common toilets failed to meet any standard and were in very poor hygiene and sanitary condition. The whole first floor had only two toilets, but no shower, no sink, no running water; just two WC in deplorable conditions without any adequate accessory to discharge water.

In order to assess better the daily inflow in IECDs, besides inspections, NPM sent a request for information to the General Directorate of Prisons on 9.10.2014, on the daily load in each IECD

over a two-week period, from 24 September to 8 October. Statistics obtained in reply of the request, listed according to the days of inspections in IECDs is as follows:

No	IECD	Official capacity (persons)	Date by months														
			Septemb							October							
			24	25	26	27	28	29	30	1	2	3	4	5	6	7	8
1	IECD Zahari, Krujë	196	204	202	203	205	205	207	206	204	203	201	205	205	203	197	199
2	Minors Correctional Faclity, Kavaja	40	55	62	60	59	59	61	60	58	57	59	56	56	53	52	51
3	IECD Ali Demi (325)	80	104	104	103	104	105	104	104	108	108	108	110	110	110	112	112
4	IECD Vaqarr	146	163	160	156	158	157	160	161	162	160	160	161	163	162	163	164
5	IECD Kosovë, Lushnjë	189	232	232	227	232	233	226	225	228	233	233	236	236	235	235	232
6	IECD Peqin	685	768	772	773	774	777	767	768	773	769	769	784	781	772	775	771
7	IECD Shën Koll, Lezhë	703	712	702	698	704	703	707	707	749	749	750	746	748	751	744	744
8	IECD Kukës	36	40	41	42	42	42	41	42	42	42	38	38	38	39	40	40
9	IECD Tropojë	25	5	5	6	6	6	6	6	6	8	9	9	9	9	9	9
10	IECD Elbasan	120	218	210	208	213	215	216	213	213	214	215	220	222	222	217	216
11	IECD Jordan Misja (313)	320	540	539	527	522	524	538	542	493	503	495	494	498	511	521	517
12	IECD Durrës	300	359	362	366	364	364	363	371	375	370	372	375	377	376	373	374
13	IECD Fushë-Krujë	312	425	424	422	426	426	421	419	422	422	423	422	422	419	422	426
14	IECD Burrel	198	219	215	215	213	213	212	213	213	211	211	212	212	209	209	208
15	IECD Berat	37	76	76	76	76	77	78	78	75	78	78	81	82	79	80	80
16	IECD Mine Peza (302)	170	238	234	230	231	229	234	234	233	236	235	231	231	231	229	233

17	IECD Drenovë	312	429	432	432	435	444	444	438	437	437	436	436	441	434	431	433
18	IECD Tepelenë	70	158	159	159	159	153	153	151	150	152	156	156	156	153	155	155
19	IECD Sarandë	31	60	60	60	60	60	59	58	58	60	60	60	60	62	62	62
20	IECD Vlorë	125	189	189	193	191	192	192	186	186	186	186	186	187	189	186	187
21	IVSHB Tiranë	99	91	95	95	90	90	91	94	99	97	91	87	87	92	92	96
22	IECD Rogozhinë	343	444	437	440	445	445	447	444	445	445	445	444	446	455	454	448

As shown above, except for Tropoja IECD and the Special Health Penitentiary Institution, all the 20 IECDs had overcrowding most of the days under scrutiny. Taken as a total, in October there were 1,230 persons over the capacity, specifically 5,767 prisoners/detainees against the 4,537. There was an ever sharper trend in November and December, with factual capacity exceeding 6,000 persons.

Overcrowding issue

Overcrowding is a great challenge for penitentiary administration and the judicial system in general, in terms of observance of human rights and efficient management of IECDs.

Data about overcrowding in prison and pre-trial detention premises in Albania during 2014 not only show the structural degradation of penitentiary infrastructure and reduced quality of services provided to persons deprived of liberty, but raise the concern of national and international about the observance of human rights in a democratic country.[19]

During their visit to Albania in 1997, the European Committee for Prevention of Torture (CPT) recommended that Detainees/Pre-trial detainees must be accommodated in rooms not less than 22 m2 where there are 6 persons, and 10.m2 when there are two persons sharing the room. Besides, rooms smaller than 6m2 do not meet minimum standards for a prison room and should be put out of service.[20]

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[19] Such a case was adjudicated by the European Court of Human Rights in the case of Sulejmanovic v Italy. In their judgement, Strasbourg judges hold that reduction of living space of detainees and prisoners beyond legal standards of contracting countries and under International Conventions constitute a breach of Article 3 of the European Convention of Human Rights. The case refers to a citizen from Bosnia and Herzegovina serving time in Rebibbia Prison, Italy, who claimed to have been subject to inhumane and degrading treatment, as he had been forced to stay for several months together with other 5 inmates in a room 16.20 m2. The Court used the CPT recommendations and standards as benchmarks. In this case, the Strasbourg court held that overcrowding in Rebbiba had been evident and than forcing a person to live in 2.7 m2, so far from minimum CPT standards constitutes degrading and inhumane treatment, as well as Article 3 of the European Convention on Human Rights. According to the judgement, the Italian State must pay a monetary compensation to the prisoner Sulejmanovic for moral damage and inhumane and degrading treatment.

[20] Albania: Visit 1997 [par.127]

Overcrowding leads to the violation of a series of rights of detainees/pre-trial detainees, because it means that there is less space and less services provided, which are even of lesser quality in the case of a pre-set number of staff. Hence, movement around the room or common premises is limited, there is dissatisfaction about the education and rehabilitation programmes, even the food. For the prisoners/pre-trial detainees, overcrowding means less involvement in activities and reduced perception of fair share.

An overcrowded prison results in the emergence / worsening of psychological problems. When a penitentiary institution has more prisoners than its capacity, the chain effect of negative consequences leads in heavy environment in the institution and violent actions by both the prisoners/pre-trial detainees and the security staff. Former prisoners who have stayed in overcrowded prisons find it more difficult to adapt to normal life. So, when they do not fully benefit from the rehabilitation programme or the medical therapy during their stay in prison, they are not ready to return to the community and often fall into recidivism. Prisoners released from overcrowded prisoners tend to have worsened, demonstrated in violent behaviour, use of drugs, problems to establish relations and recidivism.

Not only pre-trial detainees and prisoners, but also penitentiary staff has problems from prison overcrowding. They have less time to tackle the indecent behaviour and breaches of regulation, less resources to tackle crime and violence in prisons, and less chances to supervise and identify dangerous prisoners. Besides, the staff has less time to stay with prisoners / pre-trial detainees and finds it hard to ensure their involvement in education and rehabilitation programmes. Employees in overcrowded prisons are more exposed to the risk of becoming a target of ill-treatment by prisoners.

Approaches for efficient management of overcrowding

Deprivation of liberty through reprimand must not be seen as the first option, but as the heaviest measure delivered only in the cases falling under Articles 228 and 229 of the Code of Criminal, keeping in mind the reasoning of the High Court (Decisions No 8, dated 19.1.2001 and No 46, dated 28.1.1999 of the Criminal College of the High Court which stipulate that: "...for putting a defendant on remand, there must be grounded doubt that he/she could evade trial or execution of the judgement, or that there is the risk that he/she may commit another serious crime or a crime similar to the one accused of…" and "…in opting for the security measure, the court shall weigh each measure against the security called for in a concrete case…".

We encourage measures like semi-freedom, sentence in open prison institutions, etc. Release on parole must be considered one of the most efficient and constructive ways that not only reduce sentence duration, but significantly contribute to their re-integration in the community.

Efforts must focus on reducing long-term imprisonment sentence that are a heavy burden for the system. Sentences by community work must replace short-term imprisonment and judges and prosecutors must be encouraged to apply them as often as possible. For community service to become a reliable alternative to short-term imprisonment, efficient enforcement of these measures must be ensured through adequate infrastructure for their execution and monitoring.

Some crimes/offences might need to be decriminalised or reclassified, in order to prevent sentences with deprivation of liberty.

Emphasis must be placed on human dignity, on the commitment of penitentiary administration to ensure humane treatment, on awareness raising about the role of staff and on modern and efficient management methods.

Human and financial resources must be allocated, and procedural means and managerial techniques must be put in place to ensure efficient and humane application of pre-trial detention and sentence by imprisonment.

As for the above, the recommendations included:

1. Take immediate measures to observe the spirit and provisions of the Code of Criminal Procedure, notably Articles 251 and 255, concerning procedures and JPOs obligations during detention / arrest of persons.
2. Take immediate measures to address the issue of overcrowding and ensure compliance with the Code of Criminal Procedure, Article 259 (3) and (4), concerning time-frames pertaining to detention / arrest of persons.
3. Take measures to obtain funds and ensure standard-compliant renovation as well as operation of the close security rooms.
4. Take immediate measures to address the issue of security rooms inside IECDs, as not a good practice that aggravates the situation of IECDs and the detainees / arrestees.

6. The recommendations submitted under Inspections carried out during 2014 in the District Police Directorates and addiction Stations

6.1. RPD Durrës and subordinate commissariats:

Kruja Commissariat, dated 22.04.2014 – Doc. No. 201400840
Fushë-Kruja Commissariat, dated 22.04.2014 - Doc. No. 201400841
Shijak Commissariat, dated 23.04.2014 - Doc. No. 201400842
Durrësi Commissariat (RPD), dated 23.04.2014 - Doc. No. 201400843

Preliminary remarks

As stipulated in the inspection procedure, the expert team initially met the heads of the institutions to comminucate them the scope of inspection. It should be noted that all heads of institutions were cooperative throughout inspections.

Moreover, the expert group obtained information relevant to their upcoming task and met privately with persons deprived of liberty, inspected the escort and security premises as well as JPOs' offices, and looked at the records in the registries and relevant legal acts. Specifically, the overall situation and problems identified in the Durrësi Regional Police Directorate and the subordinate police bodies are presented below.

Conditions at escort premises

In Durrësi Commissariat, security and escort rooms were built new and in line with the requirements of te Law No 9749, dated 04.06.2007 "On State Police", and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police. It had 4 escort rooms, 3 of which 3x4 m, equipped with tables and chairs, meeting standards. Windows had iron grill and fencing and were big enough to ensure sufficient natural light. The three rooms had artificial light from the power grid. The wooden doors could be locked from the outside and had an opening above with an iron grill. The fourth room was 1.5x3m, had only one stool and no table. In general, the four rooms were clean and had surveillance cameras. Surveillance extended also over the corridor. Posters with the rights of escorted persons were in the corridor, but not in the escort rooms.

At the day of inspection, there was only one person escorted for attempted suicide. The inspection group spoke privately with him and understood that he had been taken the cell phone, the belt and the shoe-laces. He asserted that he had not met any psychologist or physician of the institution. The inspection team asked for explanations about the case at hand and the violation about the seizure of private items, in infringement of the legislation in force. The Chief of Commissariat said that the person was aggressive and had been escorted several times. Personal items were taken from him, considering his suicide attempt and a history of domestic violence. According to him, the person would be treated as a person against whom an investigation is ongoing.

Shijaku Commissariat had 3 escort rooms inside, separated for women, men and minors. At the moment of inspection, there were no escorted persons. Escort rooms were 4x3m; windows were

big enough to ensure adequate natural light. All the three rooms had artificial light from the power grid. One of the rooms was under reconstruction, and the Chief of Commissariat and Head of Police told the inspection team that works would be completed within the first two weeks of May. The rooms were made of wood, with 2 big latches and closed from the outside by a lock. At the end of the corridor there was a functional toilet. Rooms were clean and had a stool and table. Posters with the rights of escorted persons were both in the corridor and the escort rooms.

Kruja Commissariat had 2 escort rooms outside, both relatively clean, with windows that allowed sufficient natural light, whereas artificial light was missing because bulbs needed to be replaced. Rooms had a stool and table, whereas the wodden doors were locked by lock from the outside. The security rooms had no toilet and no posters about rights. There was no camera surveillance system. Posters were at the entrance of the commissariat, but not updated with the recent legal amendments on escorting of citizens. At the time of inspection there were no escorted persons.

Fushë-Kruja Police Station had 2 escort rooms inside, separated, one for minors and one for adults (men and women). Size of rooms was 2.5x3m and the size of windows 1x0.5m, but were unclean. Rooms had a stool and table. Doors consisted of two doors, one duralumiunium and an iron one with a latch locked by a lock. There was a toilet in the corridor, so old that it was virtually impossible to use. Artificial light was not continuous, due to frequent power cuts. Posters with the rights of detainees were put in corridors, but not in escort rooms. At the time of inspection, there were no persons escorted.

Conditions in security premises

Durrësi Commissariat had 8 security rooms: 1 for women, 1 for minors and 6 for adult males. During the inspection, there were 4 persons detained and arrested. Security rooms met all standards under the legislation in force. They had an anteroom, sufficient natural light and artificial light. Quick communication with the personnel was easy, because each room had a functional bell. Rooms had beds as per standards, worn-out covers and no sheets. Rooms had heating system installed in the anteroom; the latter was separated from the other premises by a barred door closed on the side of the anteroom, without a handle. The corridor of security premises had surveillance system. Toilets in each room were functional and clean. Each anteroom had a sink, all of them functional, except for one room, for which the staff took immediate measures to repair and transfer the person to another room. Detainees/arrestees could shower in the two showers designated for them, with warm and running water anytime, but the hygiene and sanitary conditions left to be desired. Posters with the legal rights of detainees/arrestees were put in the corridors and inside rooms.

Fushë-Kruja Commissariat had 4 security rooms outside the building. Rooms were completely out of standards: worn-out wooden floor, no beds, no heating and no toilets. There was a detained person sleeping in a mattress and covered in worn blankets without sheets. The shower, which did not have warm water at the moment of inspection, and the toilets, were at a corner of the security rooms. That environment did not provide any privacy, was cold and did not ensure normal functioning. Holding citizens in these conditions is a degrading treatment and infringes on human dignity.

Treatment of detainees / arrestees at detention premises

Detainees / arrestees in both commissariats were given food three times a day, in line with the norms on food provision provided for in the Joint Instruction No 432, dated 10.03.2008 of the Minister of Interior and the Minister of Health. In Durrësi and Kruja Commissariats, food was provided by the kitchen of the institution.

In both commissariats with security rooms, detainees / arrestees had running water anytime. Only the showers of Durrësi Commissariat had warm water. In both commissariats, provision of detainees / arrestees with items of personal hygiene such as soap, detergents, toothpastes and toothbrushes was insufficient, therefore these were supplied by their families.

In both institutions, the inspection team realised from the staff and interviews that there was no informative, didactic or artistic literature, although detainees / arrestees are entitled to it. However, interviews showed that only a few of them wished to read.

None of the commissariats inspected provided the opportunity for yard-time outside.

As regards medical treatment available to detainees / arrestees, the staff of Durrësi Commissariat informed the team that a general physician was in the organisational set-up. By internal Order of the Head of Institution, Prot. No 26, dated 01.04.2014, the physician's duties were delegated to the general physician of the Health Centre no. 7 in Durrësi. The team found that the physician regularly visited the detainees / arrestees and filled out the medical files as provided by law. There was also a visits registry kept in a locked locker together with the medical files.

The physician's room was unsuitable and two small for visits. The examination bed was inappropriate and the cabinet for medicaments was out of standard. Basic emergency medicaments were missing, together with other medicaments indispensable to an efficient health care service; there was no blood pressure apparatus. No refrigeration was available to store particular medicaments.

Interview premises

Durrësi Commissariat Lezha had a designated suitable room for interviewing and meetings with lawyers. Such room was missing at Kruja Commissariat, and the office of police staff was used instead.

The inspection team saw that judicial police offices at all commissariats lacked surveillance cameras. No objects were found to assume that violence was used against citizens during interviews.

It should be noted a common problem among all commissariats: material evidence is kept at judicial police offices, because there is no designated place for evidence to be stored.

Surveillance of detention, confinement and interviewing premises

The audio-visual surveillance system is crucial to the prevention of violent crimes against citizens and vice versa, as well as for observance of human rights and fundamental freedoms. Durrësi Commissariat was a success story of this system; it had surveillance cameras in the corridors of the security and escort rooms, as well as monitoring system inside escort rooms. The latter was missing in Shijaku and Kruja Commissariats and in the Fushë-Kruja Police Station.

Registry on escorted, detained / arrested persons and their treatment by police

Pursuant to Law No 9749, dated 4.06.2007 “On State Police” and the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units”, endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police, any police unit must have escort and security rooms, equipped *inter alia* with the Registry on Escorted Persons and the Registry on Detained / Arrested Persons. All the commissariats inspected possessed such registries.

Legal and psychological aid

During the inspection, experts found that in all cases when adult detainees / arrestees could not afford a layer and ask for legal aid, they were provided one. The list of names and contact details of lawyers were not available in each case.

As for the above, the recommendations included:

1. Take measures to immediately close security rooms in Kruja Commissariat, where stay of citizens in those conditions is degrading and infringes on the dignity of any person held in those premises.
2. Take immediate measures to install surveillance cameras in the escort rooms of Shijaku and Kruja Commissariats, and Fushë-Kruja Police Station.
3. Take immediate measures to install surveillance cameras in the corridors of detention / arrest rooms in Shijaku and Kruja Commissariats, and Fushë-Kruja Police Station.
4. Take measures to complete reconstruction of one escort room in Shijaku Commissariat and furbish it adequately.
5. Take measures to build or reconstruct escort rooms and toilets in Fushë-Kruja Police Station, by establishing three such rooms that comply with provisions and norms set out in the Law No 9749, dated 04.06.2007 “On State Police”.
6. Take measures to open physician’s rooms at Durrësi and Kruja Commissariats, in line with criteria stipulated in the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police.

6.2. Elbasani RPD and subordinate commissariats:

Peqin Commissariat, dated 18.05.2014 - Doc. No. 201401083
Cërrik Commissariat, dated 18.05.2014 - Doc. No. 201401084
Gramsh Commissariat, dated 18.05.2014 - Doc. No. 201401085
Librazhd Commissariat, dated 19.05.2014 - Doc. No. 201401086
Elbasan Commissariat (RPD), dated 19.05.2014 - Doc. No. 201401087

Specific objectives of the inspection

Inspection intended to visit, observe, collect and assess data, actions and practices of the police in fulfilling the standards defined in *Law No 9749, dated 4.06.2007 "On State Police"* and the *Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units*".

As stipulated in the inspection methodology, the expert team authorised by the Ombudsman initially met the head of each institution and communicated them the scope of visit. The heads were fully available to meet all the requests of the inspection team. During the inspection, the team had fruitful consultations with the Chief/Head of Regional Police, Heads of Police, in Ebasani, Librazhdi, Peqini and Gramshi, as well as with other officials of these police units.

The expert group obtained information relevant to their upcoming task and met privately with persons deprived of liberty. It inspected the escort and security premises as well as JPOs' offices, and looked at the records in the registries and relevant legal acts.

But, the inspection team found that some issues continue to persist, specifically:

Conditions at escort premises

Elbasani Commissariat has two escort premises in two different buildings inside the commissariat. One room 4x3.5m has an iron door and a window 1.3x1.5m that allows sufficient air and natural light. It has the necessary furniture such as tables and stools, but it unpainted and unclean. It does not have a toilet, and escorted persons are taken to the toilet of Police Commissariat that is used also by the staff. The room is used only for escorted adult males.

The other premise meets all the requirements of the Law No 9749, dated 04.06.2007 "On State Police", because it is separated for women and minor. It consists of two rooms 4x4m and corridor 4x2m, furbished with tables, chairs and couches. Rooms have normal windows that allow for sufficient natural light and air; there is also artificial light from the power grid. The toilet had all accessories and running water. However, these rooms were found out of use at the inspection day, because they had been turned into storeroom for equipment and material evidence, thus taking them off their function as escort rooms approved by the General Directorate of Police.

In the Librazhi Commissariat the old escort rooms were put out of use by Order No 239, dated 28.05.2012 of the General Director of State for failure to meet standards, as recommended by the Ombudsman. Escorted persons had to be held in the offices of the police staff, according to the

order, but not necessarily 10 hours. Besides, it specified that persons must not stay locked and without the presence of a police officer. An escort room had been renovated as recommended by the Ombudsman and could be used until complete reconstruction of the escort rooms in the ground floor of Librazhdi Commissariat, according to the manual. However, it would have complied with standards, if it did not have an iron door with latch and lock.

In Peqini Commissariat, the escort premises were in line with the Law No 9749, dated 04.06.2007 "On State Police", because it was separated for women and minor. Doors were duraluminium and had ordinary locks; the rooms were painted, clean and spacious, but there was no artificial light

It consists of two rooms 4x4m and corridor 4x2m, furbished with tables, chairs and couches. Rooms have normal windows that allow for sufficient natural light and air; there is also artificial light from the power grid. The toilet had all accessories and running water. However, these rooms were found out of use at the inspection day, because they had been turned into storeroom for equipment and material evidence, thus taking them off their function as escort rooms approved by the General Directorate of Police.

The three rooms had natural light and sufficient air, because windows had been opened following the recommendations by the Ombudsman. The toilet was inside the escorting premises; it was clean, furbished and had running water. At the moment of inspection there were no persons escorted.

In Gramshi Commissariat, the escort room for adults was put out of use, in accordance with the recommendation made by the Ombudsman. Actually, there were three escort rooms that met the requirements of Law No 9749, dated 04.06.2007 "On State Police", because it was separated for women and minor. Doors were duraluminium and had ordinary locks and artificial light. Normal windows allowed for sufficient natural light and air. There were painted and clear tables and chairs. It does not have a tolet, and escorted persons are taken to the toilet of Police Commissariat that is used also by the staff. The room is used only for escorted adult males. At the day of inspection there were no persons escorted.

Posters with the rights of escorted persons are put in all the escort premises, corridors and at the entry of the Elbasani, Gramshi and Peqini commissariats.

Conditions at security premises (pre-trial detention)

Librazhdi, Peqini and Gramshi Commissariats have no security premises. Detained and arrested persons are sent to the security rooms of Elbasani Commissariat.

Elbasani Commissariat has 17 security rooms that formerly were pre-trial detention rooms. Those were built in 1962 and were out of any living standard. Actually, only seven rooms are used: 1 for women, 1 for children and 5 for adults. 16 detained/arrested persons were accommodated in these seven rooms, two of whom minors. Although the staff and executives of the Commissariat showed particular care for hygiene, rooms did not meet the requirements of the No 9749, dated 04.06.2007 "On State Police" and the Manual on "Standard Rules and

Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", because too damp and lack of air. At their actual state, they heavily harm the health of persons detained/arrested who have to stay several days, but also of the police staff serving in these premises. There were covers, matrasses, blankets, pillows, etc., but no equipment and furniture necessary for living, such as table, stools and cupboard for putting clothes and personal items.

The toilet was clean, had running water, but did not have a door. There was access to shower, as it was functional. It lacked natural light and ventilation.

Rooms did not have emergency bells, so, communication with police services in case of distress was impossible. There was no separate yard-time premises for arrested/detained persons as provided by law (not less than 2 hours per day). Posters with rights of detainees / arrestees were put inside these rooms.

The corridor of security rooms had telephone and intercom to communicate in case of emergencies. Security rooms had surveillance cameras, one of which at the corridor. There were three monitors: one on the information room, one in the hall and one in the office of the Regional Police Director.

Treatment of detainees / arrestees at detention premises

Detainees / arrestees in both commissariats were given food three times a day, in line with the norms.

Elbasani Commissariat had a new kitchen equipped with modern appliances.

Detainees / arrestees had medical checks as provided by law (within 24 hours) and each had a medical file. Elbasani Regional Police Directorate had one general physician and a room suitable for visits. First-aid kits were secured constantly with funds from Police Directorate. There was no ambulance for emergencies or police operations.

Detainees / arrestees could read the daily press, obtained on their own expenses. They were allowed to keep paper and pencil to write, toothpaste and toothbrush, shaving cream and plastic shaving razors.

The Police Commissariat did provide them with soap, detergents, toilet paper, tissue paper for hands or towels and other items of personal hygiene.

They did not have the chance for yard time or engage in physical activity outside their cells.

Inside security rooms there were posters in Albanian and some foreign languages about the rights of detained / arrested persons.

Detainees / arrestees were not given a record-sheet for their personal belongings, because there was no dedicated place to store them.

Interview premises

Only the Elbasani Commissariat had an interview room for escorts, in a hall divided in such a way that JPOs could work with 6 people simultaneously. It was computerised, had camera surveillance, furniture, heating, abundant natural light and was clean.

In JPOs offices there were found no objects or material evidence that would expose citizens to violence during JPOs procedural actions.

Surveillance of detention, confinement and interviewing premises

Except for the Elbasani Commissariat, all the other commissariat did not have camera surveillance system for escort, security and investigation premises. The Ombudsman considers camera surveillance a crucial element for the protection of human rights and freedoms, because it is a deterrent for violent offences, both by escorted/ arrested / detained persons and the police officers themselves.

Registry on escorted, detained / arrested persons and their treatment by police

In the four police commissariats of Elbasan RPD, the registry on escorted, detained / arrested persons was designed in line with the requirements of Law No 9749, dated 4.06.2007 "On State Police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police, because the columns needed it had the columns were there, but they were not always completed as appropriate:

The column about the reason of escorting, it is noted in all police commissariats that in most cases, escorted persons are treated as suspects of criminal offences. Such treatment is in violation of Article 11(6) of the Law "On State Police", which stipulates that an escorted person is someone who has infringed an administrative rule, but not a person suspected of a criminal offence or arrested in flagrante delito. During the inspection, the team found concrete such examples.

The column about notification of family members often had inaccuracies about the name, father's name, surname and the phone number of the person notified, and the grounds for escorting, detention or arrest. This column had been filled out by simply stating "*Family, father, son, mother notified",* without specifying the person notified, time and phone number, Although the police officer claimed that family members of persons held in the commissariat are notified, we think that this claim must be proven by correctly filling out the column about the notification of family members.

Also, the phenomenon of discrepancy between the factual time of detention / arrest in flagrante and the time entered in the registries was present in this Police Directorate and its commissariats. Comparing the times entered for two persons arrested and kept in security premises, the inspection team deducted that the time entered in the registry is the time when the report is elaborated, not the time of arrest/detention.

A book of complaints of escorted, detained and arrested citizens had been open, but it was not put in use for lack of notes and complaints.

Legal and psychological aid

During the inspection, experts found that detainees / arrested had asked for legal aid and had been interviewed without the presence of a lawyer. For example, citizen L.P. from Belsh claimed that he was not given the chance to contact a layer. For minor detainees / arrestees for whom legal and psychological aid is compulsory by law, such obligation was met in the Elbasani Regional Police Directorate, because their organisation set-up included a specialised psychologist.
As for the above, the recommendations included:

1. Take measures to build the escort premises at Librazhdi Police Commissariat in line with the Law No 9749, dated 4.06.2007 “On State Police” and rogatory-letter of the General Director of State Police No. 703, dated 07.08.2008 by creating suitable and dignified premises equipped with necessary furniture for stay, and separated accordingly for women, males and minors.
2. Take measures to build new security premises in Elbasani Police Commissariats, in line with the requirements of Law No 9749, dated 4.06.2007 “On State Police” and the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".
3. Take measures to complete fully and responsibly the book/registry of persons escorted, detained and arrested.
4. Take immediate measures to make the escort rooms for women and minors at Elbasani Commissariat fully functional.
5. Take measures to observe the legal provisions of the Criminal Procedure Code regarding the entry into the record-sheet of the moment (accurate time) of arrest / detention of citizens, and not to treat them initially as escorted persons.
6. Take measures to install surveillance camera in the escort and security premises, particularly in the investigation premises, in all police commissariats of the Elbasani Regional Police Directorate where such system is missing. Surveillance must start from the entry to the commissariat building, so that the camera records without interruption from entry to the place of stay.
7. Take measures to analyse and take disciplinary actions for cases in Elbasani and Librazhd Commissariats where suspects of criminal offences or persons who could reveal facts useful to the investigation, have been treated as escorted.
8. Take necessary measures to establish a room to store personal belongings of detained / arrested persons, and to give them a copy of the checklist.
9. Take measures to make the bool of complaints for escorted, detained and arrested persons fully functional.

6.3. Lezha RPD and subordinate commissariats:

Kurbin Commissariat, dated 23.05.2014 - Doc. No. 201401125
Mirdita Commissariat, dated 23.05.2014 - Doc. No. 201401126
Mamurras Police Station, dated 23.05.2014 - Doc. No. 201401127
Lezha Commissariat (RPD), dated 23.05.2014 - Doc. No. 201401128

Preliminary remarks

As stipulated in the inspection procedure, the expert team authorised by the Ombudsman initially met the head of each institution to communicate them the scope of inspection. It should be noted that, in general, all heads of institutions were cooperative throughout inspections. However, this was not the case in Mirdita Commissariat, where the Head of this commissariat did everything he could to hamper the work of the inspection team.

Moreover, the expert group obtained information relevant to their upcoming task and met privately with persons deprived of liberty, inspected the escort and security premises as well as JPOs' offices, and looked at the records in the registries and relevant legal acts. Specifically, the overall situation and problems identified in the Lezha Regional Police Directorate and the subordinate police bodies are presented below.

Conditions at escort premises

In Lezha Commissariat, the escort and security rooms are not built in line with the Law No 9749, dated 04.06.2007 "On State Police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the Director of State Police.

It had 4 security rooms inside, 2 for adults, 1 for minors and 1 for women, all completely separated from the rest of premises by an iron door. One of the adult rooms was used to escort persons who exhibited aggression. Three rooms were 4x5m, had tables and chairs, except for the escort room mentioned above, which had no furniture. The room for women had an anteroom, but both were very small. The staff justified it with the impossibility to have natural light. The windows had iron grill and were big enough for adequate natural light. The four rooms had artificial light from the power grid. The iron doors could be locked from the outside and had an opening above with an iron grill. All the rooms were not painted, unclean and damp. The *en suite* toilets were equally unclean, and this could be detected from the smell once one entered the escort premises. These rooms did not have surveillance cameras. Posters with the rights of escorted persons were posted on the corridor.
On the inspection day there was only one person escorted, who had been accommodated in the adults room because of aggression. The inspection team asked to speak to him privately, but he refused.

Kurbini Commissariat had two security rooms outside the premises, one for women and minors, and one for men. At the moment of inspection, there were no persons escorted.
The escort rooms were 4x3m and windows were big enough for adequate natural light (partly closed with fibre). The three rooms had artificial light from the power grid. Each head two chairs

and one table, were unpainted, damp, but clean. Doors complied with standards. There were no toilets. Posters with the rights of escorted persons were posted on the corridor.

Mamurrasi Police Station did not have escort rooms inside the station. Persons detained or escorted were accommodated at Kurbini Commissariat. However, the team saw a room with barred door and locked, 2x3m, without windows or furniture, which was not used, according to the staff, except when escorted persons manifested aggression.

Mirdita Commissariat had 3 escort rooms inside the premises. They all were damp. Not painted, but clean, because the staff had been put in motion during the time the inspection team was forbidden to enter the Commissariat. Rooms were spacious and windows were big enough for adequate natural light. Artificial light was provided from the power grid. Each room had two chairs and one table, as well as the poster with the rights of persons escorted. These rooms did not have toilets. Escort premises did not have surveillance cameras. At the moment of inspection, there were two persons: one adult detained and one minor escorted.

In this commissariat, the team saw a barred windowless room at the end of the corridor, with the door locked; it had another room inside, with a barred door. It lacked any furniture. The staff informed the inspectors that it was put out of use, but the persons brought to the commissariat as escorted and detained confirmed to us in private that they had spent the time in those rooms.

Conditions at security premises

In Lezha Commissariat, the security and escort rooms are located in the same premises, just separated by a barred door. It had 4 rooms: 1 for women, 1 for minors and two for adult men, which were intended for 6 persons, according to the Chief. The inspection team found 11 persons detained/arrested, which indicates overcrowding.

Security rooms had anteroom, sufficient natural light and artificial light. A functional bell ensured timely communication of each room with the staff. Rooms had beds, as appropriate, but covers were worn-out and there were no sheets.

The rooms did not have heating system. The anteroom was separated from another premise by a barred door, closed inside anteroom, without a handle. *En suite* toilets in each room were functional, but very old and relatively clean. Each anteroom had sinks, which were functional. Detainees/arrestees could have a shower with running and warm water anytime, in a clean place. Posters with the rights of detainees/arrestees where placed on the corridor and inside rooms.

The corridor of the security premises did not have surveillance cameras.

Treatment of detainees / arrestees at detention premises

Detainees / arrestees in both commissariats were given food three times a day, in line with the norms on food provision provided for in the Joint Instruction No 432, dated 10.03.2008 of the Minister of Interior and the Minister of Health.

In this commissariat, detainees / arrestees had running water in the security rooms anytime, and warm water in the shower within the security rooms premises. Detainees / arrestees were provided by their families with items of personal hygiene such as soap, detergents, toothpastes and toothbrushes, because the institution did not provide them.

There was no informative, didactic or artistic literature in both institutions, although detainees / arrestees are entitled to it. However, interviews showed that only a few of them wished to read.

It did not provide the opportunity for yard-time outside.

As regards medical treatment available to detainees / arrestees, the staff of Lezha Commissariat informed the team that a general physician was in the organisational set-up and he was present at the moment of inspection. The team saw that visits were performed regularly by the physician who filled out the medical files as provided by law. At the moment of inspection, all detainees / arrestees interviewed were very satisfied with the health services, particularly from his willingness to provide services anytime, even outside regular working hours.

The physician's room was unsuitable and two small for visits, having only artificial light, a bed and a table, which were quite uncomfortable. No refrigeration was available to store particular medicaments and the blood pressure apparatus was obtained privately by the physician. The cabinet were medicament were kept was virtually empty, lacking all sorts of medicaments, except a small quantity of analgesics. This problem was raised also by the physician, who saw it impossible to provide health service in the institution due to significant shortages in medicaments and general, and the emergency medicaments in particular.

As regards the physician's documentation, the visits registry, the consultation registry and medical files of detainees / arrestees were kept in order and locked. It should be noted that despite unfavourable conditions and shortages, the physician's work was plausible.

Interview premises

Lezha Commissariat had a designated adequate room for interviewing and meetings with lawyers. The inspection team saw that judicial police offices at all commissariats lacked surveillance cameras. No objects were found to assume that violence was used against citizens during interviews.

In should be noted that the inspection team found an old baton on a safe at the reception hall of Mamurras Police Station, and a chair leg and a stick around 50cm wrapped, for which the competent persons were immediately informed.

Keeping material evidence in JPOs offices is a persisting practice in almost all commissariats, due to the lack of dedicated premises for storing them.

Surveillance of detention, confinement and interviewing premises

The audiovisual surveillance system is crucial to the prevention of violent crimes against citizens and vice versa, as well as for observance of human rights and fundamental freedoms. Such system was partially present or missing in all commissariats of Lezha Regional Police inspected by the experts.

Registry on escorted, detained / arrested persons and their treatment by police

Pursuant to Law No 9749, dated 4.06.2007 "On State Police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police, any police unit must have escort and security rooms, equipped *inter alia* with the Registry on Escorted Persons and the Registry on Detained / Arrested Persons. All the commissariats inspected possessed such registries, but must be said that Mamurras Police Station had an outdated version coded since 2003. Lezha Commissariat also had not updated its registry. All registries inspected had these common shortcomings:

- There were incomplete or wrongly completed columns in the Registry on Escorted Persons and the Registry on Detained / Arrested Persons.
- The column about notification of family members had missing information as regards name, father's name, surname and the phone number of the person notified. Almost in all cases, the phone number entered there belonged to the person escorted, not to their family members.
- The Registries on Escorted Persons of all inspected commissariats, in breach of the Law No 9749, dated 4.06.2007 "On State Police", the reason for escorting persons includes the commitment of criminal offence by the citizen, e.g. theft, DUI, arrest in *flagrante delicto,* wanted, offending police officers, etc.

The inspection found violations of the legislation in force as regards escorting, detention and arrests made by police officers of the Mirdita Commissariat.

As noted above, in blunt violation of the Law No 9749, dated 04.06.2007 "On State Police" and the Law No 8454, dated 04.02.1999 "On the People's Advocate", as amended, the inspection team had to cope with significant obstacles raised by the Chief of Commissariat who, at the moment of inspection, was not physically present. He communicated with the inspection team through the information specialist and refused to communicate directly, despite the efforts of the inspection team. The specialists tried to prevent examination of the relevant registries because, according to him, he had to obtain permission from the Chief of Commissariat before making them available to the inspection team.

During the inspection, the experts contacted privately with the escorted citizen A.M., who informed that he had been held for driving without driving licence at around 12:30 – 01:00 A.M. He said that he had spent the night in a barred room at the end of the corridor of the ground floor, which did not have a bed, chair or furniture. He had shared that room with the minor G.B., in violation of Article 101, "Escorting to Police premises", item 3 of the Law No 9749, dated 04.06.2007 "On State Police".

The expert team asked to meet the escorted minor G.B., but found that he was at the office of the Chief of Police, where two JPOs were taking his statement without the presence of parents, legal custodian, psychologist or lawyer, in violation of Article 27 of Law 10347, dated 04.11.2010 “On protection of child’s rights”. The child was in a heavy psychological situation, as he shed tears during the interview with the inspection team, confirming the violation of the spirit of the Law No 10347, dated 04.11.2010 “On protection of child’s rights” and Article 21 thereof. He said that he had been escorted around 12:30-13:00 A.M. that day, exceeding the 10-hour deadline. He had spent the night in a barred room at the end of the corridor of the ground floor, which did not have a bed, chair or furniture. He had shared that room with A.M. He said that he had not yet contacted his family. The inspection team informed JPOs that this was a flagrant violation of the law.

Immediately, the inspection team examined the relevant registries where the escorting time of these persons was 3:00 A.M., without entering the name of JPO handling the case, in violation of Article 103 of Law No 9749, dated 04.06.2007 “On State Police”. For both the above mentioned persons, the same person and the same phone number was put in the column for notification of family; the experts tried it and found that it was inexistent. So, it can be assumed that the families of the escorted persons, particularly the minor, had not been notified, thus breaching Article 107(2) of the Law No 9749, dated 04.06.2007 “On State Police”.

Legal and psychological aid

During the inspection, experts found that the legal obligation to notify the adult detainees / arrestees that they were entitled to a lawyer if they could not afford one and to legal aid, was respected at all times. The list of names and contact details of lawyers were not available in any of the commissariats inspected.

As for the above, the recommendations included:

1. Immediately analyse the situation described above in Mirdita Commissariat and take appropriate administrative actions against the staff.
2. Take measures to take the security room at Mirdita Commissariat out of use, in order to prevent further abuse with escorted / detained /arrested persons there.
3. Take measures to build a toilet for the escort rooms in Mirdita Commissariat, in line with provisions and requirements of the legislation in force.
4. Take immediate measures to install surveillance cameras in the escort rooms of Police Commissariats under Lezha Regional Police Directorate.
5. Take immediate measures to reduce overcrowding in the security rooms of Lezha Commissariat, focusing on observance of personal space, as provided for in the provisions and requirements of the legislation in force.
6. Take immediate measures to separate minors from adults in the security rooms of Lezha Commissariat, as provided for in the provisions and requirements of the legislation in force.
7. Take immediate measures to install surveillance cameras in the corridors of security rooms in the Lezha Commissariat.

8. Take measures to repair or renovate the security rooms, particularly the one for women, and the toilets in the Lezha Commissariat, as provided for in the provisions and requirements of the legislation in force.
9. Take measures to provide detainees / arrestees with items of personal hygiene from Lezha Commissariat.
10. Take measures to open another escort room at Kurbini Commissariat and repair the two existing rooms, all these in line with the provisions and requirements of the legislation in force.
11. Take measures to build a toilet for escort rooms at Kurbini Commissariat, in line with the provisions and requirements of the legislation in force.
12. Take measures to renovate the room inspected by the inspection team at Mamurrasi Police Station and bring it in compliance with the provisions and requirements of the legislation in force.
13. Take measures to furbish the physician's room at Lezha Commissariat as provided for in the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police.
14. Take measures to supply Lezha Commissariat with medicaments and a blood pressure apparatus.
15. Take measures to prevent the presence of objects that would expose citizens to violence during interviewing, and to establish designated places for storing material evidence in all police commissariats mentioned above.
16. Take measures to complete fully and responsibly all columns of registries on escorted and detained / arrested persons at all commissariats mentioned above.
17. Take immediate measures to ensure full compliance with the Law No 9749, dated 4.06.2007 "On State Police", Article 101, concerning escorted persons, in order to depart from the practice seen in all inspected commissariats, where registries on escorted persons included people suspected of criminal offences;
18. Take immediate measures to train the staff in all inspected commissariats on the enforcement of the Law No 9749, dated 4.06.2007 "On State Police", concerning escorting of people, as well as on the Law No 8454, dated 4.02.1999 "On the People's Advocate", as amended.

6.4. Rinasi Commissariat, Border and Migration Directorate - Dated 05.06.2014 / Doc. No. 201401200

On 05.06.2014, FRONTEX in cooperation with the Border and Migration Police coordinated the repatriation operation of Albanian citizens from EU and Schengen countries. NPM team was part of the group observing this repatriation process, exercising its legal and constitutional role in the context of Directive 2008/115/EC of the European Parliament and the Council on common standards and procedures for returning illegally staying third-country nationals.

Preliminary remarks on the repatriation operation

In fulfilling its mission in this repatriation operation, NPM was represented by the Acting Head whose functional duty is to monitor the observance of the Charter of Fundamental Rights and the

Constitution of the Republic of Albania, as safeguards for human dignity of all persons involved in the repatriation operation.

The operation resulted in the repatriation of 51 Albanian citizens from France and Finland.

Invited to observe the process, NPM was extensively informed about the repatriation procedure by FRONTEX initially, and then by the Border and Migration Directorate.

NPM had participated actively in the training “Joint Repatriation Operations" organised by FRONTEX and the Border and Migration Directorate on 25-30 May 2014, at the “Delta” Operational Centre in Vlora. This training event was a good informative initiative and crucial to the success of the repatriation process.

Monitoring of the repatriation process is very important as it guarantees:

- Humane return of persons, fully safeguarding fundamental rights
- Strict observance of EU standards
- Strict observance of the Albanian law
- Staff security and protection (escorting persons and others)

Monitoring of the repatriation process

The NPM representative flew by charter from Tirana to Lille, France, and monitored hand-over procedure and on-board escorting of persons. Two days in advance, the Department for Returnees at the Border and Migration Directorate provided NPM with all the necessary information on the return operation. A preliminary meeting was set at 7:00 of 5 June 2014 at the Rinasi Border Police Commissariat, with the Head of Operation, Coordinator of the Escort Team and the physician assigned to follow the operation. Departure was at Rinas, 9:00 A.M of 5 June. Before take-off, NPM was informed about the list of persons to be repatriated. It consisted of 51 persons and indicated their birthday and nationality. The list included 4 women and 3 minors.

During flight, the Head of Operations and the Coordinator made the deployment and security plan according to FRONTEX methodology and recommendations, assigning duties to the security staff: a woman offices was entrusted the accompaniment of women citizens; they were instructed to put families separately; persons with criminal records would be placed at the end of the place with double personnel.

Transfer from the bus, to the minibus and place
There was a small delay during transfer by minibuses to the door of the aircraft, under the supervision of foreign police officers. The Coordinator received them at the door and instructed them to reach their places, assisted by two other offices.

The first to board the plane were the citizens repatriated from Finland, and then those from France. Persons were accompanied from the bus to the door of the aircraft without handcuffs, but just led by the arm up to their seat on board.

The boarding process proceeded smoothly. The last to be accompanies were a family of five, with 3 minors. They were escorted by the women staff and were guided to sit in the first seats all together. A friendly environment was created to children and police officers tried to be out of their visual.

There was a young couple who sat together. Two women sat in the second row, with a women offices standing near.

Once they were all seated, their suitcases and personal items were brought it, together with the relevant documentation. Then, the Head of Operations and the Coordinator asked the passengers if they had any need or complaint. Two persons who needed to go to the toilet, accepted to wait until the plane took off, and then were escorted by police. Besides, the passengers were informed that their personal belongings, including money, were given to the Albanian side and would be handed over to them once reached Albania.

Boarding was completed at 13:00.

The flight proceeded smoothly. All were provided abundant food and refreshments. Persons were escorted to the toilet, without infringing on their privacy.

Debriefing

Upon arrival at 16:07, a debriefing meeting was organised in the presence of the Director and other executives of the Border and Migration Police, where it was stated that the operational was successful. The training results were positive. The presence of a women offices was strongly highlighted, because of the presence of women and children on board.

As for the above, the recommendations included:

1. Take measures to ensure a higher number of women police officers as part of the team, during joint repatriation operations.
2. Take measures to ensure that families with children board last, in order to have a lower presence of police force and potentially less psychological pressure upon children.
3. Take measures to ensure the on-board presence of a psychologist, social worker or expert on children’s rights, should the repatriation list include children.
4. Take measures to ensure preliminary notification of NPM by the Border and Migration Directorate about repatriation operations, both when the Director is directly organising such operations, or in partnership with EU countries.

6.5. Peshkopia RPD and subordinate commissariats:

Burreli Commissariat, dated 18.06.2014- Doc. No. 201401259
Bulqiza Commissariat, dated 18.06.2014- Doc. No. 201401260
Peshkopia Commissariat (RPD), dated 18.06.2014- Doc. No. 201401258

Preliminary remarks

As stipulated in the inspection procedure, the expert team authorised by the Ombudsman initially met the head of each institution to communicate them the scope of inspection. It should be noted that all heads of institutions were cooperative throughout inspections.

Moreover, the expert group obtained information relevant to their upcoming task and met privately with persons deprived of liberty, inspected the escort and security premises as well as JPOs' offices, and looked at the records in the registries and relevant legal acts. Specifically, the overall situation and problems identified in the Dibra Regional Police Directorate and the subordinate police bodies are presented below.

Conditions at escort premises

Peshkopia Commissariat officially had an escort room. At the moment of inspection, it was not used and had been turned into a storage area. Froom meetings with officers, the team understood that persons were escorted to two rooms, at the entry to the security rooms, on the right, separated from the corridor by a barred door. Both rooms played the role of escort rooms, lacked furniture and were locked from the outside, in complete violation of the Law No 9749, dated 04.06.2007 "On State Police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the Director of State Police.

There was no camera surveillance system.

During the inspection, there were no persons escorted.

Bulqiza Commissariat had one escort room, which had an entry door and a barred door locked from the outside; it separated the room into an anteroom. There was only a long stool. Another dark room was out of use, according to the Chief and staff. The anteroom had posters with the rights of escorted persons.

As for the above, the inspection team informed the Chief of Commissariat that the room was in flagrant violation of Law No 9749, dated 4.06.2007 "On State police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police.

There was no camera surveillance system.

During the inspection, there were no persons escorted.

Burreli Commissariat had one escort room having a barred door and locked from the outside. It had no windows or furniture; it consisted of two premises, one after the other. Aware that it was not in line with standards, the Chief of Commissariat and the Head of Police used a classroom as escort room. It was spacious, with natural light, tables and chairs. It was clean and had posters with the rights of escorted persons. The executives confirmed that the classroom was used as escort room, being also that the toilet was near, as requested by law.

There was no camera surveillance system.

During the inspection, there were no persons escorted.

Conditions at security premises

Peshkopia Commissariat had 14 security rooms, 10 of which in use. At the moment of inspection, there were 7 persons detained / arrested. Security rooms were in flagrant violation of the Law No 9749, dated 4.06.2007 "On State police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police. They were very cramped, with too small windows to ensure normal breathing that was made heavier by significant humidity both inside and outside rooms. Detained/arrested persons slept on worn-out matrasses and covers, without beds, lacking sheets and pillows.

The common toilets and shower were at a dark and very damp corridor. These two toilets and the shower were quite consumed by dampness and dirt, which made their function even more difficult, although detainees/arrestees confirmed that they could have a shower with running and warm water anytime.

The corridor of the security premises did not have surveillance cameras.

Posters with the legal rights of detainees/arrestees were placed on the corridor and inside rooms, together with the names and contact details of available lawyers.

Burreli Commissariat had 12 security rooms, with one located outside the building. Despite their efforts to keep it clean, it was in a state of dilapidation. Rooms were out of any standard, with worn-out wooden floor, no beds, no heating system and no toilets. At the moment of inspection, there was a person detained who slept on a mattress with one blanket, but no sheets. The extremely damp corridor, where in some places water trickled, comprised the common toilets and shower. The shower was completely worn-out, making its function even more difficult.

There were no surveillance cameras.

Posters with the legal rights of detainees/arrestees were in place.

Treatment of detainees / arrestees at detention premises

Detainees / arrestees in both commissariats were given food three times a day, in line with the norms on food provision provided for in the Joint Instruction No 432, dated 10.03.2008 of the Minister of Interior and the Minister of Health.

In both commissariats with security rooms, detainees / arrestees had running water anytime they asked, albeit provided only in the common showers and toilets. Because of humidity and problems it might cause to electrical installations, hot water was provided only when requested by detainees / arrestees; otherwise, boilers were not working. In both, provision of detainees / arrestees with items of personal hygiene such as soap, detergents, toothpastes and toothbrushes was insufficient or virtually inexistent.
There was no informative, didactic or artistic literature in both institutions, although detainees / arrestees are entitled to it.

None of the commissariats inspected provided the opportunity for yard-time premises. Those premises in Peshkopia Commissariat were closed for lack of security and dilapidation.

As regards medical treatment available to detainees / arrestees, the team found that no physician was included in the organisational set-up of both the Peshkopia and Burreli commissariats. The Burreli commissariat sent for the physician of the Burreli Prison when they needed one, whereas the Peshkopia commissariat had only an assistant physician. During the inspection, the inspection team found that a physician visited detainees / arrestees regularly in both commissariats, who filled in the medical records according to the legislation in force. Also, a visits registry and medical records was kept inside a locked locker.

The physician’s room at Burreli commissariat served also for visits from the lawyer and prosecutor. Consequently, the room was inadequate for medical visits, due to the lack of a medical bed, medication closet, basic emergency medications and other medications necessary for efficient health care, as well as the lack of a blood pressure apparatus. There was no pharmacy refrigerator. At Peshkopia commissariat, the physician’s room was clean, tidy, but dilapidated as the entire building. No medical bed, only an old closet were medicaments were kept in lock. The assistant physician informed the inspection team that the institution had all medicaments, including emergency ones. However, interviews with detainees / arrestees confirmed that medical care was not always available.

Interview premises

Peshkopia and Burreli commissariats had both designated interview rooms for investigators, as well as visitation rooms where detainees / arrestees may meet with their lawyers. As stated above, this room was used also by the physician at the Burreli commissariat.

The inspection team saw that judicial police offices at all commissariats lacked surveillance cameras. No objects were found to assume that violence was used against citizens during interviews.

It should be noted a common problem among all commissariats: material evidence is kept at judicial police offices, because there is no designated place for evidence to be stored.

Surveillance of detention, confinement and interviewing premises

The audiovisual surveillance system is crucial to the prevention of violent crimes against citizens and vice versa, as well as for observance of human rights and fundamental freedoms. Such system was missing in all commissariats inspected by the experts.

Registry on escorted, detained / arrested persons and their treatment by police

Pursuant to Law No 9749, dated 4.06.2007 "On State Police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police, any police unit must have escort and security rooms, equipped *inter alia* with the Registry on Escorted Persons and the Registry on Detained / Arrested Persons. All the commissariats inspected possessed such registries, although all inspected ones were not updated.

All registries inspected had these common shortcomings:

- There were incomplete or wrongly completed columns in the Registry on Escorted Persons and the Registry on Detained / Arrested Persons.
- The column about notification of family members had missing information as regards name, father's name, surname and the phone number of the person notified. In the Peshkopia and Bulqiza commissariats, there was virtually no case of any phone number of family members notified about the escorting operation, whereas the Burreli police did not have this column.
- The Registries on Escorted Persons of all inspected commissariats, in breach of the Law No 9749, dated 4.06.2007 "On State Police", the reason for escorting persons includes the commitment of criminal offence by the citizen, e.g. theft, DUI, arrest in *flagrante delicto,* wanted, offending police officers, production / sale of narcotic substances, illegal manufacturing and possession of fire arms, etc.

It should be noted that the Peshkopia commissariat had two additional registries, pursuant to the Order No 763, dated 27.09.2011 of the General Director of State Police, which sanctions the following rights for detained / arrested persons:

1. right to meet family members for persons convicted by final decision or convicted *in absentia,* until their transfer to IECDs;
2. right of mothers in security rooms to continue breastfeeding their infants.

As regards treatment of escorted / detained / arrested persons during police actions in Peshkopia commissariat, two arrested minors were interviewed; they claimed to have been subject of psychological violence by JPOs of Bulqiza commissariat where they were arrested, specifically the police officers B.A. and A.T. Both minors claim they were interviewed without the presence of a layer, family member and/or psychologist. One of them stated that his lawyer had signed his declaration unaware of the situation, after the procedure had been completed. On the contrary, the other minor had rejected signing the declaration.

Legal and psychological aid

Adult detainees / arrestees who could not afford a private lawyer and asked for legal aid where assigned one in all cases, as the inspection found. List of names and contact details of lawyers were available accordingly.

As for the above, the recommendations included:

1. Immediately investigate on the claims made by both minors arrested at the Bulqiza commissariat and impose the relevant administrative sanctions against the staff involved;
2. Close security rooms at Burreli and Peshkopia commissariats immediately, because keeping citizens in those conditions is degrading and violates human dignity;
3. Take immediate measures to build or rehabilitate escort rooms at all commissariats mentioned above, inspected by the NPM experts according to the legislation in force;
4. Take measures to build toilets in escort rooms in the inspected commissariats, in line with norms and provisions of the legislation in force;
5. Take immediate measures to install surveillance cameras in the corridors of escort rooms in all the commissariats inspected by NPM experts.
6. Take immediate measures to install surveillance cameras in the corridors of detention / arrest rooms in all commissariats mentioned above that were inspected by NPM experts;
7. Take measures to provide detainees / arrestees with personal hygiene means in all commissariats mentioned above that were inspected by NPM experts;
8. Take measures to set up a physician's room at Burreli commissariat, in accordance with legal criteria;
9. Take measures to improve conditions of the physician's room at Peshkopia commissariat, in accordance with legal criteria;
10. Take measures to provide medicaments and blood pressure apparatus at all commissariats mentioned above, inspected by the NPM experts;
11. Take measures to update the registries for escorted and detained / arrested persons at all commissariats mentioned above, inspected by the NPM experts;
12. Take measures to complete fully and responsibly all columns of registries on escorted and detained / arrested persons at all commissariats mentioned above, inspected by the NPM experts;
13. Take immediate measures to ensure full compliance with the Law No 9749, dated 4.06.2007 "On State Police", Article 101, concerning escorted persons, in order to depart from the practice seen in all inspected commissariats, where registries on escorted persons included people suspected of criminal offences;
14. Take immediate measures to train the staff in all inspected commissariats on the enforcement of the Law No 9749, dated 4.06.2007 "On State Police", concerning escorting of people, as well as on the Law No 8454, dated 4.02.1999 "On the People's Advocate", as amended.

6.6. Kukësi RPD and subordinate commissariats:

Kruma commissariat, date 19.06.2014 - Doc. No. 201401261
Kukësi commissariat (RPD), date 19.06.2014 - Doc. No. 201401262
Tropoja commissariat, date 20.06.2014 - Doc. No. 201401263

Preliminary remarks

As stipulated in the inspection procedure, the expert team authorised by the Ombudsman initially met the head of each institution to communicate them the scope of inspection. It should be noted that all heads of institutions were cooperative throughout inspections, except one case where experts were asked to present the People's authorisation to perform their legal task pursuant to Law no 8454, dated 4.02.1999 "On the People's Advocate", as amended.

Moreover, the expert group obtained information relevant to their upcoming task and met privately with persons deprived of liberty, inspected the escort and security premises as well as JPOs' offices, and looked at the records in the registries and relevant legal acts. Specifically, the overall situation and problems identified in the Kukësi Regional Police Directorate and the subordinate police bodies are presented below.

Conditions at escort premises

Kukësi commissariat had two escort rooms, unlabelled, while the legislation in force demands three labelled rooms for minors, adults and women. Both escort rooms were unclean, but were spacious and had adequate natural and artificial light, windows and doors according to legal parameters. There were adequate furniture such as table and chairs, but posters inside were old. They had security camera system.

No escorted persons were present during the inspection.

It should be noted that the staff was concerned that the escort rooms shared the same corridor with the so-called "interception rooms" and the recognition rooms.

Kruma commissariat had no escort rooms. However, the chief informed the inspection team that he had taken the initiative to somehow adapt two escort rooms with *en suite* toilet, as required by law. Construction of both rooms was in progress at the moment of inspection.

There was no security camera system.

No escorted persons were present during the inspection.

Tropoja commissariat had no escort rooms which was quite a concern to the staff there, as affirmed by the inspection team.

There were security cameras in the outside premises only.

No escorted persons were present during the inspection.

Conditions at security premises

Kukësi commissariat had six security rooms, four for adults, one for minors and one for women. Security rooms fully complied with the requirements of Law No 9749, dated 4.06.2007 "On State police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011. A problem identified by the inspection group was that the barred anterooms to the security rooms were locked from the outside, in violation of the legal basis mentioned above. For this, the NPM experts notified the commissariat executives.

The common shower premises were in the corridor of the security rooms, as provided by law. These premises consisting of a toilet, a shower and a sink with running water were clean and well-maintained.

At the moment of inspection, there were five persons detained / arrested in the security rooms.

The corridor leading to the security rooms had video surveillance system.

Posters with the legal rights of detained/arrested individuals were posted on corridors and inside the rooms, together with a list of names and contact details of lawyers available.

Tropoja commissariat had three security rooms situated at the Tropoja IECD, according to an agreement. The inspection team was informed that State Police officers worked alongside prison police officers at this IECD, but the team was unable to confirm that claim; the same team inspected the IECD on the same day. Inspectors asked for a copy of the agreement mentioned by the Police Chief of Tropoja Commissariat, which was promptly made available. Pursuant to the Agreement no 5740, dated 03.10.2007 between the Ministry of Interior and the Ministry of Justice "On the transfer of detention and auxiliary premises under the management of the General Directorate of Prisons, and its implementing Agreement no. 1414, dated 1.09.2007 signed between the General Directorate of Prisons and the General Directorate of State Police stipulate that the following premises shall pass under the management of the General Directorate of State Police:

1. The two-storey building of the Public Order Police Unit with all its premises
2. Building yard (back garden)
3. Area above the building, up to the Fire Brigade Station, Tropoja
4. Police kitchen premises

Neither agreement mentioned any joint management of the security rooms of the Tropoja Commissariat within the premises of Tropoja IECD. Moreover, such fact was not made known to the experts in the meeting with executives of Tropoja IECD.

There was camera surveillance only in the external premises of this Commissariat, not in the inside premises.

Treatment of detainees / arrestees at detention premises

Detainees / arrestees in both commissariats were given food three times a day, in line with the norms on food provision provided for in the Joint Instruction No 432, dated 10.03.2008 of the Minister of Interior and the Minister of Health. Both Kukësi and Tropoja Commissariat informed the inspection team that food was provided by the respective IECDs. Besides, they were informed that the food for detainees/arrestees was financed by the budget of the Commissariats.

In the Kukësi Commissariat, detainees / arrestees had running water and could shower anytime. Whereas, provision of detainees / arrestees with items of personal hygiene such as soap, detergents, toothpastes and toothbrushes was insufficient.

There was no informative, didactic or artistic literature in both institutions, although detainees / arrestees are entitled to it.

This Commissariat did not provide yard-time premises.

As regards medical treatment available to detainees / arrestees, the team was informed by the executives of the Kukësi Commissariat that the organisational set-up of did not include a physician and that a legal expert played the role of the psychologist. It had only an assistant physician. The inspection team found that the assistant physician visited detainees / arrestees regularly, who filled in the medical records according to the legislation in force. Also, a visits registry and medical records was kept inside a locked locker.

The inspection team saw that the physician’s room at the Kukësi Commissariat was appropriate for visits; it was clean, tidy, had medicaments cabinet, and the team was informed that the latter and the urgency medicaments were not lacking.

Interview premises

Kukësi Commissariat had security rooms and designated interview rooms for investigators, as well as visitation rooms where detainees / arrestees may meet with their lawyers.

The team inspected the JPOs offices in all commissariats and found no evidence or objects that would suggest exposure to violence during interviewing.

It should be noted that, in all commissariats, material evidence is kept at JPOs offices, because there is no designated place for evidence to be stored.

Surveillance of detention, confinement and interviewing premises

The audiovisual surveillance system is one of the key aspects of prevention of violent crimes against citizens and vice versa, as well as for observance of human rights and fundamental freedoms. Such system was missing in all commissariats inspected by the experts, except for the Kukësi Commissariat.

Registry on escorted, detained / arrested persons and their treatment by police

Pursuant to Law No 9749, dated 4.06.2007 "On the State Police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police, any police unit having escort and security rooms, must be equipped, *inter alia*, with the Registry on Escorted Persons and the Registry on Detained / Arrested Persons. All the commissariats inspected possessed such registries, although all inspected ones were not updated.

All registries inspected had these common shortcomings:

- There were incomplete or wrongly completed columns in the Registry on Escorted Persons and the Registry on Detained / Arrested Persons.
- In the Tropoja Commissariat, the Registry on Detained / Arrested Persons was quite outdated, as confirmed by its name "basic registry of pre-detainees". Also, the expert team found 2 registries on escorted persons, one coded and the other not. Prompt action was taken to eliminate the latter.
- The column about notification of family members has missing information as regards name, father's name, surname and the phone number of the person notified.
- In some cases, the column on the escorting reason was left blank.
- The registries of Tropoja Commissariat had significant omissions, particularly where there were escorting rooms, based on the Manual endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police.
- The Registries on Escorted Persons of all inspected commissariats, in breach of the Law No 9749, dated 4.06.2007 "On State Police", the reason for escorting persons includes the commitment of criminal offence by the citizen, e.g. theft, DUI / no driving license, wanted, accident with consequences, production / sale of narcotic substances, domestic violence, conflict with other persons, breach of public order.

It should be noted that following changes introduced to the Order No 763, dated 27.09.2011 of the General Director of State Police, which sanctions the following rights for detained / arrested persons:

1. right to meet family members for persons convicted by final decision or convicted *in absentia,* until their transfer to IECDs;
2. right of mothers in security rooms to continue breastfeeding their infants.

The General Directorate of State Police ordered all its structures on the use of 2 additional registries to record the above-mentioned provisions. Albeit received by the inspected Police Commissariats, these registries were not used in all commissariats.

Legal and psychological aid

Adult detainees / arrestees who could not afford a private lawyer and asked for legal aid where assigned one in all cases, as the inspection found. List of names and contact details of lawyers were available accordingly.

As for the above, the recommendations included:

1. Take measures to remove the padlock that locks the barred doors of the security rooms / anterooms from the outside at the Kukësi Commissariat, in line with the legislation in force.
2. Take measures to establish a third escort room and their labelling at the Kukësi Commissariat, in line with the legislation in force.
3. Take measures to complete and furbish escort rooms at Kruma Commissariat, in line with the legislation in force.
4. Take measures to establish escort rooms at Tropoja Commissariat in line with the legislation in force.
5. Take measures to ensure that the escort rooms are no longer close to the interception and identification rooms at Kukësi Commissariat.
6. Take measures to include the position of physician and psychologist in the organisational set-up of the Kukësi Region Police Directorate.
7. Take immediate measures to install surveillance cameras in the corridors leading to escort rooms in all Commissariats mentioned above and inspected by the NPM experts, where such system is missing.
8. Take immediate measures to establish detention / arrest rooms in the Tropoja Commissariat and ensure accurate interpretation of the above-cited agreements.
9. Take measures to provide detainees / arrestees with personal hygiene means at the Kukësi Commissariat, in line with the legislation in force.
10. Take measures to update the registries for escorted and detained / arrested persons at all commissariats mentioned above, inspected by the NPM experts.
11. Take measure to use 2 registries as evidence of the applied right to meet family members for persons convicted by final decision or convicted in absentia, until their transfer to IECDs, as well as the right of mothers in security rooms to continue breastfeeding their infants, at all commissariats mentioned above, inspected by the NPM experts.
12. Take measures to properly fill out all registries at Tropoja Commissariat, as provided by Order No 763, dated 27.09.2011 of the General Director of the State Police.
13. Take measures to complete fully and responsibly all columns of registries on escorted and detained / arrested persons at all commissariats mentioned above, inspected by the NPM experts.
14. Take immediate measures to ensure full compliance with the Law No 9749, dated 4.06.2007 “On State Police”, Article 101, concerning escorted persons, in order to depart from the practice seen in all inspected commissariats, where registries on escorted persons included people suspected of criminal offences.
15. Take immediate measures to train the staff in all inspected commissariats on the enforcement of the Law No 9749, dated 4.06.2007 “On State Police”, concerning escorting of people, as well as on the Law No 8454, dated 4.02.1999 “On the People’s Advocate”, as amended.

6.7. RPD Berat and subordinate commissariats:

Kuçova Commissariat, date 13.10.2014 - Doc. No. 201401924
Çorovoda Commissariat, date 13.10.2014 - Doc. No. 201401925
Berati Commissariat, date 14.10.2014 - Doc. No. 201401926

Preliminary remarks

As stipulated in the inspection procedure, the expert team authorised by the Ombudsman initially met the head of each institution, or a person authorised by the head, to communicate them the scope of inspection.

It should be noted that all not heads of institutions inspected were cooperative throughout inspections performed pursuant to Law no 8454, dated 4.02.1999 “On the People’s Advocate”, as amended.

Moreover, the expert group obtained information relevant to their upcoming task and met privately with persons deprived of liberty, inspected the escort and security premises as well as JPOs’ offices, and looked at the records in the registries and relevant legal acts. Specifically, the overall situation and problems identified in the Berati Regional Police Directorate and the subordinate police bodies are presented below.

Conditions in escort premises

Berati Commissariat had 2 escort rooms outside the commissariat, right at the entry, labelled, one for minors and one for adults. Rooms were 3x4 m, equipped with tables and chairs, in line with standards. Windows were barred and had an iron grill to allow adequate natural light. Each room had artificial light from the power grid. Posters were there. Doors were wooden, as required. There were no persons escorted at the moment of inspection. There was no surveillance camera system.

Kuçova Commissariat had 1 escort room inside. It was clean, equipped with table and chairs, 4x3 m, windows big enough to allow sufficient natural light, but without glasses. The Head of Commissariat said that glasses had been commissioned and would be placed soon. The room had artificial light from the electrical grid. The door was wooden, as required. There was a functional toilet at the end of the corridor. Posters were found in rooms and corridor, indicating the rights of escorted persons. There were no escorted persons at the day of inspection. There was no surveillance camera system.

Çorovoda Commissariat had 1 escort room inside. It was relatively clean, with windows big enough to allow sufficient natural light, but without glasses. The room had artificial light from the electrical grid and had a table and chairs. The door was wooden, as required. There was a toilet near the escort room, close to the security rooms, which should have been closed, according to the information obtained from the General Directorate of State Police and the Commissariat staff itself. Posters with the rights of escorted persons were found in the escort rooms. There were no escorted persons at the day of inspection. There was no surveillance camera system.

Conditions at security premises

Berati Commissariat had two security rooms inside the premises, as stipulated by the agreement concluded between the Ministry of Interior and the Ministry of Justice in 2012 “On temporary holding and treatment of detainees/arrestees of police commissariats of Berati, Saranda and Tropoja in the penitentiary premises of the Ministry of Justice”,

At the moment of inspection in the two rooms located at the end of the corridor, there were 7 persons detained/arrested, 4 accommodated in one room and 3 in the other. Both security rooms were small for 4 persons, lacked natural light, air, and had worn-out beds and covers. Each room had a table and 3-4 chairs, preventing free movement of persons inside the room. There was no heating system.

The corridor of the two security rooms was in poor conditions, with electrical wires exposed and becoming a high potential danger. There were surveillance cameras.

Detainees / arrestees could use common toilets and showers, same as those on remand. The team found that there were only two toilets in the whole penitentiary institution, which were quite worn out and they showered after a schedule, with showering rooms extremely damp.

Manual endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police.

Holding citizens in these conditions is not only a blatant breach of the Order No 763, dated 27.09.2011 of the General Director of State Police endorsing the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units”, mentioned above, but constitutes degrading treatment and infringes on human dignity.

Çorovoda and Kuçova Commissariats, from the information obtained from GDSP and the executives with whom the inspection team met, the security rooms should have been closed and not used. However, in two cases, the inspection team found that these rooms were not closed and sealed to indicate that they are out of use, but were found open at the moment of inspection. The staff in both Commissariats said that they had been left open to let air through. However, the team suspected that the rooms in Çorovoda Commissariat had been recently used by the staff there.

Treatment of detainees / arrestees at detention premises

Detainees / arrestees were given food three times a day, in line with the norms on food provision provided for in the Joint Instruction No 432, dated 10.03.2008 of the Minister of Interior and the Minister of Health. The food was provided by the kitchen of the Berati IECD.

In the security rooms inside Berat IECD, despite very poor conditions, detainees / arrestees had running and warm water anytime, both in the common toilets and showers. Provision of detainees / arrestees with items of personal hygiene such as soap, detergents, toothpastes and toothbrushes was insufficient or virtually inexistent.

The inspection team, as informed by the staff and the interviewed persons, noted that there was no informative, didactic or artistic literature, although detainees / arrestees are entitled to it. Detainees / arrestees were offered the chance for yard time outside, however, the interviews indicated that this was not the case.

As regards medical treatment of detainees / arrestees, the inspection team found that the physician of Berati Regional Police Directorate could hardly perform his duties, because of the lack of appropriate premises for visits. From the inspection of the documentation, the team concluded that there was no visits registry, whereas the files of detainees / arrestees were filled out properly. There was shortage of medicaments, particularly those needed for emergencies. For cases of chronic diseases, detainees / arrestees claimed that secured them from their families.

The inspection team found that the registries for security premises pursuant to the Order No 763, dated 27.09.2011 of the General Director of the State Police about the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units” were not kept in a closed compartment under lock. This was made known to the Head of Commissariat and the person responsible for the security rooms.
Nevertheless, all registries were open and filled out properly, as laid down in the above-cited Order.

From interviews with detainees / arrestees, the inspection team realised that 4 of 7 persons had been kept in the security rooms for more than 24 hours, without giving them the chance to meet anybody, including the physician, lawyer or JPO. Such a claim was confirmed by checking the relevant registries.

Furthermore, in Çorovoda Commissariat, the inspection team found that escorted persons were taken their personal belongings, including the cell phone, in blunt violation of the legislation in force.

The corridor leading to the security rooms had video surveillance system.

Interview premises

The security rooms of Berati Commissariat were at Berati IECD, which had 2 rooms used for meetings with families and lawyers and for interviewing, which is in violation of the Order No 763, dated 27.09.2011 of the General Director of State Police endorsing the “Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units”.

The team inspected the JPOs offices in all commissariats and the premises had no surveillance. In JPOs offices there were found no objects that would expose citizens to violence during JPOs procedural actions, except for material evidence left there for lack of storage space.

Surveillance of detention, confinement and interviewing premises

The audiovisual surveillance system is one of the most important aspects for prevention of violent offences against citizens and vice versa, in upholding the fundamental human rights and freedoms. Surveillance cameras were not present in all commissariats the team inspected.

Registry on escorted, detained / arrested persons and their treatment by police

Pursuant to Law No 9749, dated 4.06.2007 “On the State Police” and the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units”, endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police, any police unit having escort and security rooms, must be equipped, *inter alia*, with the Registry on Escorted Persons and the Registry on Detained / Arrested Persons. All the commissariats inspected possessed such registries, except for the Çorovoda Commissariat which did not have a registry on detained/arrested persons. Kuçova and Berati Commissariats had not updated this registry.

In flagrant breach of the official letter of the General Director of State Police No. Prot. 4577/1 dated 18.09.2014 which draws attention on escorting procedure and observance of the rights of persons escorted to the State Police Premise, the following problems were found in all the registries checked:

- There were incomplete or wrongly completed columns. The column about notification of family members has missing information as regards name, father's name, surname and the phone number of the person notified.
    - In Kuçova Police, the column about notification of family members was virtually incomplete in all cases. In one case there was no departure hour, and in another there was not the JPO’s name.
    - In Çorovoda Commissariat, the column about the phone number of the person notified by the escorted person either does not exist, or they had entered the number of the escorted person.
    - The same problems were found in the Berati Commissariat.
- The column about the escorting reason included almost in all cases the commitment of criminal offence by the citizen, e.g. theft, DUI / no driving license, wanted, production or sale of narcotics, domestic violence, conflict with other persons, breach of public order, etc. In the three commissariats inspected, the persons responsible for these registries, in violation of the legislation in force and contrary to the instructions of the GD State Police, admit that persons come as escorted in all cases and, during their stay in the commissariat premises, the JPOs complete the required documentation for their detention/arrest.
- The inspection group found cases where escorted persons were detained / arrested for more than the legal deadline of 10 hours.

Legal and psychological aid

During the inspection, experts were informed by the staffs of inspected Commissariats that the legal obligation to notify the adult detainees / arrestees that they were entitled to a lawyer if they could not afford one and to legal aid, was respected at all times. However, the list of names and contact details of lawyers to be assigned, were not available.

As for the above, the recommendations included:

1. Take measures to open escort rooms in Berat, Kuçova and Çorovoda Commissariats as provided for in the Law No 9749, dated 4.06.2007 “On State Police” and the Order No 763, dated 27.09.2011 of the General Director of the State Police endorsing the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", by creating proper, dignified and furbished premises for stay, separated accordingly for women, males and minors.
2. Take measures to close and seal security rooms in the Kuçova and Çorovoda Commissariats.
3. Take immediate measures to install a camera surveillance system in the corridors of security rooms in Berat, Kuçova and Çorovoda Commissariats.
4. Take immediate measures to close security rooms in Berat IECD, because stay of people in those premises is degrading and in violation of the Law No 9749, dated 4.06.2007 “On State Police” and the Order No 763, dated 27.09.2011 of the General Director of the State Police endorsing the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units”.
5. Take measures to equip the physician’s room at Berat Commissariat, in line with the criteria laid down in the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police.
6. Take measures to provide detainees / arrestees with items of personal hygiene at Berat Commissariat.
7. Take measures to update the registries on detainees / arrestees in all the above-cited commissariats that were inspected by NPM experts.
8. Take measures to complete fully and responsibly all columns of registries on escorted and detained / arrested persons at all commissariats mentioned above, inspected by the NPM experts.
9. Take measures to implement Order No 763, dated 27.09.2011 of the General Director of the State Police, endorsing the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", as regards keeping the registries of security rooms on a single compartment under lock.
10. Take immediate measures to ensure full compliance with the Law No 9749, dated 4.06.2007 “On State Police” and implementation of the official letter of the General Director of State Police No. Prot. 4577/1 dated 18.09.2014 which draws attention on escorting procedure and observance of the rights of persons escorted to the State Police Premises.
11. Take immediate measures to train the staff in all inspected commissariats on the enforcement of the Law No 9749, dated 4.06.2007 “On State Police”, concerning escorting of people, as well as on the Law No 8454, dated 4.02.1999 “On the People’s Advocate”, as amended.
12. Take immediate measures to provide the physician with a coded visits registry, where he should enter records of all visits conducted in this institution.

6.8. Gjirokastra RPD and subordinate commissariats:

Tepelena Commissariat, dated 10.11.2014 - Doc. No. 201402159
Përmeti Commissariat, dated 10.11.2014 - Doc. No. 201402160
Gjirokastra Commissariat (RPD), dated 11.11.2014 - Doc. No. 201402161

Preliminary remarks

As stipulated in the inspection procedure, the expert team authorised by the Ombudsman initially met the head of each institution, or a person authorised by the head, to communicate them the scope of inspection.

It should be noted that all heads of institutions inspected were cooperative throughout inspections performed pursuant to Law no 8454, dated 4.02.1999 "On the People's Advocate", as amended.

Moreover, the expert group obtained information relevant to their upcoming task and met privately with persons deprived of liberty, inspected the escort and security premises as well as JPOs' offices, and looked at the records in the registries and relevant legal acts. Specifically, the overall situation and problems identified in the Gjirokastra Regional Police Directorate and the subordinate police bodies are presented below.

Conditions at escort premises

Tepelena Commissariat had 3 labelled rooms outside, right at the entrance, for minors, women and adults. Rooms were 4x4 m and had only chairs, except for the room for women which had chairs and table. Windows with iron grill were big enough to ensure adequate natural light; all the three had artificial light from the power grid. Posters were in place. Doors of the women's and minors' rooms were made of wood, but were locked from the outside with a latch. The adults' room was wooden on the outside and iron on the inside. It was closed by a latch and had a small window over it. All the rooms had poor hygiene and sanitation. The toilet was far from the escort rooms.

At the moment of inspection there were 2 persons escorted. The inspection team met with them privately and found that one of them was taken the mobile phone and personal items. He also said that he had been escorted in handcuffs and had not notified his family. The team asked for explanation about the case and the violation about the seizure of personal items and handcuffed escorting, in violation of the legislation in force. The Chief of Commissariat informed that a serious occurrence had happened in a Tepelena village that morning and the person had information about it.

There was no camera surveillance system.

Përmet Commissariat had 3 labelled rooms, for minors, women and adults. Rooms were clean and had tables and chairs. They were 4x4 m and had windows with iron grills, big enough to ensure adequate natural light; all the three had artificial light from the power grid. There were wooden doors, as per standards. The room for women and minors had a sink with running water.

A functional toilet was at the corridor of the escort rooms. Rooms and corridors had posters with the rights of escorted persons.

At the moment of inspection there were not persons escorted.

There was no camera surveillance system.

Gjirokastra Commissariat had 2 labelled rooms inside its premises, one for adults and one for women and minors. The first one was relatively clean, with windows that ensured adequate natural light; it also had artificial light from the power grid. It had only one stool and no table. The wooden door met the standards. The toilet was in the corridor. The room for women and minors had two premises, one with beds and covers to sleep in, and the other with one table and no chairs. There was a toilet inside the escort premises, but in poor hygiene and sanitary conditions as the whole escort premises. The wooden door complied with standards. Both rooms had posters with the rights of escorted persons placed accordingly.

At the moment of inspection there were no escorted persons.

There was no camera surveillance system.

Conditions at security premises

Gjirokastra Commissariat had 8 security rooms, including one for women and minors. During the inspection, there were 6 persons detained/arrested. These premises met all standards of the legislation in force. Rooms had anterooms and adequate natural and artificial light. Rooms had beds, but covers were worn out. There was a central heating system. The room and the anteroom were separated by a barred door closed on the side of the anteroom, without a handle. The corridor of security premises had surveillance system. *En suite* toilets in each room were functional and clean. Each anteroom had sink, all of them functional. Detainees/arrestees could shower with warm water anytime, but the hygiene and sanitary conditions left to be desired. Posters with the rights and legal obligations of detainees/arrestees were placed in the corridor and inside rooms. Hours of daily activities were also placed inside rooms. Rooms lacked bells, but the detainees/arrestees informed the inspection team that communication with the service personnel was possible and smooth in case of emergency.

Tepelena and Përmeti Commissariats, according to the information obtained from the GDSP and the executives there, the security rooms were closed and were not used.

Treatment of detainees / arrestees at detention premises

Detainees / arrestees were given food three times a day, in line with the norms on food provision provided for in the Joint Instruction No 432, dated 10.03.2008 of the Minister of Interior and the Minister of Health. The food was provided by the kitchen of the Gjirokastra. The inspection team saw that food quality was very good, but noted that food samples were not maintained in locked refrigeration; this was made known to the Head of Commissariat, physician and kitchen staff.

Detainees / arrestees in the security rooms of Gjirokastra Commissariat had running and warm water anytime. Provision of detainees / arrestees with items of personal hygiene such as soap, detergents, toothpastes and toothbrushes was insufficient or virtually inexistent.

The inspection team, as informed by the staff and the interviewed persons, noted that there was no informative, didactic or artistic literature, although detainees / arrestees are entitled to it. Detainees / arrestees were offered the chance for yard time in line with standards laid down in the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Unit", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police.

As regards medical treatment of detainees / arrestees, the inspection team found that the ass. physician of Gjirokastra Regional Police Directorate performed his duties in premises appropriate for visits, in a room with good hygiene, but with an examination bed unsuitable for medical visits. From the inspection of the documentation, the team concluded that there was a visits registry and the files of detainees / arrestees were filled out properly, but this was the case for only one copy that was attached to the documents of the personal file forwarded to IECD.

A good example was the fact that the hospital in Gjirokastra had a designated room for detained / arrested persons which remained locked anytime there were no detained / arrested patients, as provided for in the cooperation agreement concluded between the Ministry of Internal Affairs and the Ministry of Health.

The inspection team found that the registries for security premises pursuant to the Order No 763, dated 27.09.2011 of the General Director of the State Police about the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units” were kept in the same compartment under lock. All registries were open and filled out properly, as laid down in the above-cited Order.

The corridor leading to the security rooms had video surveillance system.

Gjirokastra Commissariat had a designated room for interviews and for meetings with lawyers, in line with Order No 763, dated 27.09.2011 of the General Director of the State Police about the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units”.

In JPOs offices there were found no objects or material evidence that would expose citizens to violence during JPOs procedural actions.

Surveillance of detention, confinement and interviewing premises

The audiovisual surveillance system is crucial to the prevention of violent crimes against citizens and vice versa, as well as for observance of human rights and fundamental freedoms. Such system was missing in all commissariats inspected by the experts, except for the Gjirokastra Commissariat.

Registry on escorted, detained / arrested persons and their treatment by police

Pursuant to Law No 9749, dated 4.06.2007 "On the State Police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police, any police unit having escort and security rooms, must be equipped, *inter alia*, with the Registry on Escorted Persons and the Registry on Detained / Arrested Persons. All the commissariats inspected possessed such registries, except for the Tepelena Commissariat which did not have a registry on detained/arrested persons. Gjirokastra and Përmet Commissariats had not updated this registry.

In flagrant breach of the official letter of the General Director of State Police No. Prot. 4577/1 dated 18.09.2014 which draws attention on escorting procedure and observance of the rights of persons escorted to the State Police Premise, the following problems were found in all the registries checked:

- There were incomplete or wrongly completed columns. The column about notification of family members has missing information as regards name, father's name, surname and the phone number of the person notified. This was particularly true on the Gjirokastra and Tepelena Commissariats.
    - In Kuçova Police, the column about notification of family members was virtually incomplete in all cases. In one case there was no departure hour, and in another there was not the JPO's name.
    - In Çorovoda Commissariat, the column about the phone number of the person notified by the escorted person either does not exist, or they had entered the number of the escorted person.
    - In Tepelena Commissariat, data were often entered in the wrong columns. In the last 4 cases, nothing was written about names and phone number of families, or the relevant JPO.
    - The column about the escorting reason included almost in all cases the commitment of criminal offence by the citizen, e.g. theft, breach of public order, illegal connection of electricity, property conflict, wanted, production or sale of narcotics, domestic violence, conflict with other persons, etc. In the three commissariats inspected, the persons responsible for these registries, in violation of the legislation in force and contrary to the instructions of the GD State Police, admit that persons come as escorted in all cases and, during their stay in the commissariat premises, the JPOs complete the required documentation for their detention/arrest.
- The inspection group found in the three commissariats cases where escorted persons were detained / arrested for more than the legal deadline of 10 hours, such as the concrete cases in Tepelena Commissariat.

Legal and psychological aid

During the inspection, experts were informed by the staffs of inspected Commissariats that the legal obligation to notify the adult detainees / arrestees that they were entitled to a lawyer if they

could not afford one and to legal aid, was respected at all times. However, the list of names and contact details of lawyers to be assigned, were not available in each case.

As for the above, the recommendations included:

10. Take measures to analyse the situation found by the inspection group in Tepelena Commissariat and take appropriate measures.
11. Take measures to remove latches from doors of security rooms in the Tepelena Commissariats and adjust the door of the security rooms for adults as provided for in Order No 763, dated 27.09.2011 of the General Director of the State Police endorsing the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".
12. Take measures to establish another security room, as well as paint and clean existing premises at Gjirokastra Commissariat, in order to create suitable and dignified premises equipped with necessary furniture for stay, and separated accordingly for women, males and minors.
13. Take measures to furbish the escort rooms in Gjirokastra and Tepelena Commissariats with the required furniture as provided for in Order No 763, dated 27.09.2011 of the General Director of the State Police endorsing the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".
14. Take measures to open suitable toilets near the escort rooms at Tepelena Commissariat, as provided for in Order No 763, dated 27.09.2011 of the General Director of the State Police endorsing the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".
15. Take immediate measures to install the camera surveillance system in the corridors of escort rooms at Tepelena and Përmeti Commissariats.
16. Take measures to provide detainees / arrestees in the Gjirokastra Commissariat with items of personal hygiene.
17. Take measures to install bells in the security rooms of Gjirokastra Commissariat, as provided for in Order No 763, dated 27.09.2011 of the General Director of the State Police endorsing the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".
18. Take immediate measures to ensure that medical files of detainees / arrestees at Gjirokastra Commissariat are kept in two copies, so that one is maintained as document at the physician’s office.
19. Take measures to improve hygiene and sanitary conditions in the escort rooms, particularly in Tepelena and Gjirokastra Commissariats.
20. Take measures to improve hygiene and sanitary conditions in the showers of the security rooms at Gjirokastra Commissariat.
21. Take measures to update the registries of detainees / arrestees in all the above-cited commissariats inspected by NPM experts.
22. Take measures to complete fully and responsibly all columns of registries on escorted and detained / arrested persons at all commissariats mentioned above, inspected by the NPM experts, in line with the official letter of the General Director of State Police No. Prot. 4577/1 dated 18.09.2014 which draws attention on escorting procedure and observance of the rights of persons escorted to the State Police Premises.

23. Take immediate measures to ensure full compliance with the Law No 9749, dated 4.06.2007 "On State Police" and implementation of the official letter of the General Director of State Police No. Prot. 4577/1 dated 18.09.2014 which draws attention on escorting procedure and observance of the rights of persons escorted to the State Police Premises.
24. Take measures to strictly respect the 10-hour deadline for escorted persons in the Commissariats inspected by NPM experts and take relevant action for identified cases of violation.
25. Take immediate measures to train the staff in all inspected commissariats on the enforcement of the Law No 9749, dated 4.06.2007 "On State Police", concerning escorting of people, as well as on the Law No 8454, dated 4.02.1999 "On the People's Advocate", as amended.

6.9. Tirana RPD and subordinate commissariats

Tirana Regional Police Directorate, dated 24.10.2014- Doc. No. 201402369
Police Commissariat No. 1, dated 22.10.2014- Doc. No. 201402370
Police Commissariat No. 2, dated 24.10.2014- Doc. No. 201402371
Police Commissariat No. 3, dated 24.10.2014- Doc. No. 201402372
Police Commissariat No. 4, dated 03.12.2014- Doc. No. 201402373
Police Commissariat No. 5, dated 22.10.2014- Doc. No. 201402374
Police Commissariat No. 6, dated 03/ 11.12.2014- Doc. No. 201402375
Kavaja Commissariat, dated 23.04.2014- Doc. No. 201400839
Rrogozhina Police Station, dated 23.04.2014- Doc. No. 201400838

Preliminary remarks

As stipulated in the inspection procedure, the expert team authorised by the Ombudsman initially met the head of each institution, or a person authorised by the head, to communicate them the scope of inspection.

It should be noted that all heads of institutions inspected were cooperative throughout inspections performed pursuant to Law no 8454, dated 4.02.1999 "On the People's Advocate", as amended.

Moreover, the expert group obtained information relevant to their upcoming task and met privately with persons deprived of liberty, inspected the escort and security premises as well as JPOs' offices, and looked at the records in the registries and relevant legal acts. Specifically, the overall situation and problems identified in the Tirana Regional Police Directorate and the subordinate police bodies are presented below.

Conditions at escort premises

Tirana Regional Police Directorate had 3 escort rooms for minors and adult males and women inside the premises. The room for minors was 3x3m and had two chairs. The one for adult males and women was 3x5m and had 16 and 18 chairs, but no tables. Overall, the rooms were in poor

hygiene and sanitary conditions. Windows were barred and had iron grill. There was sufficient natural and artificial light. There were two persons escorted at the moment of inspection. A surveillance monitoring camera was in place.

Commissariat no.1 had 1 escort room inside the premises. Big only 3x4m, it was in poor hygiene and sanitary conditions, with only 5 chairs in series, a corner by the window which could give rise to claims of abuse; all these out of line with the pre-set standards. A window with iron grill was big enough to ensure adequate natural light. Another window barred and with iron grill divided this room from the office. It had artificial light from the power grid, but electrical wires were exposed and a potential danger to persons in these premises, as admitted by the Commissarial staff themselves. Posters were in place. The door had an iron grill, but out of standards. There were no persons escorted at the moment of inspection. There was no camera surveillance system.

Commissariat no.2 had 3 escort rooms inside the premises, labelled, for women, males and minors. There were no persons escorted at the moment of inspection. There was no camera surveillance system. Escort rooms were relatively clean, equipped with table, chairs and a couch at the room for minors and women. Rooms were big 4x3m and had windows big enough to ensure adequate natural light. There was also artificial light from the power grid. Doors were made of wood, as by standard. Posters with the rights of escorted persons were placed on corridors and rooms. There was no camera surveillance system.

Commissariat no.3 had 2 escort rooms inside the premises, labelled, for women, males and minors. Rooms had artificial light from the power grid. The room for women and minors and 2 chairs in series, no table, with windows that ensured adequate natural light and a wooden door as by standards. The room for males had an iron grill and an external latch. It had 7 chairs in series, but no table. There was no adequate natural light. Posters with the rights of escorted persons were placed on corridors and rooms. There were three persons escorted at the moment of inspection. There was no camera surveillance system.

Commissariat no.4 had 1 escort room inside the premises, completely out of standards. The room had an iron grill and was closed with latch from the outside. It had two stools, but no table. The window was too small to provide adequate light, while artificial light was also poor. The same premises were used for both escorted and detained/arrested persons. The inspection team found there two adults detained/arrested, and two minors escorted, but who were not in these premises. Minors had been escorted during the night of 15 December 2014 around 01.00 A.M. in breach of Article 101 of Law No 9749, dated 04.06.2014 “On State Police” and they stood all night on stools in the corridor. The registry on escorted persons was not filled out properly for this case, and family was informed only around 9.00 A.M. The inspection team met with the parents who were concerned, as they had no information where their children were during the night. The minors were released and joined their families at around 11:00 A.M.

Commissariat no.5 had 2 escort rooms inside the premises, labelled, for minors and adult women and males. The room for women had a wooden door, as per standards, but no furniture. In had *in suite* toilet, but unclean. The room for males had no door, a very worn-out table and 2 chairs, and one cupboard. This premise led to an office were documents were kept; it had a very

unclean toilet. The inspection team found these rooms were separated from the other part of the commissariat by a big barred door. Also, there was another room with 2 stools, good natural and artificial light, but the staff informed the inspectors that it was not used for escorting.

Commissariat no.6 had no escort rooms, as the inspection team was informed by the Chief of Commissariat, while the staff said that a container located in the yard served as an escort room. The inspection team went inside the container which had a big number of cupboards, one TV, 2 broken chairs and lacked artificial light. There were cigarette butts on the ground, indicating the presence of persons not long ago. In order to confirm whether escorted persons were held in the container, the NPM experts made another inspection around 9:30 P.M of 11 December 2014, where still found no escorted persons.
There were still items there that indicated the presence of persons (cigarette butts, a 1.5 litre bottle and an umbrella).

Kavaja Commissariat had 3 escort rooms inside the premises for women, males and minors. These were separated from other premises by a door with iron grill, locked at the moment of inspection. There were surveillance cameras and posters with the rights of escorted and detained persons, with the latter present also in the escort rooms. Rooms were 4x4m, with windows big enough to ensure adequate natural light. The room for males had only chairs, which were quite worn-out and dirty. There was no table. The rooms for women and minors and cleaner, but had no chairs/tools or tables. Doors were made of wood and could be locked by key. A functional toilet was in the corridor.

In the Rrogozhina Police Station, the inspection team found that there were neither escort rooms nor security rooms.

Conditions at security premises

Tirana Regional Police Directorate had 8 security rooms: one for women, one for minors and 6 for adult males, fully in line with requirements of Order No 763, dated 27.09.2011 of the General Director of State Police endorsing the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units". Size of rooms and natural and artificial light complied with the manual. At the moment of inspection there were 30 persons detained/arrested; some of them on remand.

There was central heating system.

The corridor of security rooms and the entire premises were in line with the pre-set standards of the manual. It had a bell for each room and surveillance cameras.

In addition to the *en suite* toilets, there were common toilets and showers in very good condition.

Commissariat no.1 had 3 security rooms, 1.5x2m, with worn-out mattresses and covers, without beds. Windows were too small to ensure adequate natural light and air, while artificial light was too weak. At the moment of inspection there were 2 persons. Inside room there was another

premise for yard-time and meetings, with big windows that provided abundant natural light, but had no glasses. It was equipped with chairs and table.

There was no central heating system.

The corridor of security rooms and the rooms themselves failed to meet any pre-set standards of Order No 763, dated 27.09.2011 of the General Director of State Police endorsing the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".

Detainees/arrestees could use a common toilet that was quite worn-out and in terrible hygiene and sanitary condition.

Holding citizens in these conditions is not only a blatant breach of the Order of the General Director of State Police mentioned above, but constitutes degrading treatment and infringes on human dignity.

Commissariat no.2 had 3 security rooms, 1.10x2.65m, 1.67mx2.65m and the third one bigger than both. The three rooms had beds and covers, but extremely worn out. Windows were too small to ensure adequate natural light and air, while artificial light was too weak, almost inexistent. At the moment of inspection there was 1 person detained / arrested.

There was no heating system.

The corridor of security rooms and the rooms themselves failed to meet any pre-set standards of Order No 763, dated 27.09.2011 of the General Director of State Police endorsing the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".

Detainees/arrestees could use a common toilet that was quite worn-out and in terrible hygiene and sanitary condition.

Holding citizens in these conditions is not only a blatant breach of the Order of the General Director of State Police mentioned above, but constitutes degrading treatment and infringes on human dignity.

Commissariat no.3 had 2 security rooms and 1 technical room. Both were 3x2m, without beds, only worn-out covers. Windows were too small to ensure adequate natural light and air, while artificial light was too weak, almost inexistent. At the moment of inspection there were 7 persons detained / arrested.

There was neither heating system, nor surveillance cameras.

The corridor of security rooms and the rooms themselves failed to meet any pre-set standards of Order No 763, dated 27.09.2011 of the General Director of State Police endorsing the Manual on

"Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".

Detainees/arrestees could use a common toilet that was quite worn-out and in terrible hygiene and sanitary condition.

Holding citizens in these conditions is not only a blatant breach of the Order of the General Director of State Police mentioned above, but constitutes degrading treatment and infringes on human dignity.

Commissariat no.5 had 3 security rooms and 2 for identification. Rooms were 2.5x.2.5m, in poor hygiene and sanitary conditions and not all persons had a bed; most slept in worn-out covers on the ground. Windows were too small to ensure adequate natural light, while artificial light was weak. Adequate air was impossible in such conditions. At the moment of inspection there were 8 persons detained / arrested, with 6 under remand in prison.

There was neither heating system, nor surveillance cameras.

The corridor of security rooms met the pre-set standards of Order No 763, dated 27.09.2011 of the General Director of State Police endorsing the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".

Detainees/arrestees could use a common toilet that was quite worn-out and in terrible hygiene and sanitary condition.

Holding citizens in these conditions is not only a blatant breach of the Order of the General Director of State Police mentioned above, but constitutes degrading treatment and infringes on human dignity.

Commissariat no.6 had 1 security rooms and 2 locked rooms, which the staff said they did not have the key to open them. However, PNM inspectors checked and confirmed there were no people inside. The open room was 1.5x.2.5m, in very poor hygiene and sanitary conditions, without any bed, only extremely worn-out covers. Windows were too small to ensure adequate natural light, while artificial light was weak. Adequate air was impossible in such conditions. At the moment of inspection there were no persons detained / arrested. The PNM found untouched food items inside the rooms; the staff explained that the person was in court and would return.

There was neither heating system, nor surveillance cameras, although the security room was outside the Commissariat building, at the entrance, specifically.

The corridor of security rooms was very small and completely out of line with pre-set standards of Order No 763, dated 27.09.2011 of the General Director of State Police endorsing the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".

Detainees/arrestees did not have any toilet for their personal needs.

Holding citizens in these conditions is not only a blatant breach of the Order of the General Director of State Police mentioned above, but constitutes degrading treatment and infringes on human dignity.

Kavaja Commissariat had 3 security rooms, for women, males and minors. At the moment of inspection there were 4 people detained, all adult males. Although rooms were constructed in line with the standards defined in the above-cited manual, covers were worn-out, the same as the *en suite* toilets. Detainees told the inspection team that they went to another premise for their personal needs. At the moment of inspection, there were 2 persons in each room; one slept in bed, the other on the ground, on two mattresses one above the other. The living premises were unclean. Detainees had a shower and warm water was available upon the request of detainees/arrestees. The showering premises was worn-out. Cameras were installed in the corridor.

None of the police units mentioned above, except for the Regional Directorate and Kavaja police, provided access to shower. Such a degrading treatment is in blunt breach of the above-cited Order of the General Director of State Police.

Treatment of detainees / arrestees at detention premises

Detainees / arrestees were given food three times a day, in line with the norms on food provision provided for in the Joint Instruction No 432, dated 10.03.2008 of the Minister of Interior and the Minister of Health. Food was provided mainly through catering.

Detainees / arrestees in the security rooms in the units above had running but not warm water in the common toilets, except in the Tirana Regional Police Directorate where there was running and warm water anytime. Provision of detainees / arrestees with items of personal hygiene such as soap, detergents, toothpastes and toothbrushes was insufficient or virtually inexistent.

The inspection team, as informed by the staff and the interviewed persons, noted that there was no informative, didactic or artistic literature, although detainees / arrestees are entitled to it. Detainees / arrestees were not offered the chance for yard time in the outdoor premises.

As regards medical treatment of detainees / arrestees, the inspection team found that there were shortcomings in all commissariats. Most detainees / arrestees that the physician or his assistant had not contacted with them. Also, the visits registry and medical files had incomplete entries.

The Health Sector at Tirana Regional Police Directorate had one physician and an assistant. Examination of the documentation showed that in the majority of cases of completed files, the records had not been entered in the visits registry and vice versa. Besides, the inspection team found some blank spaces in the visits registry. In all commissariats, the physician’s documentation was kept in closed compartment under lock.

As regards medical treatment, detainees / arrestees claimed there was a shortage of both the emergency and chronic medicaments, and these were provided mostly by their families.

However, our inspection group saw a variety of medicaments in the Regional Directorate kept in a locker at the physician's room.

The physician at the Kavaja Commissariat was in the organisational set-up, but was not present, as confirmed from meetings with detainees / arrestees. The staff said that the physician came anytime there were detainees / arrestees, but this fell short of confirmation from the persons in the security rooms at the moment of inspection. The visits registry was completed until 20/03/2014, the same as the medical files, which were kept locked. The physician's room was inadequate, small, worn cabinet, lack of basic and emergency medicaments. There was a refrigerator, but it was used for purposes other than the appropriate.

The inspection team found that, in all police units inspected, the registries for security rooms pursuant to the Order No 763, dated 27.09.2011 of the General Director of the State Police about the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units" were there and were kept in order. New registries required pursuant to the change in the above-cited manual were missing in the Police Commissariats no. 2 and 3, as well as the Regional Police Directorate. In the Police Commissariat no. 6, there was a complaints box, but not the registry.

From interviews with detainees / arrestees, the inspection team found that there were people in in some commissariats had received their security measures and continued to be kept in the security rooms, without being transferred to pre-trial detention.

Some detainees / arrestees said that they had not been visited by the physician, and their claim was backed by the relevant registries.

The inspection team found from interviews and talks with the staff that, in some commissariats, escorted persons were taken their personal belongings, including the cell phone, in blunt violation of the legislation in force.

The corridors leading to the security rooms in the above-cited police units did not have any video surveillance system, except for the Regional Police Directorate.

Interview premises

The security premises in the police units mentioned above, except for Commissariat no. 5, Kavaja Commissariat and the Regional Police Directorate, there were no interview rooms or premises to meet with lawyers, in violation of the Order No 763, dated 27.09.2011 of the General Director of State Police endorsing the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units". Police units having no such rooms, the security function was played by the offices of the supervisors of security rooms.

The team inspected all the JPOs offices in commissariats, but these had no surveillance. There were found no objects that would expose citizens to violence during interviewing, however, there were material evidence due to lack of storage space.

Surveillance of detention, confinement and interviewing premises

The audiovisual surveillance system is crucial to the prevention of violent crimes against citizens and vice versa, as well as for observance of human rights and fundamental freedoms. Such system was missing in all commissariats inspected by the experts, except for the Kavaja Regional Police Directorate and the Kavaja Commissariat.

Registry on escorted, detained / arrested persons and their treatment by police

Pursuant to Law No 9749, dated 4.06.2007 "On the State Police" and the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units", endorsed by Order No 763, dated 27.09.2011 of the General Director of the State Police, any police unit having escort and security rooms, must be equipped, *inter alia*, with the Registry on Escorted Persons and the Registry on Detained / Arrested Persons. All the commissariats inspected possessed such registries, except for Commissariat no.4, which did not have a registry on detained/arrested persons. The Regional Police Directorate and Commissariats no.5, 3 and 1 had such registry not updated.

In flagrant breach of the official letter of the General Director of State Police No. Prot. 4577/1 dated 18.09.2014 which draws attention on escorting procedure and observance of the rights of persons escorted to the State Police Premise, the following problems were found in all the registries checked:

- Not all columns were completed correctly.
  - The column about notification of family members has missing information as regards name, father's name, surname and the phone number of the person notified.
  - In Commissariat no.1, the last column about claims of escorted persons was left blank in all cases; the same situation was also in Commissariat no.2.
  - Commissariat no.4 had not notified family members for the escorting of the two minors in the early hours, putting there the note "did not notify because too late".
- The column about the escorting reason included almost in all cases the commitment of criminal offence by the citizen, e.g. theft, DIU / no driving licence, person wanted, production or sale of narcotics, domestic violence, conflict with other persons, breach of public order, etc. In all police units inspected and in all cases, the persons responsible for these registries, in violation of the legislation in force and contrary to the instructions of the GD State Police, admit that persons come as escorted in all cases and, during their stay in the commissariat premises, the JPOs complete the required documentation for their detention/arrest.
- Virtually in all police units inspected, the team found that escorted persons were released or detained/arrested in the limit of the 10-hour deadline, or by exceeding it.
- In Commissariat no.4, the inspection team found a non-coded registry in the corridor before the escort room, which showed the entry-exits of persons from the escort room at that police units.
- The Regional Police Directorate had a non-coded registry before the escort room and the entrance to the security rooms, for which the team did not obtain any clear explanation about its use and purpose.

Legal and psychological aid

During the inspection, experts were informed by the staffs of inspected police units that the legal obligation to notify the adult detainees / arrestees that they were entitled to a lawyer if they could not afford one and to legal aid, was respected at all times. However, the list of names and contact details of lawyers to be assigned, were not available in each case.

Psychological aid during interview of minors escorted or detained in police commissariats of Tirana Regional Police Directorate, albeit a legal obligation, not always was made available. Such aid was not provided to two minors escorted on the evening of 15.12.2014 at Commissariat no.4.

As for the above, the recommendations included:

1. Take immediate measures to analyse the situation found by the inspection group in Police Commissariat no. 4 as regards treatment of two minors escorted there, and take appropriate disciplinary actions.
2. Take immediate measures to stop use of non-coded registries found by NPM experts at Regional Police Directorate and at Police Commissariat no. 4.
3. Take measures to reduce overcrowding at Tirana Regional Police Directorate, Commissariats no. 3 and 5.
4. Take immediate measures to close the container used as escort room at Police Commissariat no. 6.
5. Take measures to renovate all security rooms in all above-cited police units, except for the Regional Police Directorate and Kavaja Commissariat, as provided for in Law No 9749, dated 04.06.2007 “On State Police” and the Order No 763, dated 27.09.2011 endorsing the Manual on “Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units,” in order to create suitable and dignified premises equipped with necessary furniture for stay, and separated accordingly for women, males and minors.
6. Take measures to renovate all common toilets and showers in all above-cited police units, except for the Regional Police Directorate, in line with standards set out in the legislation in force.
7. Take measures to equip escort rooms with all accessories and ensure natural and artificial light in all above-cited police units, in line with standards set out in the legislation in force.
8. Take measures to open 3 security rooms and renovate the actual room in Commissariat no. 1, in line with standards set out in the legislation in force.
9. Take measures to make the escort room for adult males in Commissariat no. 3, in line with standards set out in the legislation in force.
10. Take measures to open 3 escort rooms and renovate the actual room in Commissariat no. 4, in line with the requirements of the legal framework mentioned above.
11. Take immediate measures to install the camera surveillance system in the corridors of escort rooms in all above-cited police units, except for the Regional Police Directorate and Kavaja Commissariat.

12. Take measures to provide items of personal hygiene to detainees / arrestees in all police units having security rooms.
13. Take measures to update the registries of detainees / arrestees in all the above-cited police units inspected by NPM experts.
14. Take measures to open and use the registry of detainees / arrestees in police units not having one.
15. Take measures to complete fully and responsibly all columns of registries on escorted and detained / arrested persons at all commissariats mentioned above, inspected by the NPM experts, in line with the official letter of the General Director of State Police No. Prot. 4577/1 dated 18.09.2014 which draws attention on escorting procedure and observance of the rights of persons escorted to the State Police Premises.
16. Take measures to open and use registries required following recent changes to the Order No 763, dated 27.09.2011 of the General Director of the State Police endorsing the Manual on "Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units".
17. Take measures to open and use the register for applications / complaints at the Police Commissariat no. 6.
18. Take measures to complete fully and responsibly all columns of registries on escorted and detained / arrested persons at all police units mentioned above, inspected by the NPM experts.
19. Take immediate measures to ensure full compliance with the Law No 9749, dated 4.06.2007 "On State Police" and implementation of the official letter of the General Director of State Police No. Prot. 4577/1 dated 18.09.2014 which draws attention on escorting procedure and observance of the rights of persons escorted to the State Police Premises.
20. Take immediate measures to train the staff in all inspected commissariats on the enforcement of the Law No 9749, dated 4.06.2007 "On State Police", concerning escorting of people, as well as on the Law No 8454, dated 4.02.1999 "On the People's Advocate", as amended.
21. Take immediate measures to provide informative, didactic and artistic literature as well as yard-time outdoors for detainees / arrestees.
22. Take measures to ensure medical treatment of detainees / arrestees and that visits registries and medical files are filled out correctly.
23. Take measures to ensure psychological aid to minors during interviewing in the Tirana Regional Police Commissariats, and notify their families since the first moment of escorting or detention in the police premises.

6.10. Vlora RPD and subordinate commissariats

Delvina Commissariat, dated 11.11.2014 - Doc. No. 201402222
Saranda Commissariat, dated 12.11.2014 - Doc. No. 201402223
Himara Commissariat, dated 13.11.2014 - Doc. No. 201402224
Vlora Commissariat (RPD), dated 13.11.2014 - Doc. No. 201402225

Preliminary remarks

As stipulated in the inspection methodology, the expert team authorised by the Ombudsman initially met the head of each institution and communicated them the scope of visit. The heads were fully available to meet all the requests of the inspection team. During the inspection, the team had fruitful consultations with the Chief/Head of Saranda Commissariat, the Chiefs/Heads of Public Order and Security in Vlora and Delvina Commissariats, as well as with other officials of these police units.

The inspection team was informed by the police staff about the implementation of the tasks assigned following the draw of attention by the General Director of State Police regarding the escort premises and observance of the rights of escorted persons to the premises of State Police, through document No. Prot. 4577 dated 18.09.2014 and addressed to Regional Police Directorates. The inspection team found that this Police Directorate had taken some measures, but some issues still persisted, as explained below.

The expert group obtained information relevant to their upcoming task and met privately with persons deprived of liberty. It inspected the escort and security premises as well as JPOs' offices, and looked at the records in the registries and relevant legal acts.

Conditions at escort premises

In the Saranda and Delvina Commissariats, the old escort rooms were put out of use by Order No 239, dated 28.05.2012 of the General Director of State, as recommended by the Ombudsman along the years. Escorted persons had to be held in the offices of the police staff, according to the order, but not necessarily 10 hours. Besides, it specified that persons must not stay locked and without the presence of a police officer.

In the Himara Police Station had only one escort room 3x3 m, with windows 80x50 cm, iron doors kept under lock and latch, without electricity, without heat, unpainted and unclean. It lacked the necessary furniture for living, such as a bed, table, stools, for persons to sit. Matrasses, blankets and pillows were very worn and unclean. The room lacked audiovisual equipment (camera) for keeping the detained/arrested person surveyed. The escort room was not spacious and had no windows for airing and for adequate natural light. It was being used at the day of inspection, albeit put out of use by Order No 239, dated 28.05.2012 of the General Directorate of State Police.

In the Vlora Commissariat, the escort premises were in the first floor of a two-storey building outside the Police Commissariat. There was an anteroom and a room with dimensions 3.5x3.5m and 4x4m, with normal windows that allow adequate airing and natural light. The anteroom had

a steel door with lock and latch, with electricity light, painted, clean, but without heating. Rooms were equipped with necessary furniture such as tables and chairs for persons to sit. There was an out-of-function toilet inside, as there was water and it was damaged. Rooms were not separated for women, males and minors, as stipulated by Law No 9749, dated 04.06.2007 "On State Police". Posters with the legal rights of escorted persons were posted in the escort premises. At the moment of inspection there were two persons escorted.

The People's Ombudsman had found inadequate premises during previous inspections and provided recommendations to Vlora Regional Police Directorate and its subordinate commissariats. Although welcome in principle, these recommendations were not addressed in practice, because no concrete efforts seemed to have been made to improve the situation.

Conditions at security premisës

Delvina Commissariat lacked security premises and detained/arrested persons were sent to the security rooms of Vlora Commissariat.

In the Saranda Commissariat, the old security rooms were put out of use by Order of the General Director of State Police for failure to meet the standards, as recommended by the Ombudsman and international organisations (CPT). However, the inspection team found an arrested person in the security rooms. The police staff claimed that he was placed there because the rooms had been recently put again into use. The arrested person would stay in those premises until they received the order by the General Directorate of Penitentiary Police that determines which institution he should serve his remand or sentence. Overall, these persons were held in these premises from 5 to 15 days. This commissariat had little chance of transporting the arrestees to the security rooms of Vlora commissariat, due to long distance and because actual conditions in these premises were conditioned suitable and legally compliant.

Police staff of Saranda commissariat were convinced that holding detainees / arrestees or suspects of criminal offences in the premises put out of uses, did not constitute violation of the Order No 239, dated 28.05.2012 of the General Directorate of State Police. It should be noted that these premises did not meet the standards, as there were no separate rooms for women, males and minors. Security rooms fell short of the technical norms and parameters of living for an arrested or detained person, because the overall area was not 10 square meters and was not divided into a stay premise (room) 6m^2 and an anteroom 4m^2. Moreover, there were no necessary furniture for living, such as a bed, table, stools, etc. Matrasses, blankets and pillows were very worn and unclean. The room lacked audiovisual equipment (camera) for keeping the detained/arrested person surveyed.

Vlora Commissariat had two security rooms 4x3 m, with windows 50x30 cm that were barred and with iron grills, and metallic doors kept under lock and latch. Rooms had a corridor 5x1.2 m with two entry barred doors.

Security rooms did not comply with standards laid down in the Law No 9749, dated 04.06.2007 "*On State Police*" and the Manual on *"Standard Rules and Procedures on Treatment and Security of Persons Arrested and Detained in Police Units"*, as they were not separated for

women, males and minors. Rooms did not meet the technical norms and parameters of living for an arrested or detained person, because there were no necessary furniture for living, such as a bed, table, stools, etc. Matrasses, blankets and pillows were very worn and unclean. Windows did not provide adequate air and natural light. There was no audiovisual equipment (camera) for keeping the detained/arrested person surveyed. There was also an *en suite* toilet, with functional shower, but without running water for showering.

The conditions of the security premises in Vlora Commissariat were quite concerning, given also the big inflow of detainees/arrestees from the commissariats and regional police stations of Vlora Region Police Directorate.

The police staff at this directorate informed the inspectors that there was a project to build new security rooms that complied with standards, but it had stalled for lack of funds.

At the moment of inspection, there were 4 persons detained/arrested within the deadlines of their remand.

Treatment of detainees / arrestees at detention premises

In the Saranda Commissariat, detainees / arrestees did not have access to warm showers and lacked washing and cleaning facilities, because toilets were not furbished.

Detainees / arrestees were not provided the opportunity to read the daily press, which could be obtained on their own expenses. Individual radios working with batteries and headphones were forbidden. There was no place for religious rites, and they were not allowed to keep paper and pencil to write, toothpaste and toothbrush, shaving cream and plastic shaving razors. Besides, the Police Commissariat did not provide them with soap, detergents, toilet paper, tissue paper for hands or towels and other items of personal hygiene, as provided for in the norms and rules in force.

Room windows could not provide sufficient air and there were no conditions for ventilation or circulation of air. Detainees / arrestees were not given yard time, as provided by law, because there were no such premises.

In the Vlora Commissariat, detainees / arrestees had not been provided food for over one month, in violation of point 2.4 of the Chapter *"On food"* and point 16 of Chapter "*On the rights of persons detained /arrested in the State Police premises"*. Failure to provide food had resulted from termination and non-renewal of the contract by the Vlora Regional Police Directorate with the catering firm. During this period, detainees / arrestees had been given food only by their families.

Detainees / arrestees had medical checks as provided by law (within 24 hours) and each had a medical file. Vlora Regional Police Directorate had one general physician and a room suitable for visits. First-aid kits were secured constantly with funds from Police Directorate.

Detainees / arrestees could read the daily press, obtained on their own expenses. They were allowed to keep paper and pencil to write, toothpaste and toothbrush, shaving cream and plastic shaving razors.

The Police Commissariat did not provide them with soap, detergents, toilet paper, tissue paper for hands or towels and other items of personal hygiene, as provided for in the norms and rules in force.

There were no posters in Albanian and foreign languages inside rooms indicating the rights of detainees / arrestees.

Interview premises

Kukësi and Saranda Commissariats had no interview rooms for investigators, and for meeting with their lawyers. Both commissariats lacked any surveillance in the room for procedural actions of JPOs

In JPOs offices there were found no objects or material evidence that would expose citizens to violence during JPOs procedural actions.

Monitoring of escorting, custody and investigation facilities

There is no camera monitoring in any of the police commissariat to survey escorting, custody and interviewing facilities. It must be emphasized that Ombudsman considers camera monitoring as an important element to protect human rights and freedoms because it has a preventive effect against violent acts either from detainees or arrested persons or from state police employees.

Register of detained/arrested persons as well as treatment of escorted/detained/ arrested persons used during police actions:

In the police station of Himara was found that escorting logbook was not properly completed according to requirements provided in Law no. 9749, dt. 04.06.2007 “On State Police”, and Manual “On Rules for treatment and security of Detainees and Escorted persons in Custody Rooms of Police Units”, because this register was of a very old template and was used both for escorted persons and detained/arrested persons. Consequently, not all rubrics could be completed with data of escorted persons, because the escorting unit has other specifications and legal requests from the one of detained/arrested persons.

In the Police Commissariat of Saranda there was no register for escorted persons and the Chief of Commissariat explained that since there were no escorting facilities this Commissariat couldn’t escort citizens as it is provided in Articles 11 pt. 6 of the law “On State Police”. According to NPM there is a need to make a clear assessment and review in relation to this procedure and its lawfulness from Regional Police Directorate of Vlora.

While it was found in the Police Commissariat of Delvina and Vlora that escorting / detention and arrest registers were designed in compliance with requirements of the Law No. 9749, data

04.06.2007 “On State Police” and Manual “On Rules for Treatment and Custody of Detained and Arrested Persons in Custody Rooms of Police Units”, because all rubrics where could be entered were included for escorted, detained / arrested persons, but cases were also found where rubrics where not completed according to requirements of the law. Specifically, the rubric with the heading “family was informed” still is not properly completed, because records of the person who received this information were not entered. Emphasis must be put on the fact that notification of family members about escorting a person in the police and legal grounds for that, are a legal obligation for police employees laid down in Article 107 of the Law “On State Police”. Police employees claimed that family members were notified, but the simple fact that such information was not entered in the register raises grounds for reasonable suspicion that such notification was not done.

When the monitoring group checked some of the police work practices with escort registers of citizens it turned out that in some cases persons have been escorted in the police against legal criteria provided in Articles 11/ 6, 101/ 1/ “a” and “b” and 106 of Law No. 9749, dt. 04.06.2007 “On State Police”. People who were suspects of committing criminal acts such as thefts, murders, objection of police forces, wanted persons, persons who had conflicts, persons who breached public order, domestic violence, violation of traffic rules, etc. were still treated as escorted persons even though they have already been identified.

Groups of persons illegally escorted who were identified during the inspection could be divided as follows:

- Persons who committed or are suspects of committing criminal acts and offences such as murder, objection of police forces, breach of public order, persons who exercised domestic violence, etc. In these cases the police must act according to legal provisions, Article 253 of Criminal Procedure Code.
- Persons needed to provide any type of information, which could be used to prevent a risk, to identify other persons who might have information about potential risk or incident and identify potential offenders. Police employees must apply the legal right “notification to go to the police”, stipulated in Article 100 of the Law “*On State Police*” and not escort them to police units.
- Wanted persons. It must be emphasized that for this category of persons subject to penitentiary conviction as well as in cases when a person has already committed an offense in the past or who is suspect offender for a criminal act (not under flagrant circumstances), persons must be escorted pursuant to Articles 253 and 464 of Criminal Procedure Code
- Persons escorted due to a conflict, action which is not stipulated in the law “On State Police”. Given that the purpose of escorting them in this case is to prevent a potential crime between persons in conflicts with each other, the inspection group doesn’t necessarily considers police acts as non-compliant, but they must not be considered as escorted persons. Persons apprehended on the scene while committing an offence, or immediately after must be arrested according to Article 251 of Criminal Procedure Code and not be treated as escorted persons for 10 hours. Police employees for persons who are useful for an investigation, must apply the legal right stipulated in Article 312 of Criminal Procedure Code and Article 100 “On the State Police” notifying them by an

order or summon and warning them about forced escorting in the event of not showing and due to a legal impediment.

It still continues in many cases escorting in Police Commissariats “for verification purposes”. This reason is very generic and there is a need to clearly specify on what specific grounds is verification needed. From checks of escorting registers and questions made to the police it turns out that the reason is written “for verification”, but it could as well be that the persons is escorted for other above mentioned cases.

It shows, based on information received from police employees that all escorted persons are subject to personal body search and are removed and seized their personal items. This action is in violation with Article 106, point 3 of the Law no. 9749, dt. 04.06.2007 “On State Police” which provides that: “The police employee shall check and perform physical examination in order to take Safeguards against mentally ill persons, drunken persons, drug addicts or people with infectious diseases”. Whereas about seizure of personal items, Article 208 of the law “On State Police” defines: “Items can be only be blocked if it is completely unavoidable to prevent imminent threats to public order and safety”.

It was also found again during the inspections that, in most of Police Commissariats legal criteria of Law no. 9749, dt. 04.06.2007 “On State Police” and Criminal Procedure Code were not applied about time of the arrest or arrest of citizens. In their arrest or detention logbooks was entered the time when their records were prepared and not the actual time when they were deprived of their freedom. In fact they are not accounted for the time as escorted persons, during pre-trial detention and later on as convicts, time during which the police could does various checks and other procedures which could take up to 10 hours. According to Articles 144, 250 of Criminal Procedure Code, time in the records of time limits (hour) of the arrest or detention is an important element based on which they start calculating pre-trial effects. Whereas based on Article 258 of Criminal Procedure Code from the (hour) time of the arrest and detention start the application of 48 hours rules, within which time the Prosecutors applies for the remand order from the court where arrest and detention took place.

Police employees justify this by reasoning that, “if we will arrest persons immediately than we cannot carry out procedural acts to prove the committed offence. This attitude and justification does not have any legal grounds, on the contrary it is in violation with provisions of Criminal Procedure Code. According to Articles 30 and 294 of C.P.Code, judicial police, whose attributes have also State Police employees, “even after referring the case to prosecutor, are entitled with their own initiative to continue their legal duties such as prevent further consequences of the criminal act, identify offenders, carry out investigation and collect any information that serves enforcement of criminal law”.

Such problems are still present despite recommendation of the Ombudsman and Instructions of Director General of Police No. 4577, dt. 18.09.2014 “On Escorting and respecting the rights of persons escorted from State Police”. In the context of the later it is foreseen that, persons suspected as offenders and convicts with final court decision must no longer be treated as escorted, but they must be subject to the measure of detention or arrest on the spot.

During interviews with detained and arrested people the working group paid special attention to physical treatment of persons during their stay in these facilities. There no claims during the interviews of any physical violence exercised from police employees in custody rooms. Based on the information received from police staff who works in custody facilities it turns out that in custody rooms are kept pre-trial detainees whose custody measure “arrest with imprisonment” has been decided, as well as persons detained for enforcement of criminal decision of imprisonment given in absentia. They were not transferred on time in pre-trial detention institutions or penitentiary institutions due to Directorate General of Prisons, which continuously created obstacles. Their duration of stay in police facilities after their custody or detention measure has been taken, lasts up to 15 days.

Complaints register of escorted, detained and arrested persons was present in all Police Commissariats of Vlora Regional Police Directorate, but it was never completed or put in use.

Legal and psychological aid

During the inspection there were no cases found of adults detained/arrested who did not have financial means to hire a private lawyer and ask for legal aid or being interrogated without the presence of a legal attorney. Whereas, for juvenile detainees / arrestees for whom legal and psychological aid is mandatory, it was found that there was a specialized psychologist in the staff of Vlora Regional Police Directorate.

Health Care service

There was a general practitioner in the structure of Regional Police Directorate of Vlora and there was an appropriate room where one could do check-up examinations.

During monitoring visit in this institution and private conversations with persons in custody rooms it was found that doctor had carried out medical checks for all detained / arrested persons in Vlora Police Commissariat.

Doctor’s room was not inside the premises so the doctor had to do his medical examination either in the custody rooms or rarely in his room.

When checking doctor’s documentation it was observed that there was a medical records register properly kept from his side. Also, there were medical records completed for each and any detainee / arrested person and one copy was stored in doctor’s room.

Supply with medicine was done by the institution for chronicle diseases and mainly emergency medicine, but there were cases when they would prefer to have their family cover their medical needs.

In Police Commissariat of Saranda there was no doctor’s room and no doctor and as a result medical check-ups were not provided within 24 hours as it is stipulated in the law, because until recently there were no custody facilities approved for detained / arrested persons in this Commissariat.

In Police Commissariat of Saranda there was no doctor's room and no doctor and as a result, because there were no custody rooms for detained / arrested persons in this Commissariat.

As per above it was recommended:

1. Taking measures to refurbish escorting facilities of Police Commissariats in Vlora, Saranda and Delvina and Police Station of Himara according to the requirements of the law no.9749, date 04.06.2007 "On State Police", to create proper and dignified facilities with necessary items for stay, separated for females, males and minors.
2. Taking measures to build new custody facilities in Vlora and Saranda Police Commissariats according to requirements in Law.9749, date 04.06.2007 "On State Police" and Manual "Rules for Treatment and Custody of Detained and Arrested Persons in Custody Rooms of Police Units".
3. Reviewing procedures and lawfulness of putting back in use custody rooms of Saranda Commissariat, the conditions of which lead to degrading treatment and violate the dignity of any persons who is kept in these facilities.
4. Taking immediate measures to provide medical service in Saranda Police Commissariat in order to provide medical check-up within 24 hours as it required by the law for detained / arrested persons.
5. Taking immediate measures to provide food to detained / arrested persons in Vlora Commissariat, according to requirements defined in normative acts.
6. Taking measures to complete with accountability the register of escorted persons in Commissariat of Saranda and Delvina and Police Station of Himara.
7. Taking measure to put in use as soon as possible the complaints register of escorted, detained / arrested persons in all Police Commissariat subordinate to Regional Police Directorate of Vlora.
8. Taking measures to respect legal provisions of Criminal Procedure Code in relation to writing in the register the actual time (exact hour) of the arrest and detention of citizens and not treat them in the beginning as escorted persons.
9. Taking measures to install monitoring system in all escorting and custody facilities, in particular in the interviewing room for all Police Commissariat subordinate to Regional Police Directorate of Vlora.
10. Taking measures to establish monitored interviewing rooms for citizens from Judicial Police Officers, in Regional Police Directorate of Vlora and subordinate Commissariats.

6.11. RPD Fier and subordinate Commissariats:

Police Commissariat Lushnje, date 16.12.2014- Nr. Dok. 201402528
Police Commissariat Mallakastër, date 16.12.2014- Nr. Dok. 201402527
Police Commissariat Fier (DPQ), datë 16.12.2014- Nr. Dok. 201402526

Preliminary remarks

Prior to the visit, monitoring group collected all legal information necessary for the monitoring process (Codes, Laws, Decision of Council of Ministers, order and guidelines) Monitoring went through the planning stage of issues which would be considered, approach used, identification of performance and progress indicators and indicators that show the need for further approve.

Monitoring aimed at inspections, making visits, collecting and assessing data, actions and procedures followed by the police to meet standards defined in Law no. 9749, date 04.06.2007 "On State Police" and Manual "On Rules of Treatment and Custody of Detainees and Arrested persons in Custody Rooms of Police Units", and taking immediate measures to comply with its recommendations, as well as checking fulfillment of Ombudsman's recommendations to establish escorting and custody rooms according to legal standards, to put out of use those facilities which do not meet necessary criteria and apply legal requirements for escorting, detaining/arresting citizens.

According to the methodology of the inspection, the working group first organized a meeting with Heads of these institutions and informed them on the purpose of the visit. The responsibles of these units expressed their availability to meet all requests of inspection group. Following the inspection, the team had fruitful conversation with Chiefs of Police Commissariats in Lushnje, Chiefs of Public Orders in the Police Commissariats of Fier and Mallakastër as well as other officials of these police units, who provided all necessary information to perform their tasks and privately they contacted persons deprived of freedom. Working group also inspected custody facilities, offices of judicial police officers as well as reviewed all documentation in relevant registers and acts.

During the conversation with police personnel, the monitoring group was informed on the level of implementation of duties issued by Director General of State Police about escorting institution and respect of rights of persons escorted in police units, such duties were issued through Doc. No. 4577 prot. Date 18.09.2014. Throughout the inspection the working group identified that even if some measures were taken in this Police Directorate, problems were still present and specifically:

Conditions of escorting facilities

In **Police Commissariat of Fier**, escorting facilities have been constructed just recently in compliance with all requirements of Law No.9749, date 04.06.2007 "On State Police". They are separated for females, males and minors. Surface and spaces of escorting rooms for females and minors were appropriate for stay. Rooms had windows to provide natural light and air. However, furniture in these rooms (tables and chairs) was damaged to that point that it was no longer appropriate. Escorting room for minors were empty with no chairs or tables. There was a toilet,

with equipment completed damaged so it was not functional. Doors were still ironed, but not locked with locks and latches. Referring to point 4 of Instructions No. 703, date 07.08.2008 of Director General of State Police escorting rooms must be "…without iron doors, normal size windows which allow natural light and air, chairs and desks, painted and clean, according to criteria of a reception room ".

There were no people detained during the inspection.

In relation to escorting facilities of **Lushnja and Mallakastra Commissariats**, Ombudsman has recommended construction of new facilities according to requirements in law no.9749, date 04.06.2007 "On State Police" in order to create conditions for an appropriate and dignified treatment. But, from the inspection carried out it was found that despite maintenance done from the staff of these Commissariats, the situation is almost the same and specifically:

In Police Commissariat of Lushnja, escorting rooms remain with dimensions 5m x 4.5m, wooden door and two windows with a size 1.2m x 1.3m, which create the possibility for natural air and light. The room was under refurbishment, painting and furniture were according to standards. This room was used only for male adults, whereas minors and females were kept in the corridors of Police Commissariat or offices of police. Since there was no toilet for escorted persons, in case of needs they were sent to the toilet of the Commissariat which was also used by the staff of the Commissariat.

During the inspections there were no people escorted.

The Police Commissariat of Mallakastra was also constructing escorting facilities with one hall and a room with a size of 4m x 4m, with natural light. We were informed by the staff that this facility would be used only for male adults and females and children would still be kept in the corridors of the Commissariat. During the inspection there were no people detained.

Conditions of custody facilities

In the Police Commissariat of Mallakastra there were no custody rooms and all detained/arrested persons were sent in the custody rooms of Fier or Lushnja Commissariat.

Police Commissariat of Fier has six custody rooms. Facilities have been built in compliance with requirements of Law No.9749, date 04.06.2007 "On State Police" and Manual "On Rules for Treatment and Custody of Detainees and Arrested persons in custody rooms of Police Units", because they were separate for males, females and minors. Rooms met norms and technical living standards for a detained/arrested person, because the overall surface was 10 square meter, divided in a living facility (room) 6 m^2 and hall 4 m^2. Facilities were equipped with all necessary living equipment, beds, tables, benches, etc. There was opportunity to clean joint toilets and there was hot water all the time. Mattresses, blankets and pillows were in good conditions, but there was a need to wash them more often. Windows enabled enough air and natural light. There was an emergency bell that enabled communication with police in case of emergencies. For detainees/arrested persons with infectious diseases there was a separated room, isolated from

others. During the inspection there were 3 persons present who were within time lines for the custody measure of the Prosecution.

In Police Commissariat of Lushnja the situation was more of a concern in the custody rooms, because the rooms are underground, with limited air and very humid. The state in which they were leads to serious health problems for the health of detainees/arrested persons who might stay some several days there (10-15 days), but also for the health of police employees who work in these facilities. Even with the staff of the Commissariat was taking care of the hygiene, the rooms still didn’t meet standards set by law. Rooms were not furnished with necessary living equipment such as beds, chairs, tables, benches, etc. Mattresses, blankets and pillows were old and not clean. The toilet was clean and had running water, but it was not separated for males and females. Detainees/ arrested persons had access to showers because they were still working. There was no ventilation or natural light in this facility. There was no emergency bell and consequently there could be no alert to the police in case of need. There was no dedicated room for detainees/arrested persons who might have infectious diseases. There was a fresh air space and detained/arrested persons could go out according to the law (not less than two hours per day). There was no camera surveillance system. At the moment of the inspection there were 5 persons in this facility, 2 within the timelines for the validation of custody measure and 3 waiting to be transferred in the Penitentiary Institution.

Treatment of detainees / arrestees in the custody facilities

Monitoring group interviewed 8 detained/arrested persons, all males. Persons interviewed confirmed that they had been treated in a proper way during their time in police custody. No claims aroused from interviewed persons about any degrading, inhuman treatment or use of psychological and physical violence.

Psychological state of the interviewed was stable and did not give any hints of consequences caused by maltreatment. The interviewed persons did not show any fear, intimidation or didn’t report any cases of maltreatment.

The persons interviewed were able to tell any time the identity of the police they had contacts with. The persons of Fier Commissariat said that during their detention / arrest also a non-uniformed police employee had been present, but he had identified himself.

Monitoring group didn’t identify any minors in the group of detained/arrested persons.

Most of the interviewed persons confirmed that the process of detention/arrest, transfer in the Commissariat was done according to legal procedures stipulated in Criminal Procedure Code, Law “On State Police” and Manual of Rules and Procedures for treatment and custody of persons detained and arrested in police units”, approved by Order no. 763, date 27.09.2011 of Director General of State Police.

From the interviews with detained/arrested persons there were no claims of non-compliance of arrest/detention time and the time written in the registers about flagrant arrest.

From information collected from interviews, it was found that detained/arrested persons had been given the opportunity to talk to a relative after the arrest. However, when checking the register of detained/arrested persons it was observed that a considerable number of detained/arrested persons were not given the opportunity to inform family members' right after their deprivation of freedom. From relevant registers it showed that it was missing in the respective column notification of family members.

During the visit in custody facilities of Fier and Lushnja Commissariat it was found that there was no telephone which detained/arrested persons could use to inform their family members.

Detainees/arrested persons were provided with three meals per day according to Joint Order no. 432, date 10.03.2008 of Minister of Interior and Minister of Health. In both commissariats Fier and Lushnje food was provided from catering service.

Detainees/ arrested persons were not offered the opportunity to read the press, which could be provided with their own expenses. They were not allowed to listen to individual radios with batteries and earphones. There were no facilities for religious rites and they were not allowed to keep pen and paper to write, toothpaste or toothbrush or classified razors. Also, they were not provided from the Commissariat with soap, detergents, hygienic paper, hand paper, towels or any other items for personal hygiene according to rules and norms. These items were provided by their family members most of the time.

Legal aid

From meetings and information collected during the interview it was found that some of the interviewed persons had access to a lawyer from the first moment of deprivation of freedom, so the lawyer was present all the time during the interrogation from police. However, from interviews it turned out that there were delays in providing a lawyer, and formal statements had been taken from detained/arrested persons without the presence of a defense attorney. A part of the persons declared that even when they asked to have an attorney, such request was not met throughout their stay in the custody rooms. It was also found, that detainees/arrested persons couldn't select a lawyer, because the list of *ex officio* lawyers was not displayed.

Both in the custody rooms of Fier and Lushnja were posters with the rights of detainees and arrested persons, in Albanian and in some other languages.

During the visit in police Commissariat, it was observed that in corridors, offices of judicial police officers and custody and detention facilities posters with the rights of escorted/detainees/arrested persons were displayed. In some of the interviews however, it turned out that detained/arrested persons were never informed on their rights at the moment of deprivation from freedom.

Lack of information of escorted, detained/arrested persons consists in failure to inform family members about deprivation of freedom and failure to give access to a lawyer from the first moment of deprivation of freedom. This could be easily proven from the blank rubrics in the register of detained/arrested persons. Also, from the interviewing of monitoring group cases were

identified that arrested persons were never informed on their right to stay silent or on their right to have a lawyer.

Interrogation and investigation facilities

In the Police Commissariat of Fier there was a room for interrogation of citizens from the accusing party and lawyer, whereas there was no facility monitored with cameras for procedural actions from Judicial Police Officers in none of the subordinate commissariats of Regional Police Directorate.

No items or exhibits were found in offices of police officers which could hint use of violence towards persons subject to procedural actions.

With the exception of Police Commissariat of Fier, there is no camera monitoring system in any other commissariat to be able to keep under surveillance escorting, custody and investigation facilities. The Ombudsman considers camera monitoring process as an important element for protection of human rights and freedom because it has a preventive effect against violent and punishable acts either from escorted, detained/arrested persons, but also from State Police employees.

Health Care service

There was a general practitioner in the Regional Police Directorate who worked in an appropriate room to perform medical check-ups. Medicine of first aid kit was continuously provided with the funds of Police Directorate. There was no ambulance for emergency cases, or for police operations.

Detainees / arrested persons in the Police Commissariat of Fier were provided with medical check-up according to the law (within 12 hours) accompanied with medical records for each. At the moment of the inspection, the doctor of the institution was not on duty, so all the information was received by management staff and personnel of custody facilities. From the interviews with detained/arrested persons in the custody rooms, it was found that doctor had followed all necessary procedure from check-up to preparation of medical records.

Health service in Lushnja Commissariat was provided by the doctor of RPD Fier. Based on the information received from the personnel in custody rooms, the doctor did medical check-ups three times per week in this Institution.

At the moment of the visit, after reviewing personal files of detained/arrested persons in custody rooms, the group of experts concluded that medical check-ups were not done within 12 hours according to rules provided in the Standard Operating Procedures for Treatment of detained/arrested persons. Inspection group, identified that medical records were completed in a delay due to the distance and his part time deployment in Lushnja Police Commissariat

As it is provided in the Standard Operating Procedures for treatment and custody of detained/arrested persons in police units (Chapter II, point 7), for arrested/detained persons, prior to accommodation in custody rooms they must be interrogated and doctor must check for

any signs of violence, maltreatment or diseases. Provisions also foresee that each detained/arrested person must be subject to medical check – up (upon their will) from assistant doctor, or doctor of directorate or commissariat within 12 hours from the detention/arrest. The right to access a doctor (including doctors chosen by detainee/arrested person) is provided in the manual and also the right to have free medical aid during their stay in custody rooms (Chapter III, pt. 1.9, 1.10). Proper application of these provisions prevents potential maltreatments from police.

Register of escorted, detained/arrested persons as well as treatment of escorted, detained/arrested persons during police activities.

In all three Police Commissariats of RDP Fier, it was identified that the register for escorting, detaining and arresting citizens has been established according to requirements in Law No. 9749, dt. 04.06.2007 "On State Police", and Manual "On rules for Treatment and Custody of Detainees and Arrested persons in custody rooms of Police Units', because it had all rubrics where all data could be entered for escorted, detained/arrested citizens, but some of the rubrics were not completed according to the law, specifically:

In the rubric referring to reasons for escort it was noticed in most of police commissariats that most of escorted persons were treated as suspects for a criminal act. This treatment is in violation with Article 11 point 6 of Law "On State Police" which specifies that, a person escorted is someone who has violated an administrative rule and not someone who is a suspect of a criminal act or who is arrested on the spot.

In the rubric for notification of family members, it is not always clearly noted down name, father name, last name and the phone number of the person who has been notified and the reason of the escort, detention or arrest. It was observed that this rubric is only completed by writing down "family, father, son, mother was informed", but not specifying the name of the person who was informed, time and phone number. Despite the fact that police employees pretend that family members are informed, we consider that this claim must be proved by completing the rubric of notification of family members according the above mentioned requests.
The phenomenon, also identified from Ombudsman about the actual time of detention or arrest on the spot of citizens, is present in this Police Directorate and its subordinate Commissariats. From the comparison that the inspection group made between the time written down in the registers of detention or arrest on the spot, two citizens G.H and E.N arrested in 12 and 13 December respectively, and who were still in the custody cell during the inspections, and the time written down in the rubric 'detained/arrested persons' in the register of detainees/arrested persons, the conclusion was drawn that in the registers it is not written the actual time of the detention, but the time when the report was prepared.

The complaints' registers of escorted, detained, arrested citizens was present in the commissariats, but were never used since there were no notes or complaints.

As per above, it was recommended:

1. Taking measures to finish reconstruction and use escorting facilities in Police Commissariats of Mallakastra and Lushnja according to requirements in Law no.9749, date 04.06.2007 “On State Police”, by creating proper facilities, furnished with necessary equipment for accommodation and separated for females, males and minors.
2. Taking measures to build new custody facilities in Lushnja Police Commissariat according to requirements in Law No.9749, date 04.06.2007 “On State Police”, Manual “ On Rules of Treatment and Custody of Detainees and Arrested persons in Custody Rooms of Police Units” .
3. Taking necessary measures to make sure that all detained/arrested persons from the police are fully informed on their fundamental rights from the first moment of deprivation of freedom.
4. Taking immediate measures to provide medical service in Lushnja Police Commissariat in order to provide medical check-ups of detainees/arrested persons within 12 hours according to requirements of the law.
5. Taking measures to complete properly the register of detainees in Police Commissariats in Mallakastra, Lushnja and Fier .
6. Taking measures to make use of complaints register of escorted, detained/ arrested persons in all Police Commissariats subordinate to Regional Police Directorate of Fier.
7. Taking measures to respect legal provisions of Criminal Procedure Code about the actual time (exact hour) of arrest and detention of citizens and not treat them as escorted persons initially.
8. Taking measures to install monitoring system in escorting facilities and interrogation room in particular, in Police Commissariats of Lushnja and Mallakastra.
9. Taking measures to establish monitored rooms for interrogation from Judicial Police officers and subordinate Commissariats.
10. Taking necessary measures as police units to inform detained/arrested persons on their right to have a defense lawyer and the actual opportunity to contact one, before the investigation is carried out.
11. Take necessary measures to give the opportunity to all escorted/detained/arrested persons to contact their family members in the moment of the arrest/detention and this must be clearly entered in respective logbooks and registers of escorted/ detained / arrested persons.

6.12. Recommendations on the situation of overpopulation in Regional Police Directorates and their subordinate Commissariats - Date 06.01.2014 / Doc. No. 201402451

National Mechanism for Prevention of Torture in accordance with legal rights and obligations to carry out inspections in all institutions of lawful deprivation of freedom, in 2014 has carried out inspections in all police units nationwide.

From inspections carried out, police units which have in their structure facilities to keep detained and arrested persons, as well as their official capacities[21], results as follows:

No.	Police Units	Official capacity (persons)	Detained/ arrested in the moment of the inspection
1.	Police Commissariat Krujë	5	1
2.	Police Commissariat Kavajë	4	4
3.	Police Commissariat Durrës	9	4
4.	Police Commissariat Elbasan	5	16
5.	Police Commissariat Lezhë	4	11
6.	Police Commissariat Peshkopi	8	7
7.	Police Commissariat Mat	4	1
8.	Police Commissariat Kukës	9	5
9.	Police Commissariat Tropojë	2	0
10.	Police Commissariat Berat	2	7
11.	Police Commissariat Nr. 1	4	2
12.	Police Commissariat Nr. 5	5	8
13.	Police Commissariat Nr. 3	3	7
14.	Police Commissariat Nr. 2	4	1
15.	Regional Police Directorate of Tirana	10	30
16.	Police Commissariat Korçë	7	9
17.	Police Commissariat Gjirokastër	9	8
18.	Police Commissariat Sarandë	4	1
19.	Police Commissariat Vlorë	5	2
20.	Police Commissariat Lushnjë	10	5
21.	Police Commissariat Fier	8	3

As it is shown in the table, a part of police commissariats were overpopulated at the moment of the inspection. The Commissariat of Elbasan, Lezha, Berat, Korça, Commissariat no. 3, 5 and Regional Directorate of Tirana are clearly over the official capacity.

Additional to the inspection, in order to better analyze daily flow of custody rooms, NMP addressed a request for information to General Directorate of State Police on date 9.10.2014, about daily flow of each commissariat that has a custody cell, for a period of two weeks from 24th of September to October 8th. Statistics received as a response to the request, reorganized per days of inspection in relevant commissariats are as follows:

[21] According to Memo of General Directorate of State Police No. 6426/ 1 Prot., date 14.11.2014.

No.	Police Unit	Official Capacity (persons)	Dates per month														
			September							October							
			24	25	26	27	28	29	30	1	2	3	4	5	6	7	8
22.	Police Commissariat Krujë	5	1	1	1	3	3	3	2	1	1	1	-	-	-	-	-
23.	Police Commissariat Kavajë	4	4	1	1	1	1	2	-	1	-	-	-	-	-	-	-
24.	Police Commissariat Durrës	9	12	8	12	11	13	16	12	6	7	8	8	9	7	5	5
25.	Police Commissariat Elbasan	5	12	14	16	16	5	6	4	4	9	9	9	9	9	1	9
26.	Police Commissariat Lezhë	4	11	9	4	7	8	7	5	6	5	6	3	7	8	8	4
27.	Police Commissariat Peshkopi	8	3	1	1	1	-	-	-	-	-	1	1	-	-	-	-
28.	Police Commissariat Mat	4	-	-	-	-	-	1	1	1	-	-	-	-	-	-	3
29.	Police Commissariat Kukës	9	3	1	-	1	2	11	-	3	1	3	3	3	4	5	2
30.	Police Commissariat Tropojë	2	2	2	1	-	2	2	3	1	-	1	2	2	1	-	1
31.	Police Commissariat Berat	2	3	2	1	1	1	2	2	2	-	-	3	3	2	2	1
32.	Police Commissariat Nr. 1	4	-	2	2	2	3	3	8	3	3	-	-	2	2	4	4
33.	Police Commissariat Nr. 5	5	3	6	6	6	6	3	6	5	6	3	6	6	6	6	6
34.	Police Commissariat Nr. 3	3	4	4	7	7	7	3	6	6	6	6	8	8	7	7	8
35.	Police Commissariat Nr. 2	4	3	4	4	4	4	6	14	5	3	3	5	7	7	8	8
36.	Regional Police Directorate Tirana	10	10	10	10	11	16	16	31	24	19	19	23	19	25	27	31
37.	Police Commissariat Korçë	7	12	9	9	6	1	3	2	3	4	4	4	7	7	12	12
38.	Police Commissariat Gjirokastër	9	2	2	-	-	-	3	2	-	2	3	3	2	-	2	6
39.	Police Commissariat Sarandë	4	2	2	4	4	3	2	5	5	4	4	4	4	3	4	4

40.	Police Commissariat Vlorë	5	9	7	9	5	5	6	6	5	8	9	7	7	6	7	3
41.	Police Commissariat Lushnjë	10	4	7	2	-	1	-	2	1	-	-	-	-	1	1	1
42.	Police Commissariat Fier	8	1	5	3	2	4	2	3	2	5	3	2	3	-	6	6

As it shows above, the majority of commissariats were overpopulated most of the time during the inspection. Regional Directorate of Tirana, Commissariat of Lezha, Elbasan, Durres, Korca and Commissariats no. 3 and no. 5 of Tirana Region and almost in all the 10 randomly chosen days they have been overpopulated. Compared also to overpopulation from the inspection from NPM it results that Regional Directorate of Tirana, Commissariat of Lezha, Elbasan and Commissariat no. 3 and no. 5 of Tirana Regional work most of the time over the official limits.

Overpopulation problems

Overpopulation in custody facilities of police units throughout the country is a present and tangible problem which must be immediately addressed, because it violates the rights of people deprived of freedom, it impacts quality of services provided to this category and leads to likelihood for inhuman and degrading treatment.

Throughout the inspection carried out, heads of police units inspected admitted to assistant commissioners of NPM that overpopulation is a problem present which adds on to inappropriate conditions of custody rooms in Commissariats. Exceptions from above are Commissariats which have had investments in their custody rooms such as Commissariat of Durres and Kukes. In other police units, custody rooms didn't meet standards according to Order of Director General of State Police no. 763, date 27.09.2011 "On Approval of the Manual for Rules and Standard Procedures for Treatment of Persons Arrested and Detained in Police Premises", and some have been closed leading to transfer of persons in other police units which have custody rooms. As a consequence the latter are overpopulated.

Also, during the inspection NPM has found cases of persons with custody measures still held in custody rooms of the Commissariat which is in conflict with legal base[22]. According to the information received, persons issued with a custody measure could stay some several days ranging from 10 – 20 days in Commissariats, before they are transferred in relevant penitentiary institutions. While, pursuant to Article 258 par. 1, of CPC, a suspect of a criminal act can only be detained by the police, according to their competences, up to 48 hours and within this period it must be referred to responsible prosecutor. Pursuant to Article 257 of CPC within the 48 hours from the arrest, the prosecutor must refer that to a responsible judge and the latter has a deadline of 48 hours from the receipt of the request to announce the decision and validate the measure and determine a custody measure based on articles 258 par. 2 and Article 259 of CPC. Almost in all cases, chiefs of police units who met with NPM expressed their concerns about delays for

[22]Based on Article 259 of CPC, par. 3, 4, persons for whom the court has issued the custody measure "arrest with imprisonment" must be transferred in Institutions of Execution of Criminal Decisions waiting for their trial. .

transfer of persons subject to custody measure of pre-trial detention due to the fact that Penitentiary Institutions extremely overpopulated.

Another problems which aggravates situation of detained / arrested persons is their physical stay in the facilities of Penitentiary Institution, due to the agreements between Ministry of Justice and Ministry of Internal Affairs, based on which Penitentiary Institutions provide facilities as custody rooms managed by relevant commissariats. Such situations have been identified in Penitentiary Institution of Tropoja, Penitentiary Institution Berat, and Penitentiary Institution Saranda, where additional to overpopulation and failure of Penitentiary Institution to meet standards, placement of detained / arrested persons in that facility aggravates more the situation.

In addition to the above, based on register inspected from NPM it results that during the inspection, the majority of persons in custody rooms, but also those transferred have been detained / arrested for criminal acts such as:

- Driving without a license (most of persons interviewed were minors),
- Drunk driving,
- Illegal connection of electricity,
- Domestic violence,
- Producing / distribution of narcotics, etc.

It must be emphasized that the first three criminal acts have been recently included in the Criminal Code. Consequently, one very important factor which led to overpopulation is tightening of criminal police measures, which is not the only tool to enforce public order and even less the rule of law. European trends are now towards alternative punishments, in particular for juveniles.

As per above it was recommended:

1. Taking immediate measures to respect in principle and in paper the Criminal Procedure Code, in particular Articles 251 and 255 related to procedures and obligations of JPO during the detention / arrest of persons.
2. Taking immediate measures to address the situation of overpopulation, respecting Criminal Procedure Code, Article 259 of CPC, par. 3, 4, about terms of detention / arrest of persons.
3. Taking measures to reallocate funds for reconstruction according to standards and putting back to use closed custody rooms.
4. Taking measures to address the issue of custody rooms within Penitentiary Institution, as a non-good practice which aggravates the situation of Penitentiary Institution, but also the one of persons detained / arrested.

7. Recommendations sent based on inspections carried out in 2014 in the Armed Forces

7.1. Military Police Battalion Sauk, Tirana - Date 02.12.2014 / Doc. No. 201500026

Preliminary remarks

Inspection visit in Military Police Battalion in Sauk, Tirana was carried out in the framework of periodic plan of monitoring visits of Ombudsman for 2014. In accordance with the procedure for development of monitoring, the inspection group met first with Director of the Institution who showed cooperation to fulfill the purpose of the visit pursuant to Law No. 8454, date 04.02.1999 "On Ombudsman", changed. Experts of inspection group were offered the opportunity to access within the rules and without any difficulties all facilities and meet all persons subject to monitoring.

After having received necessary information to perform their task, the inspection group met privately with the only military person subject to the measure "*disciplinary detention*" present in the Institution, inspected custody rooms and joint facilities of these room as well as got acquainted with documentation entered in relevant registers and acts.

More specifically, the general situation and problems observed in this Institution are as follows:

Conditions in the custody facility

Military Police Battalion of Sauk, Tirana had custody rooms used to detain militaries subject to custody measure "*disciplinary detention*" according to the law No. 8671, date 26.10.2000 "*On Commanding and Leading Powers and Authorities of AF of RA*", changed with Law no. 9183, date 05.02.2004 "*On Military Discipline in the Armed Forces of RA".*

Custody rooms in this institution were located in a long corridor, divided from the rest of facilities of the institutions by an iron door. At the end of the corridor without coverage from surveillance cameras, there was an ironed environment which served for meeting with family members. Meeting facility didn't meet either standard about hygiene and sanitary conditions or with appropriate furniture to act as such.

From all custody rooms, only 4 were functional. Rooms had a space of 6×5m with enough natural and artificial light, but very cold and humid, because heating was missing. They were furnished with 3 beds with old covers and toilet with poor hygiene and sanitary conditions. In one of them the sink was broken. There was running water in the toilet, but no hot water. Electronic bells were missing in the rooms.

During the inspection in these rooms there was only one person with the measure "*disciplinary detention*", who had no complaints about the followed procedure for the issued measure and either for the conditions and treatment in the custody rooms.

Inspection group found that posters with rights and obligations of militaries for measure "*disciplinary detention"* were missing.

There was no dedicated airing space for militaries subject to measure "*disciplinary detention"*, but according to the staff they were given the chance to get out of custody rooms once in a while.

Inspection group in this Institution found that filling of rubrics in registers for detained militaries was deficient.

Treatment of persons with measure "disciplinary detention" in the custody facilities

During monitoring visit, in the office of the person responsible for custody rooms in BPU it was observed a baton and handcuffs which are considered as intimidation items and psychological pressure.

Persons with the disciplinary measure "*disciplinary detention*" were provided with meals three times per day in the canteen of the Institution. Canteen and kitchen were clean and no deficiencies were identified there.

There was running water all the time in the custody rooms of this Institution. There was almost no supplying militaries with personal hygiene items such as soap, cleaning liquids, toothpaste and toothbrushes, etc.

Inspection group found that information / learning / literature materials were missing, even if this was a right of the persons subject to "*disciplinary detention*".

With regards to medical treatment, the inspection group found that this service was regularly delivered by the doctor of the institution. In the events when there was a need for more specialized consultation or treatment for health issues, this service would be provided by Central University Military Hospital Tirana.

Documentation administered by the personnel of custody rooms of the institution was comprised of disciplinary detention register, logbook, and register of prohibited items. From the examination of these books it was found that the column for entries and exits of persons subject to disciplinary measures was not completed for some cases.

As per above it was recommended:

1. Taking disciplinary measures to reconstruct facilities for disciplinary detention in the Military Police Battalion, Sauk, Tirana and install electric bells.
2. Taking measures to display posters with the rights and obligations of militaries subject to "*disciplinary detention"* and provide heating in the custody rooms.
3. Taking measures to provide full package of personal hygiene items.
4. Taking measures to improve conditions of the room used for meeting with family members according to standards provided in the "*European Convention of Human Rights*

and Freedoms" as well as additional protocols, ratified by the Republic of Albania with Law no. 8137, date 31.7.1996.

5. Taking immediate measures to install camera surveillance monitoring system in the corridor where custody rooms are located.
6. Taking measures to complete with full accountability all the rubrics in disciplinary detention registers.
7. Taking immediate measures to remove means of force such as batons and handcuffs from the office of the chief of custody rooms in Military Police Battalion, Tirana.

7.2. Land Forces Command, Shkodra - Date 10.12.2014 / Doc. No. 201500023

Preliminary remarks

Compliant to monitoring developing procedures, the inspection group initially carried out meeting with authorized staff from Director of Institution, who showed commitment in fulfilling the purpose of the visit pursuant to Law No. 8454, date 04.02.1999 "On Ombudsman", changed. The experts of the inspection group were offered the opportunity to have access within the rules and without any difficulties to meet all persons and visit all facilities to be monitored.

After having received necessary information to perform their duty, inspection group inspected custody rooms and joint facilities of these rooms as well as got acquainted with documentation in relevant registers and acts.

Specifically, the overall situation and identified problems are as follows:

Conditions of custody facilities:

In the Land Forces Command, Military Unit No. 1010 Vau i Dejës, Shkodra, there were custody rooms which served for detention of militaries subject to measure "*disciplinary measures*" according to Law. 8671, date 26.10.2000 "*On Commanding and Leading Powers and Authorities of AF in RA*", changed and law No. 9183, date 05.02.2004 "*On Military Discipline of Armed Forces in RA*".

Custody facilities used for the measure of "*disciplinary detention*" were located in a separated facility from the premises of this institution. It was divided into a hall and a room. Both had iron doors and windows which were used by the guard to control. The room had a bunk bed, table and two chairs. There was a toilet inside which was functional, but there was problems flushing water down the toilet. Hall was equipped with table, chairs and bath with shower. Doors and windows were spacious and provided enough natural lighting. Also, artificial lighting was enough in the facility. Heating was missing. Rooms were clean and well maintained.

Rights and obligations of militaries subject to "*disciplinary detention"* were displayed in the hall, as well as the time of their activities.

Meeting room with family members of detained militaries was missing.

For airing of persons under disciplinary detention was used a space of dimension 1.5 x 3m surrounded by aluminum net, outside the premise a hall and custody room were located.

The hall and custody room where detained militaries were kept, were not equipped with bells and surveillance monitoring cameras in the corridor were missing.

During the inspection of these facilities there wasn't any military subject to "*disciplinary detention*".

It was found that chief was custody rooms hadn't properly filled out documentation with regards to date and time of the beginning and completion of detention measure.

Treatment of persons subject to "disciplinary detention" in custody facilities:

Persons subject to "*disciplinary detention*" were provided with meals three times per day in the canteen of the institution. Facilities of canteen and kitchen were clean and no deficiencies were identified.

There was running water all the time in the custody rooms of the institution.

With regards to medical treatment, inspection group found that this service was regularly provided by the doctor of the institution. In the events when due to the health conditions of the detainee there was a need for a more specialized service or consultation, this service was offered by Central University Military Hospital of Tirana.

Documentation administered by the personnel of the custody rooms in this institution, was comprised of disciplinary detention register, log books and register of prohibited items. It was found, from the examination of these logbooks that columns for entries and exits of persons subject to disciplinary measures were not filled out in some cases.

As per above it was recommended:

1. Taking measures to reconstruct rooms of disciplinary detention in Land Forces Command, Military Unit No.1010 Vau i Dejës, Shkodra and install electric bells.
2. Taking measures to provide heating in custody facilities.
3. Taking measures to establish meeting rooms with family members according to standards foreseen in "*European Convention for Protection of Human Rights and Freedoms"* as well as additional protocols, ratified by the Republic of Albania with law No. 8137, date 31.7.1996.
4. Taking immediate measures to install camera surveillance monitoring system in the corridors and custody rooms.
5. Taking measures to fill with accountability all rubrics in the registers of disciplinary detention.

8. Recommendation submitted to Psychiatric Hospitals based on inspection carried in 2014

8.1. In treatment Psychiatric Hospital "Sadik Dinçi" Elbasan - Dated 23.06.2014 / Doc. No. 201401340

Preliminary remarks

Maximum capacity of psychiatric hospital "Sadik Dinçi" is 310 beds, including person's hospitalized waiting for their diagnosis and medication or persons who have been hospitalized for years in this hospital and have now become residents there. At the moment of inspection there were 332 persons in the facilities of the hospital which shows clearly overpopulation in this institution.

According to monitoring development procedure, the inspection group initially carried out meeting with the director of the institution who expressed his availability for cooperation to achieve the purpose of the inspection. During the meeting, inspection group requested initially information about the rights and treatment of patients, as well as the approach of the institution towards the problems identified in the previous inspection of this institution.

The head of this institution informed experts that Psychiatric Hospital of Elbasan has a territorial coverage of 1 363 903 inhabitants, including districts of Elbasan, Gramsh, Librazhd, Peqin, Korça, Devoll, Pogradec, Lushnja and Durrës. This hospital is divided in 8 wards and one admission ward. Wards 2 and 8 were still treating persons with mental retardation, in conflict with the law on Mental Health and its bylaws. There were three wards (I, III, IV) where persons who have been residents for years were treated, otherwise called "chronic", three other wards (V, VI dhe VII-ta), where persons who were hospitalized for the first time were treated and persons who have been residents for years in this institution due to the abandonment from their families. Also, there is an admission ward in this institution which was supposed to serve as such only for first time hospitalization and acute cases, but since a long time now it is used to hospitalize 'chronic' men and women and makes it very difficult for new hospitalizations in the other wards.

The institution has two subordinate homes: Home "Drita" Elbasan, where 10 women patients live there and Home Shtëpiza "Jeta" Cërrik where 6 women and 7 men live. These homes have medical staff, nurses and caregivers deployed.

Emphasis must put on the fact that infrastructural improvements have been made in the hospital, both indoor and outdoor.

Treatment

Monitoring group had the goal to collect information about the treatment of patients, identify cases where physical violence was used beyond limits foreseen in normative acts, or any psychological pressure put to this category, as well as health service provided to persons hospitalized in this hospital. From the information collected, conversation in group and privately

with the hospitalized, the monitoring group didn't identify any flagrant case of torture or excessive use of force.

In psychiatric hospital of Elbasan, at the moment of inspection there were no complaints about food, in particular the quality of cooking.

Based on the information that inspection group received from psycho-social staff, in the last six months in this institution there were 8 cases, which required removing the ability to act. In this regards, psycho – social staff has not been informed on the procedure followed, which according to legislation in power is part of the multidisciplinary team of the institution. Consequently, this creates problems with principles of transparency based performance within the institution.

Safeguards

During the monitoring, experts group found that legal sector was missing in the institution which is a necessary structure, considering the above concerns. The presence of such sector would enable legal protection of the interests of the institution, but also the ones of the persons treated by this institution who in many cases are left unprotected / legally represented and vulnerable to institutional and / or family abuse.

Doctor's commission of hospitalization consultations was comprised of only two doctors of the hospital, whereas psychiatric doctor with relevant education has been left out from this commission and doesn't take part in any decision making process for patients who need hospitalization in this hospital. Also, admission of patients in the emergence unit of the hospital is completely in violation with human rights and freedoms, by bringing them handcuffed by public order police, unaccompanied by family members based on the excuse that they are dangerous to themselves and others. Hospitalization of persons in the hospital is made based on consultation, but in most of cases, in conflict with principle of treatment of persons with mental health problems in the community and the latter is immediately accepted for hospitalization. Consultation and hospitalization register was regularly updated from the nurse of the admission ward.

Experts group also identified a serious problems still left unsolved which is lack of nurses and caregivers in the organizational structure of this hospital so the number is still fairly small compared to number of patients per ward. It must be emphasized that there was a visible difference in number from one ward to the other.

No facilities of the institution have camera surveillance monitoring system.

In terms of measures of physical restraint or seclusion of persons under treatment, there were rare or almost completely lacking. They were offered opportunity to meet with family members or relatives any time they wanted, however this mainly happened for new hospitalizations. While, cases that were housed for years in this institution were almost completely abandoned from their family members, and meetings with them were rare or not happening at all.

From the Head of the institution and based on the monitoring carried out by inspection group it showed that official cases of involuntary hospitalizations were missing.

Complaints and requests of patients were managed by psycho-social staff. Then, this staff reported problems raised by persons subject to treatment based on their complaint / request.

In all joint facilities, within the wards, corridors or other premises of the institution posters were missing, also information about human rights and telephone number of Ombudsman Institution.

Material conditions

As mentioned above, hospital premises were partly reconstructed, but during the visit of the expert in the wards, it was observed that they were old, humid, but the staff responsible was trying to maintain a good hygiene.

In the beginning the inspection group visited the ward in the first floor of the building with a maximum capacity of 8 persons. At the moment of the visit there were six chronicles and three acute patients. Material conditions in this ward were good, but people were hospitalized in this hospital entirely in conflict with the law 'On mental health' and bylaws issued pursuant to the law. Wards II and VIII had 32 patients and 25 patients respectively with the diagnosis "mental retardation" which were kept in this institution in conflict with the Law no. 44/ 2012 "On Mental Health". Even with all continuous requests that heads of this institution have addressed to relevant bodies to find a solution for this category of persons, the situation remains unchanged. Wards, III, IV, V and VI were respectively hospitalizing 35, 36, 35 and 26 persons, while in wards I and VII the number of hospitalized persons was respectively 67 and 71 persons. In ward VII were kept together 'chronicle' and acute patients. This led to serious problems in terms of management and appropriate treatment for them.

Not all wards respected living standards space per person, due to overpopulation. There were joint toilets were for each ward, worn-out and humid. Showers, in general in all wards were worn-out, in poor hygienic and sanitary conditions and visible humidity.

None of the wards of this hospital had camera monitoring surveillance system.

The rooms of each ward had enough natural light and were all furnished with beds in good conditions. Inspection group identified that some rooms had nightstands and some others not. Mattresses, sheets and blankets were provided by humanitarian aid of voluntary international organizations.

Kitchen was tidy and clean, supplied with necessary furniture. Food items were kept in the locked refrigerator.

There was running water, which enabled persons under treatment to meet their needs normally.

The institution had central heating.

Laundry room was recently refurbished and fully operational.
Within the yard of this hospital there were two daily centers “Tulipan” and “Rilindja”, supplied with all appropriate furniture. They were clean and tidy and different handmade and artistic products of persons under treatment were displayed on walls by creating so a relaxing and comfortable environment.

The ambulance was in use, but amortized.

Nurses’ rooms in all the wards, even with their attempts to keep them clean and tidy were furnished with worn-out furniture. Dentist’s room was clean, but unit and autoclaves, dental materials and instruments were missing. Consequently, also this service was lacking.

Social service and activities

Organizational chart of this service is composed of four psychologists and two social workers. Their work was divided per ward to prepare the files of each patient, either the ones hospitalized for the first time or those residents for many years in this institution. They were also working with individual treatment plan for each of them.

Psycho – social staff organized activities mainly in the daily centers of the hospital. They were delivered from 09:00hrs -14:00hrs, and included painting, handcrafts in particular for women, religious days and outdoor activities such as picnic, movies, etc..

Vocational training courses were missing in this institution, but handcrafts and artistic creative activities were delivered there.

All activities delivered within a year in this institution were supported by “Shpresa Association”, international voluntary organizations and civil society.

Health Care service

In the organizational chart of the health sector were four full time doctors, out of which only one has the four year education for psychiatry, while two have one year education and the other one is a general practitioner with some years of experience in this hospital. The organizational chart of the hospital also includes two doctors who work in Community Center of Mental Health, Elbasan. Also, part of staff is composed of three voluntary general practitioners who meet the needs of hospital for the 24 hour service. From the observations of inspection group it was found that one of psychiatric doctors addressed the institution with continuous requests to become part of 24 hour service, but he was rejected, creating room for complaints.

During the inspection in this institution, it was found that there were a range of problems leading to a poor health service for all hospitalized persons in this hospital. Starting with overpopulation and low number of beds has turned this hospital more into a residence for persons with mental health problems, rather than a hospital service according to the law and bylaws for mental health.

Also, doctors of this hospital face every day difficulties to perform medical check-ups, examinations and consultation with patients of the General Hospital of Elbasan, who often stigmatize this category of illness. Extremely difficult for this service is the understaffed number of nurses and caregivers, in particular for wards with over 70 patients where for each shift there is a nurse and one or no caregiver at all. This is in particular a problem for afternoon and night shifts.

For years this institutions has a serious problem, lack of medicine such as: Antipsychotic, antidepressant, anxiolytic, Hypnos-sedatives, as well as mood stabilizers. From the information received from the staff of the hospital, in the laboratory of the general hospital kits for measuring the level of blood and the mood stabilizers Tegretol and lithium carbonate are missing.

Recently, the institution received a EKG device, but never used it due to lack of specialized staff which could perform such examination.

Dental service was completed with one dentist, but as it was mentioned above this service could only provide tooth extraction, due to lack of dental materials and tools.

From examination of medical staff documentation, doctors in particular; it was found that new approved files approved pursuant to the new Law were already put in use. In terms of register of consultation for admission it was noticed that very detailed description of the patient was entered which should have been filled instead only with data about generalities, data about accompanying documents, accompanying diagnosis and the one given by the consultation and finally recommended medication. Registers of 24 hours information of nurses were kept properly and clearly completed.

As per above it was recommended:

1. Taking immediate measures to reduce overpopulation in the hospital and respect private space, increase number of exits according to legislation in power.
2. Taking immediate measures to apply basic criteria for hospitalization, only when the person has been referred from QKSHM.
3. Taking immediate measures to find a solution about the 57 persons with mental retardation, who have been residents of this hospital for years, in conflict with legislation in power.
4. Drafting a Memorandum of Understanding between the Ministry of Health and Ministry of Social Welfare and Youth to find a solution to the problem of persons with mental retardation, residents in psychiatric hospital “Sadik Dinçi”, Elbasan.
5. Taking immediate measures to establish a legal sector, as an essential and operational part of the organizational chart of the institution, to protect the rights of persons under treatment and the institution itself.
6. Taking immediate measures to increase number of nurses and caregivers in the institution.
7. Taking measures to include the psychiatric doctor with all rights and obligations to perform an efficient service, by making him part of 24 hour consultations.

8. Taking measures to divide acute patients from the ones residents in this institution in order to simplify the work of personnel in relevant wards.
9. Taking measures to install a camera surveillance monitoring system in the facilities of this institution, as one of most important aspects to prevent violent acts towards citizens and vice versa in order to respect human rights and freedoms.
10. Taking measures to divide proportionally the number of personnel in wards per number of patients per ward.
11. Taking immediate measures about the humidity in wards, showers and toilets and take measures to improve the latter.
12. Taking measures to apply the Law on Mental Health with regards to multidisciplinary team including psycho-social staff in decision making for all cases treated in this institution, with a particular focus in the important decisions to remove the ability to act and giving custody, to persons treated in this hospital.
13. Taking immediate measures to facilitate laboratory analysis, examinations and consultations in the general hospital to give immediate access to persons who request such type of health services.
14. Taking immediate measures to supply with medicines of the group të Antipsychotic, antidepressant, anxiolytic, Hypno-sedatives, as well as mood stabilizers of different groups.
15. Taking immediate measure to put in full use EKG device.
16. Taking measures to supply dentist's room with dental tools and materials.
17. Taking immediate measures to start completing the consultation registers in each column.

8.2. In treatment Psychiatric Hospital "Ali Mihali", Vlora - Dated 14.11.2014 / Doc. No. 201402312

Preliminary remarks

Maximum capacity of Psychiatric Hospital "Ali Mihali" is 180 beds, including persons hospitalized, for evaluation of diagnosis or medication, or persons who have been hospitalized for years in this hospital and have become residents there. At the moment of inspection, there were 163 persons in the hospital, out of which 110 "chronic" and 53 acute and sub-acute.

According to monitoring development procedure, inspection group first met with Head of the Institution who expressed her availability to cooperate in order to achieve the purpose of inspection. During the meeting, inspection group initially asked for information about rights and treatment of patients and the way how the institution handled problems identified in the previous inspection.

The Head of the Institution informed the experts that Psychiatric Hospital of Vlora has a territorial coverage including district of Vlora, Saranda Tepelena, Gjirokastra, Përmet, Skrapar, Berat, Fier. This hospital was divided in 6 wards and one admission ward. Wards 1, 2 and 3 with official capacity of 37 beds, ward 4 official capacity 72 beds where are hospitalized chronicles women patients, ward 6 and 7 with an official capacity of 37 beds with acute and sub-acute men patients as well as admission ward with an official capacity of 14 beds. It must be emphasized

that out of these figures there 40 patients with mental retardation who are treated in this hospital in conflict with the law On Mental Health.

Also, subordinate to this institution are two Homes with 10 patients women and men respectively live there. These Homes have medical staff deployed, nurses and caregivers.

It is worth mentioning that the infrastructures, premises of the hospital were extremely damaged, with the exception of admission ward. It was expected that the new hospital for acute and sub-acute patients would be opened soon.

Treatment

Monitoring group aimed at collecting information about treatment of patients, identify any cases of excessive use of physical force beyond what is foreseen in normative acts, or any psychological pressure put to this category, as well as medical service provided to all persons hospitalized in this institution. Monitoring group, from the information received, group or private conversation with hospitalized patients, did not find any flagrant cases of torture or excessive use of force.

At the moment of inspection in the psychiatric hospital of Vlora, there were no complaints about food, or the quality of cooking in general.

Based on the information that inspection group received from management staff, a serious problem remain people abusing with narcotics and/or alcohol, because after being provided with the emergency service they have turned into residents of the hospital. While another earlier problem are the 9 patients who do not fall into the territorial coverage of Vlora, but are residents in this hospital.

Safeguards

During monitoring visit, the expert identified that there was a legal sector in this institution which enabled to defend legal interests of the institution and persons treated in this institution, who are left legally unprotected / unrepresented in several cases and vulnerable to institutional and / or family abuse. Monitoring group was also made available internal regulation of the institution, approved. In terms of measures of constraint only straitjackets were found in this institution, while for seclusion of patients there was no specific protocol, because isolation / seclusion room was missing. According to management staff, after these cases were entered in a dedicated register, they were kept in the rooms of the ward, but regularly observed from nurses and/or hospital caregivers.

The commission for hospitalization was composed of three doctors of the hospital where the patient was initially kept under observation and then based on the situation would be proceed with hospitalization or return home by recommending ambulatory medication. Even the later are carried out after a long consultation with three psychiatric doctors. From the information received from director of this institution, involuntary hospitalizations in this hospital were carried out in accordance with the law on mental health and its bylaws. However, during monitoring visit it was observed that there were doctors who didn’t follow legal procedures for

involuntary hospitalization, in conflict with human rights and freedoms and in conflict with law no. 44/ 2012 “On Mental Health” as well as its bylaws reasoning that procedures to follow this measure would take up to one month and during this time the patients might have already been rehabilitated and left the hospital. This urged doctors to persuade within some days the patients to approve hospitalization by signing in the file.

One problem identified in this hospital was admission of ill people in the emergency unit of the hospital, in conflict with human rights and freedoms, by bringing them handcuffed from public order police, unaccompanied by family members with the excuse that they are a danger to themselves and/or to the community. Also, another problem were court decisions to remove the ability to act of patients of this hospital, but the staff was not part of the process and in case this decision would be made, the latter wasn’t even informed.

There wasn’t camera monitoring system in any of the facilities of the institution.

Patients hospitalized in this hospital were offered the opportunity to meet their family members or relatives any time they wanted. Meantime, those cases housed for years in this institution were almost completely abandoned by their family members and their meetings were very rare or non-existent.

Complaints and requests of patients were managed by psycho-social staff. Then, the same staff reported problems raised by persons under treatment through their complaint / request.

In the joint spaces, within the wards, corridors or other facilities of these institutions, posters, information about human rights and the phone number of Ombudsman Office were missing with the exception of the entry and consultation room.

Material conditions

Premises of the hospital were completely damaged and humid and the facilities where patients were kept, were in violation with human rights and freedoms. An exception was admission ward which had optimum conditions.

At the beginning the inspection group visited admission ward which was in a separate building. In the first floor of the building was a consultation room, doctors’ room and a rehabilitation room where psycho – social staff organized activities with the patients admitted. The later was furnished and clean.

In the second floor of the building was admission ward with a maximum capacity of 14 beds. At the moment of the visits 7 patients’ women and 7 men were present. This hospital was supplied with necessary equipment. Patients had no complaints about food or treatment of hospital staff. Bathrooms and toilets were clean and maintained.

The situation was different in the other wards, where hygiene and sanitary conditions were good in general, but furniture was missing, beds were damaged, living spaces of rooms was in violation with standards and not respecting human rights. Inspection group also identified that

these rooms were hospitalizing from 15-18 patients, they had big windows and enough natural light, but humidity was visible because there was water leaking from the ceiling of one room. Heating was provided through radiation, but it was not enough for that big space. Bathrooms had no tiles and broken taps, while showers were 4×4m with six divisions, but completely out of standards so the service provided was inhuman and degrading. Mattresses, sheets and blankets were provided through humanitarian aid of international voluntary organizations.

In this hospital are also hospitalized patients who are not treated with medicaments, but who are now residents of this hospital for years causing an overload to the staff and a financial burden to the budget of this hospital. This category is considerable in number 39 persons with the diagnosis "mental retardation", status *Postmeningoencefalitis*, "Cerebropathia Congenitale", or/ and Epilepsy", and they were accommodated in wards 1,2,3,4 of men and women. This was in conflict with the law "On Mental Health" and its bylaws recently issued. Despite the efforts of the head of this institution to find a solution for this category of people, the situation remains unchanged.

There wasn't camera monitoring surveillance in any of the wards of the hospital.

Kitchen was missing in this institution, because food was provided through catering based on a contract that the hospital had with a restaurant of the city. There was a canteen and eating space for patients. It was clean and tidy, but heating was missing as well as necessary equipment and furniture was damaged. There were also some closets serving as staff wardrobes. Food items were kept in a locked fridge.

There was running water provided which enabled persons perform their needs.

There was an ambulance in the hospital, but also a minivan for the staff which was used for activities organized by psycho-social staff outdoor.
Central heating was missing, but heating in wards was provided through radiators and with air conditioners in some others, which was not enough for all the space of the rooms with dimensions 12×5.5 m.

Laundry was completely worn-out and almost out of order, manifesting a problem related to the washing and drying of clothes in this institution.

Nurses rooms in all wards, despite their attempts to keep them clean, were equipped with old furniture. Dentist's room was out of standard with only basic equipment, such as the seat and very old dental tools and materials, but unit and autoclave were missing. Consequently, the institution didn't provide a proper dental service.

Social service and activities

The structure of this service was composed of two psychologists, one social worker and one occupational therapist. Their work for preparing files of each patient was divided according to wards, either for those hospitalized for the first time or those residing for years in this institution. They also worked with individual treatment plans for each of them.

Psycho-social staff organized activities in relevant rooms of the wards, but also outside the institution, in the community. They were organized from 09:00hrs-14:00hrs, and included painting, handcrafts, religious celebrations, birthdays of patients as well as outdoor activities such as picnic, cinema, etc.

Vocational training was missing in this institution, but creative activities were organized such as handcrafts and artistic ones.

All activities organized within the year in this institution were supported by "Shpresa" Organization and international voluntary organizations and civil society.

Health Care service

The structure of health sector was composed of seven full time doctors, out of who only three had the four year education in psychiatry, while others had one year education or had a background as general practitioners, but with some several years of experience in this hospital. With regards to the rest of healthcare staff it was completed with nurses, caregivers and sanitary staff.

At the moment of the monitoring visit, out of all ill people treated in this hospital for mental health problems, there were diagnosed with other chronicle illnesses such as 20 with diabetes, 26 with cardiac pathology, 3 for nephrology, 3 with dermatological diseases etc.

During the inspection in this institution it was found that a problem carried in years was the considerable number of patients with different diagnosis who have become residents in this hospital.

Inspection group also found that there was radiology, micro- surgery and dental service as well as a clinical – biochemical laboratory which had medical staff deployed and provided an efficient service, apart from the dental cabinet, which was completely out of standards. This institution was lacking EKG device. Whereas, the staff was the institution didn't raise any complaints about the analysis, examinations and consultation of patients in the general hospital of Vlora. They were carried out on time and without any difficulties from staff of other services.

During the inspection in the pharmacy of the hospital it was found that it was supplied with variety of Antipsychotic, antidepressant, anxiolytic, Hypno sedative- and mood stabilizers. It was also noticed there was no lacking of medicine for other chronicle, cardiac, endocrinological, neurological and dermatological illnesses.

From the examination of medical staff files and doctors in particular it was found that the new files approved with the new law were already put in use. They were filled out regularly in accordance with bylaws of the Law No. 44/ 2012 "Mental Health". Also, all the registers of this institution, hospitalization register, observation register, involuntary hospitalization register, register of visits and consultations in Vlora Pre-trial detention Institution, the register of visits referred by QKSHM Vlorë, register for notification of family members as well as register of

patients who were brought in the hospital by public order police were all filled out clearly and rigorously from the staff of the hospital. Similarly, also the 24 hour information registers were clearly completed by nurses

As per above it was recommended:

1. Taking immediate measures to improve conditions of the patients in this hospital and respect their living space.
2. Taking measures to find a solution about the 90 persons with Mental Retardation and 9 patients which don't belong to the jurisdiction of this hospital and who have been residents for years in conflict with legislation in power.
3. Developing a Memorandum of Understanding between the Ministry of Health and Ministry of Social Welfare and Youth to solve problems of persons with mental retardation, residents in the psychiatric hospital "Ali Mihali", Vlora.
4. Taking measures to open the new hospital with the new wards for acute and sub-acute patients.
5. Taking immediate measures to provide a separate isolation room in accordance with the new law on Mental Health and its bylaws.
6. Taking immediate measures to apply all procedures for involuntary hospitalizations according to Law No. 44/ 2012"On Mental Health" and its bylaws.
7. Taking measures to install a camera monitoring surveillance system in the facilities of the institution as one of the most important aspect for prevention of violent acts towards citizens and vice versa in order to respect human rights and freedoms.
8. Taking measures about heavy humidity in wards, showers and toilets and take measures to improve the latter.
9. Taking measures to involve staff of the hospital in judicial processes for the removal of ability to act of the patients of this institution as well as inform staff when court makes such decisions.
10. Taking immediate measures to open a dental cabinet all necessary tools, unit, autoclave, dental tools and materials to provide an adequate dental service in accordance with standards.
11. Taking immediate measures to provide an EKG device to this institution as a necessity to do such examination for all patients who have been treated with antipsychotics.
12. Taking immediate measures to refurbish laundry room of the hospital and putting it in full use.

8.3. Psychiatric Hospital Shkodra - Dated 11.12.2014 / Doc. No. 201402546

Preliminary remarks

This was periodical monitoring visit of Ombudsman in the Psychiatric Hospital of Shkodra for 2014. The Director of the Institution informed that maximum capacity in this hospital was 35 beds. At the moment of the inspection, there were 27 persons in the facilities of the hospital, out of which two were residing for about four months in the hospital because of lack of family and social support and three others were respectively staying in the hospital for 3, 5 and 6 years

subject to the measure “mandatory medication”, the objection of which faced difficulties due to administrative delays from District Court of Shkodra. The rest of persons treated in this hospital were acute and sub-acute patients.

Based on the monitoring procedure, inspection group at the beginning had a meeting with the director of the institution, who expressed her availability to cooperate to achieve the goal of the inspection. During the meeting, inspection group requested initially information about the rights and treatment of patients as well as the way the institution handled problems identified in the previous inspection.

Director of the institution informed the experts that Psychiatric Hospital of Shkodra had a wide coverage area including districts of Shkodra, Malësisë së Madhe, Bajram Currit, Puka, Lezha, Krumës, Kukës, Rrëshen, Peshkopi, Laçi and Burreli. The hospital was divided into 3 wards: the ward for men with official capacity of 15 beds, the ward of women with the official capacity of 12 beds and the admission ward with an official capacity of 8 beds.

It is worth mentioning that this hospital was built two years ago and in general met the standards of a temporary psychiatric hospital. So, there were no residents in this hospital, except the five above mentioned cases. After the construction of the hospital, all residents were accommodated in “Mimoza” Home with a capacity of 10 persons and in four other homes with a capacity of 52 persons. There were cases where people returned to the community with the assistance of civil society and international and local humanitarian organizations.

Treatment

Monitoring group aimed at collecting information about treatment of patients in this hospital, in identifying use of force beyond limits foreseen in normative acts, or putting psychological pressure to this category, as well as for health service provided to hospitalized persons. Monitoring group, from information received, conversation in group or privately with patients, didn’t find any flagrant case of torture or excessive use of force.

At the moment of inspection in the psychiatric hospital of Shkodra, there were no complaints about food or quality of cooking.

Based on the information that inspection group received from management staff of this institution, a serious problem remained the case of two persons who were treated for over three months in this hospital and the three others that were hospitalized for years under the measure of “*mandatory medication*”.

Safeguards

During the monitoring visit, experts group observed that from the time this institution was built it was transferred under the responsibility of Public Health Directorate of Shkodra. Consequently, legal sector which was supposed to defend legal interests of the institution, but also enforce legal obligations according to the law no.44/ 2012 “On Mental Health”, was covered by a legal staff of PHD. However, during the monitoring visit, experts’ group found that the legal officer hadn’t

dealt with cases of involuntary hospitalizations in this institution, but only legal representation for cases of "*mandatory medication*", and was not clear on her role for the legal procedures to applied by the institution pursuant to Articles 21, 22, 23, 24 of Law no.44/ 2012 "On Mental Health". According to this law, within 48 hours from hospitalization of patients subject to involuntary treatment, the head of the institution which provides in treatment mental health service, referred by chief of services and with the assistance of legal personnel must address the district court to validate the procedure followed in case of involuntary treatment of the patient in order to continue with such treatment. Also, in each case when health conditions of the patients which led to involuntary hospitalization have improved, the director of the institution with the assistance of the legal officer must submit a request to the competent court to revoke the decision of the court which assessed and ordered involuntary treatment of the patient.

In terms of measures of constraint in this institution, the head of the hospital informed that means of physical restraints were lacking, whereas for the seclusion of patients there was no special protocol in place because isolation / seclusion room was missing. Also, there wasn't any dedicated register for persons hospitalized with involuntary hospitalization.

The commission of doctors for hospitalization consultations was composed only of one doctor, who was the head of this hospital. After a preliminary assessment, the patients was kept under observation and based on the situation would either be hospitalized in the hospital or return home and continue with outpatient medication. Even for the latter the decision was made by the only doctor of the hospital.

From the information received by the director of this institution, involuntary hospitalizations were not followed according to the new law "On mental health" and its bylaws. During the monitoring visit it was found that the doctor of this hospital didn't apply legal procedures for involuntary hospitalization according to Law no.44/ 2012 "On Mental Health" and its bylaws, claiming that procedures to revoke such measure would last up to one months, during which time the patient might be rehabilitated to leave the hospital. This urged the doctor of the institution and psycho-social staff to persuade the patient to approve hospitalization by signing also the file. This is a problem observed also in psychiatric hospitals of region countries and it has been found a similar solution. Also, emphasis must be put that even with the delays caused by the court in reviewing such cases; hospitals must apply involuntary hospitalization procedures according to the law.

One problem observed in this hospital was admission of ill persons in the emergency unit of the hospital in violation with basic human rights and freedoms by being brought handcuffed by public order police, unaccompanied by family members with the excuse that they were a danger to themselves and / or community. Also, a problem was court decisions to lift the measure "mandatory medication". For such cases, the doctor of the hospital after a professional assessment would address the court with a request to revoke this measure, but there were delays from the court in carrying out this procedure.

There was a camera monitoring system in this institution, but not throughout its facilities and they couldn't be accessed any time and in any case.

Patients hospitalized in this institution were offered the opportunity to meet family members or relatives any time they wanted.

Complaints and requests of patients were managed by psycho-social staff. Then, this staff would report the problems raised by persons under treatment, based on their complaint / request.

In the joint spaces of wards, corridors or other facilities of the institution were missing posters with information on human rights and the telephone number of the Ombudsman Office.

Material Conditions

The premise of this hospital was new and well organized in infrastructure, clean and tidy. The medical staff tried to maintain it which was obvious in all the inspected facilities. In the first floor of the building there were the admission ward on one side and on the other side an ergo therapy room where psycho-social staff organized activities with admission patients. In the second floor there were two wards for acute and sub-acute patients.

At the beginning the NPM staff visited admission ward which had 4 rooms, two beds each. In this room it was also consultation room, nurses' room and the canteen of the admission ward. These facilities were kept clean and tidy.

There was a cabinet in the nurses' room which was used to keep the medicine of daily therapy and of the emergency.

The canteen where meals were provided 4 times per day for all patients treated in this ward, was clean and furnished with 3 tables and 12 chairs.

Also, the ergo-therapy room where meeting of psycho-social staff were organized with persons treated in this hospital, entertaining activities, watching television and having different conversations, was clean and equipped with furniture and a small kitchen.

In the second floor were the wards of men and women. These two wards were infrastructural symmetrical, with rehabilitation rooms and with bathrooms each, one with two showers and the other one with three, and running hot water all day. Women's ward had nine rooms and at the moment of the visit there were ten persons, while men's ward had 8 rooms and at the moment of the visit there were 9 persons. Facilities were tidy and clean respecting European standards either in terms of living space, but also hygiene and sanitary conditions for these persons. Linens, mattresses, sheets and blankets were new and clean.

Also the kitchen in this institution was clean. Four meals were prepared daily and menu was displayed. Food items were kept in the fridge, but not locked. This kitchen had all appliances in compliance with standards.

There was running water provided, by enabling persons to meet their personal needs.

Institution had central heating which provided 24/7 heating to persons treated in this hospital.

Social services and activities

There were four psychologists and one social worker in the structure of this hospital. Their work was divided per wards in preparing files of each patient for those hospitalized in the admission ward, also the ones treated in the two other wards. Also, they worked based on individual treatment plans for each.

Psychologists and social workers contacted daily persons treated in this hospital. Patients were followed by psycho-social staff in all their daily activities, by sensitizing them to take care of personal hygiene, in taking part in therapy and eating food. Most of activities were organized in rehabilitation rooms and were watching TV, artistic works and handcrafts for women, playing cards, domino for men, individual / group counseling, etc.

Members of the staff worked as multidisciplinary team about familiarization with new hospitalization, filling out files and individual treatment plans based on the new law "On Mental Health" and its bylaws.

In addition to activities in the hospital, employees also organized different socio-cultural outdoor activities. These activities were supported by international and local humanitarian organizations. A particular support was provided to persons leaving the hospital and to those transferred to Supported Homes.

From analysis of the psycho-social documentation it was found that there were personal files for each person treated in this institution that were properly completed.

Health Care service

The structure of health service was understaffed with doctors, while the rest of the staff was enough in number with nurses, caregivers and cleaners. The institution had one doctor who was working full time. In terms of 24 hours service, other doctors from Community Center or one doctor following specialization to Tirana Psychiatric Hospital "Mother Tereza" would come to help.

The pharmacy was completed with a variety of antipsychotic, antidepressant, anxiolytic, Hipno - sedative, and mood stabilizers. There wasn't any lacking of medicine for other chronicle, cardiac, endocrinological, neurological, dermatological illnesses, etc. Nurses' rooms in all wards were clean and tidy.

Other services in this institution such as dental service, clinical-biochemical laboratory, imaging examinations, EKG, or consultations with specialists of other areas of health care were provided by Regional Hospital of Shkodra. There was a Memorandum of Understanding between the latter and Psychiatric Hospital which was considered by the Director of this institution as fruitful and respected by both parties.

From the examination of documentation of the medical staff, in particular the one of the doctor it was found that the new files were already put in use. They were filled out properly in accordance with bylaws of Law No. 44/ 2012 “On Mental Health”. Also, all registers of this institution were properly and rigorously completed by the staff of this hospital. All data were properly entered in the 24 hour information registers of nurses.

As per above, it was recommended:

1. Taking immediate measures from the Ministry of Health to organize a training for all psychiatric practitioners of mental health services provided in hospitals in Shkodra Elbasan and Vlora with the support of Psychiatric Service of QSUT “Mother Tereza” Tirana, about involuntary hospitalizations in this institutions pursuant to articles 19, 20, 21, 22, 23, 24 and Law No. 44/ 2012 ”On Mental Health”.
2. Taking immediate measures to apply all procedures for involuntary hospitalizations according to Law No. 44/ 2012 ”On Mental Health” and its bylaws.
3. PHD of Shkodra must take immediate measures to deploy a legal officer in the psychiatric hospital who shall assist the institution to apply procedures pursuant to articles 21, 22, 23, 24 and Law no. 44/ 2012 “On Mental Health”, in order to address the court to assess the procedures carried out in the events of involuntary return of patients and continuation of this treatment as well as file requests in the responsible court to revoke court decisions which have examined and ordered keeping patients in involuntary hospitalizations.
4. Taking immediate measures to anticipate procedures of revocation for mandatory medication for persons subject to this measure to Psychiatric Hospital of Shkodra with the legal support of legal officer of PHD until the deployment of a lawyer in this Institution.
5. Taking immediate measures to provide a separate isolation room in accordance with the new law “On Mental Health” and its bylaws.
6. Taking measures to supply the hospital with means for physical restrictions in accordance with European standards and its bylaws of the law “On Mental Health”.
7. Taking measures to install a camera monitoring system in all facilities of this institution and make it operational.
8. Taking immediate measures to complete the organizational chart of the institution with psychiatric doctors.
9. Taking measures about food items in the kitchen of the institution, which are locked.
10. Taking measures to involve the staff of the hospital in hearings related to removal of ability to act for the patients of this institution as well as inform the staff when such decision is made by the court.

9. Recommendations for Centers, based on the inspections for 2014

9.1. National Receipt Center for Asylum Seekers - Dated 03.10.2014 / Doc. No. 201401745

Preliminary remarks

Official capacity of the National Asylum Seekers Receipt Center is 150 persons for 2014. At the moment of the inspection, there were 30 persons present in the facilities of the institution; 5 families with different nationalities (Kosovo, Turkish, Bulgarians, etc.)

According to monitoring procedures, inspection group first had a meeting with the head of this institution who expressed her availability to achieve the goal of the inspection. During the meeting, inspection group initially asked for information about the rights and treatment of persons in the center as well as the way that this institution handled problems encountered in the previous inspection.

Experts were informed by the head of the institutions that National Asylum Seekers Center is an opened center which provides housing for asylum seekers in the Republic of Albania. She also informed that the majority of recommendations made the previous year have been taken into serious consideration and have been met according to budget opportunities of this center.

Treatment

Monitoring group aimed at collecting information about asylum seekers on the treatment of asylum seekers housed in the center, in identifying cases of excessive use of force beyond the limits foreseen in normative acts or putting psychological pressure to this category. Monitoring group, based on information received, group and private conversations with asylum seekers, didn't identify any flagrant cases of torture or excessive use of force.
At the moment of inspection in the National Receipt Center of Asylum Seekers, there were no complaints about treatment, food or other matters related to stay of persons in this center. They raised their concern about clothing, which despite all efforts of the staff of this institution were not enough.

Safeguards

All persons accommodated in the National Receipt Center of Asylum Seekers, interviewed by the inspection group admitted that they could go out from the institution any time and run their personal errands without problems.

What was noticed from the monitoring group, but also raised as a problem from the staff of the center, was the lack of a lawyer who should work on the documentation of each individual sheltered in the center, taking into account that this center houses foreign citizens. Another unsolved problem was the long duration of stay of persons in this center. From the interviews it resulted that the majority of families have been more than 7 years residing in the shelter.

Inspection group noted that a long stay, even in an opened center, doesn't help integration of these families in the society.

In terms of surveillance, National Receipt Center of Asylum Seekers, even being an opened center for asylum seekers, was equipped with cameras in the outdoor facilities, but not indoor. While the surveillance of facilities of the Center was provided by a private company and camera system was monitored by the surveillance employee.

Material conditions

This center was composed of six one store buildings, two out of which were used as administrative offices, one was the canteen, one building library, laundry room, showers, storage and the rest was residence facilities for asylum seekers.

It must be emphasized that the Head of this institution, based on recommendations made last year from NPM, has made her best to get funds to reconstruct a part of facilities. Inspection group checked the undergoing construction of some buildings and also checked some of completed buildings. The latter were bedrooms with 2-3 new beds and new linens, closets and nightstands and tables. One of the premises was turned into a two bedrooms apartment and one toilet with shower.

Toilets and common showers were just finished and were functional, considering the fact that this center might also have a high flow of persons.

In general, living rooms had natural and artificial light and were equipped with all necessary furniture. There was no presence of insects or rats noticed.

From all the interviews conducted, inspection group identified there was no lacking of linens, personal and common hygiene items for asylum seekers, but there were problems with clothing.

There was running water and no problems were identified about electrical power. There was a generator just in case.

There was a laundry which worked on schedule for persons accommodated in the center.

There was no central heating in the institution. Consequently, in winter heating was provided by appliances provided by the staff of the center and equally in summer.

There was ambulatory facility (doctor's room) which was also reconstructed the same as the rest of the center. Also, there was a considerable amount of medicine available for asylum seekers in case of emergencies and as first aid.

Monitoring group observed an outdoor facility which was used for basketball and football, but there was no playground for children.

National Receipt Center of Asylum Seekers had a library which was also serving as a classroom for computer classes. Library was clean and had a considerable number of books and computers, all functional.

Inspection group noticed that kitchen and canteen were relatively clean and tidy. Daily menu was displayed. There were 3 meals provided per day for adults and 4 for children. Food was stored in a refrigerator. As it was already identified on the spot from inspection team, but also according to the interviews with asylum seekers, food was of a high quality. At the moment of the inspection there were no specific requests about nutrition diet, even though staff was already prepared for this matter.

Activities

Taking into account that this is an opened center, persons residing there were free to work, go out from the center or carry out other personal activities. Adding on to that, the staff of the center organized once in a while joint activities such as birthday parties, trip to swimming pools, football and basketball matches, etc.

The center has signed a Memorandum of Understanding with Ministry of Education about 9-year education of children sheltered in this center. The inspection group was informed from interviews with children that they attended school regularly.

Library was functional and had a considerable number of books. Taking and returning a book was done by entering relevant data in a personal file.

Also, there was a common place in the canteen where they could watch television shows together.

According to the approved organizational chart there is only one psychologist and social workers by leaving aside posts which are very important for its area of responsibility such as educators, caregivers, legal staff and at least one social worker and psychologist. The inspection group, taking into account the fact that there were families residing for years in the center and based on the way the center works, drew the conclusion that the center is understaffed to meet all needs of the center despite the fact that the director of the institution and staff worked in shifts to cover most of the day.

While checking documentation, inspection group noticed that the staff worked hard to create an e- register for all persons sheltered in the center. Also, another protocol register was created besides the e-register. Each of them had a specific file with proper documentation.

Health Care service

There was no doctor or dentist foreseen in the organizational chart, so this service was not provided by the staff of the center. However, with the reconstruction of facilities there was a dedicated doctor room with all necessary tools established. At the moment of the inspection, this

room was under reconstruction so all medicine including the emergency ones, were locked in another facility.

Health service was provided by family doctor of Health Center no.10, who is also in charge of the area where this center is established. From the interviews carried out, the inspection group was informed that this service was provided on time, according to their requests. In terms of dental service it is provided according to procurement procedures.

Institution has no ambulance. In case of emergencies, they would use vehicles of the center to transport asylum seekers in hospitals.

Also, health booklets were opened for all asylum seekers accommodated in the center and reimbursement scheme of medicine was completely functional. Medicine was reimbursed equally as other citizens of the Republic of Albania. While, medicine not subject to reimbursement was bought according to public procurement procedures.

As per above, it was recommended:

1. Taking measures to add staff of the center minimally one social worker, psychologist, educator, caregiver, legal officer and medical staff. The latter should be at least part time.
2. Taking measures to finish refurbishment of the interior living facility of the center.
3. Taking measures to prepare a Memorandum of Understanding with the Ministry of Social Welfare and Youth to offer opportunities for vocational training in Vocational Education Centers and offer employment from Regional Employment Offices, which are subordinate to this Ministry, for all interested persons housed in NCAS.
4. Taking measures to treat persons housed in NCAS with economic aid as it is stipulated in Law no. 10060, date 26.01.2009, “On some amendments and changes in Law no. 8432, date 14.12.1998, “On Asylum in the Republic of Albania”.
5. Taking measures to supply with clothing according to seasons and age groups of persons housed in this center.
6. Taking measures to integrate in the society persons shelter in the center which must include persons with short stay in this center.
7. Taking measures to create a playground for children.
8. Taking measures to guard this center with staff from ASP.

9.2. National Reception Center for Victims of Trafficking - Dated 08.10.2014 / Doc. No. 201401744

Preliminary remarks

This was the periodic monitoring visit of Ombudsman in the National Shelter for Victims of Trafficking, for 2014. At the moment of the inspection, there were 13 victims / potential victims of trafficking (VT/PVT) in relation to the official capacity of 100 beds in the center.

According to monitoring procedure, inspection group at the beginning had a meeting with director of the institution who expressed his availability to cooperate to achieve the goal of this

inspection. During the meeting, inspection group requested information about the rights and treatment of citizens in the center as well as the way the institution handled problems identified in the previous inspection of this institution.

The director of the institution informed experts that National Reception Center for Victims of Trafficking is a closed center, of high level security that houses persons identified based on Standard Operating Procedures for Identification and Referral of Victims / Potential Victims of Trafficking.

This center has been established based on the Decision of Council of Ministers no. 589, date 28.08.2003 “On Establishment and Functioning of National Reception Center for Victims of Trafficking”, which amongst others not only doesn’t stipulate duties of this institution or services it provides, but it also stipulates in point 3 that this center treats clandestine crossing through Albania. Inspection group noted that NCVT, based on Law no. 90/ 2012, date 27.09.2012 “On organization and functioning of state administration” must change the legal basis of how it runs taking into account the above mentioned concerns.

Treatment

Monitoring group aimed at collecting information about treatment of VT/PVT housed in the center, to identify cases of excessive use of force beyond limits foreseen in normative acts or putting psychological pressure to this category. From the information received, group and private conversations with VT/PVT, monitoring group didn’t identify any flagrant cases of torture or excessive use of force.

What the monitoring group noticed, but it was also raised as a concern from the staff of the center was the understaffed situation of center, specifically lawyer and psychologist who were both currently working part time. Both the lawyer and psychologist were working, based on Order no. 387/ 15 prot., date 27.04.2014, in the National Receipt Center for Victims of Domestic Violence, despite the fact that they were paid from NCVT. Same problem was noticed for the position of the cleaning lady, who based on Order no. 571, date 12.03.2014, was deployed in the Elders House in Tirana, but her salary was paid from NCTV. Both orders create serious problems in terms of wellbeing and treatment of VT/PTV. The presence of a lawyer and psychologist is particularly important, considering the legal problems and mental health of this target group.

At the moment of the inspection in the National Receipts Center for Victims of Trafficking, there were no complaints about treatment, food or any other matters related to accommodation of persons in this shelter. They raised their concerns about clothing which was not enough.

Security

All persons accommodated in the National Receipt Center for Victims of Trafficking interviewed by the inspection group admitted being there voluntarily and some of them had criminal proceedings ongoing and as a consequence to that, they were accommodated in the center.

In relation to security, national Receipt Center for Victims of Trafficking is due to its nature, a closed center and guarded by Albanian State Police based on an agreement of 2003 between Ministry of Social Welfare and Youth (former Ministry of Labor and Social Affairs), IOM and Ministry of Internal Affairs (former Ministry of Public Order). NCVT, but despite its importance, it was not equipped with surveillance cameras neither in the outdoor facilities or indoor spaces.

Material conditions

This center was composed of two premises. During the monitoring in both premises, the inspection group identified that posters were displayed not only about the rights of VT/PVT, but also rights and obligations of personnel deployed in the center, bits and pieces of the internal regulation of the center, etc.

Some refurbishments were made in the first premise which was mainly administration offices and some other common facilities for the beneficiaries of the center and consequently it was somehow better than the second premise. As a result, this building was used in winter to house beneficiaries to avoid humidity and damaged facilities of the second building. For this purpose 6 rooms were used, furnished with bunk beds and mattresses, but extremely worn-out. There was a lack of funds for this matter.

There was a common facility in this premise (atelier) which was used in the past to deliver computer and hairdresser's trainings, etc. at the moment of the inspection there were about 6 computers, only two of them working and maintenance was problem due to lack of funds and problems with electric power.

There were also toilets in this premise which despite their good hygiene and sanitary conditions were not all in use. Also, there were washing machines, but only one was working.

During the inspection of the second building, expert's group observed visible humidity in all interior facilities, very old doors in the rooms of the beneficiaries, etc. Each of the rooms was equipped with bed and mattresses, nightstands and closets but extremely damaged.

Also, this building had common facilities such as television room, classrooms, etc., but all humid and very old and damaged furniture. Toilets and showers, all common facilities, despite the hygiene needed an immediate change.

There was lack of appropriate clothing for the beneficiaries and due to lack of funds; the staff was only expecting from different donations. During monitoring, it was observed that there was no lack of hygiene and sanitary items and there was 24 hours running water. In terms of electric power, the staff informed that there were many problems. The power cuts and changes in voltage led to the burning of the few appliances available in the center.

NCVT must be provided with central heating, considering installment system observed by the group of experts. In fact, it was found that, in addition to damaged heating appliances installed in

walls, lack of funds to put in use the heating led to the fact that heating was provided from alternative heating appliances.

In terms of food offered to persons accommodated in the center, inspection group identified that the kitchen, despite having all necessary appliances, was damaged and humid. There was a variety and enough food, and food items were stored in the fridge without a lock. Canteen was in another facility in the same building and it had 8 eating tables, but still worn-out.

Medical treatment was provided by the doctor of the center, who was accommodated in a dedicated room in the second building. There was a bed and closet to store medicine and another cabinet for files of each beneficiary.

Monitoring group observed that there was a playground for children but very few and worn-out items.

Activities

Considering the fact that this is a closed and high level security center, it is very difficult to organize outdoor activities also due to lack of funds and staff.

From the last inspection and recommendation made about signing an agreement with the Ministry of Education about secondary 9 – year education of children housed in this center, it was found that such recommendation was not met. At the moment of the inspection there was only one child a pre-school age in the center, who attended neither a nursery nor kindergarten.

Seven of the beneficiaries of the center attended vocational courses in Vocational Training Center no.4 in Tirana, three times per week for hairdressers, cooking, tailoring, etc. At the moment of the inspection they were expecting the anti-trafficking week to start soon so they were all committed to open a handicrafts exhibition of the beneficiaries and some materials were bought for this reason.

During the examination of documentation, inspection group noticed that there was detailed information for all psycho-social services provided to beneficiaries. However, records kept for individual and group consultations, showed that consultation was merely information about conversations had rather than specific goals and interventions, approaches used, description of mental state, etc.

Health Care service

There was a doctor in the structure of the center, who was working full time in the institution and as a result the service was qualitative on in time. Medical check - ups were carried out in the visits room and medicine, including the emergency ones, was put in an unlocked cabinet. For cases which needed a more specialized consultation, the service would be offered without any delays from specialized doctors of QSU “Mother Tereza” Tirana.

While checking documentation of the doctor of this institution, it was found that there was a register of visits and files for each beneficiary that was properly filled out and were kept on the desk of the doctor. During her time in the institution the doctor also delivered informal trainings with beneficiaries about family planning and protection measures. These training were delivered once a week.

Medicine was provided from the budget of the center and there was e medical file for each person. Dental service was regularly provided by a private company based on an agreement that the center signed with the dental clinic.

The institution had no ambulance. In case of emergencies vehicles of the institution were used to transport VT/ PVT in hospitals.

None of the beneficiaries of the institution was provided with health booklet so reimbursement scheme of medicine failed to work, but for cases with health problems the center provided medicine with its own budget. One beneficiary was diagnosed with chronicle schizophrenia and she was subject to second invalidity group "KEMP", which offered the opportunity to receive proper medication, according to her.

As per above it was recommended:

1. Taking measures to change Decision of Council of Ministers no. 589, date 28.08.2003 "On establishment and functioning of Receipt Center for Victims of Trafficking", pursuant to law no. 90/ 2012, date 27.09.2012 "On organization and functioning of public administration", to stipulate duties of this institution, services it provides as well as definition of beneficiaries according to Operating Standards Procedures for Identification and Referral of Victims / Potential Victims of Trafficking.
2. Taking measures to deploy full time a lawyer and psychologist.
3. Taking measures to reconstruct completely building number two which is completely damaged.
4. Taking measures to draft a Memorandum of Understanding with Ministry of Education about the education of beneficiaries in this center and / or their children in the 9 year secondary education.
5. Taking measures to provide employment from Regional Employment Office in Tirana considering that beneficiaries receive vocational training in the Vocational Training Center no. 4 Tirana.
6. Taking measures to properly fill out personal files with details of consultation according to professional standards.
7. Taking measures to supply clothes per each seasons and age groups of persons housed in the center.
8. Taking measures to improve playground for children.
9. Taking measures to reestablish heating system in both premises.
10. Taking measures to fix toilets which don't work and improve showers facility.
11. Taking measures to open health booklets and make use of reimbursement scheme of medicine for all beneficiaries of the institution.
12. Taking measures to fix washing machines that don't work.

13. Taking measures to fix and maintain computers.

9.3. Closed Reception Center for Aliens, Kareç - Dated 05 and 18.11.2014 / Doc. No. 201402003

Preliminary remarks

Closed Reception Center for Aliens, Kareç has been established with DCM no. 1083, date 28.10.2009, pursuant to article 100 of the Constitution and point 2 of article 83 Law no. 9959, date 17.7.2008 "On Aliens", with the aim to house irregular aliens in the territory of the Republic of Albania, subject to detention measure according to legislation in power. The closed Center is a structure subordinate to Border and Migration Department in the General Directorate of State Police, Ministry of Interior. Internal Regulation of the Center has been approved by Order of Director General of State Police. Official capacity of the Center is 125 persons.

In the first day of the inspection there were 64 aliens in the facilities of the institution, out of which 55 from Syria, 6 from Eritrea, 1 from Ukraine, 1 Nigeria and 1 from Iraqi. 54 were in the readmission process from the Greek country, 9 had no documents and 1 was in trial process. The second day of inspection there were 61 persons.

According to monitoring procedure, inspection group first had a meeting with the Head of the Institution who expressed his availability to cooperate and fulfill the goal of inspection. During the meeting, the inspection team requested information about the rights and treatment of persons in the center and the way the institution dealt with encountered problems. The Head of the institution informed experts on a range of problems and the way the center was functioning and how they were all addressed. For that purpose, an external working group was set up which was in the process of drafting a report.

Another serious problem were the cases of aliens running away from the center due to the conditions of the building and perimeter wall as well as limited number of security staff. Until the day of the visit there had been some several cases of escapes with a total number of 30 persons, 22 out of which were apprehended and returned to the Center. Director of the Center had requested from supervisors to take measures to increase the security of the center, but no specific step had been taken yet.

Another problem was the failure to prevent infectious health problems through an adequate medical examination from the moment of admission in the institution. Due to lack of a doctor in the structure, this service was delivered by a charge nurse who was also performing as a secretary and archive staff. In relation to this matter, inspection group was informed that two weeks prior to their visit in the institution, the staff had found cases of skin rashes (scratches) and after an examination from Public Health Directorate of Durres, Hygiene sector, it resulted that it was scabies. It must be emphasized about this diagnosis, that the staff of the institution that was in direct contact with aliens, was informed for the first time on the monitoring day, date 05.11.2014. After the results, some several measures were taken to treat and cure the cases found with scabies. Persons who showed symptoms of this disease were applied local medication

Benzyl Benzoate 200ml/ bottle, the first time, whereas the other times, as it was admitted by the charge nurse, it was applied upon their request. Their clothes were washed in a washing machine and dried outside, but the protocol for the prevention of spreading the disease requires eliminating the clothes, if they are not washed in a very high degree and not dried in a drying machine. According to the director, on 24/ 09/ 2014, Public Health Directorate of Durres, Hygiene Sector, disinfected all interior facilities of the institution.

As a consequence of the above, monitoring group decided not to access indoor facilities the first day of the monitoring, but just receive written and verbal information from the staff and meet with aliens in the outdoor facilities. In order to check internal facilities of the institution, another monitoring group was set up composed of Mrs. Jorida Rustemi and Mr Hortenc Balla on 18.11.2014.

Treatment

During the two monitoring visits, inspection group aimed at collecting information about treatment of aliens sheltered in the center and identify any cases of excessive use of force or psychological pressure beyond limits foreseen in the normative acts for this category. From the information received, group and private conversation with aliens, monitoring group didn't identify any flagrant cases of torture or excessive use of force.

At the moment of the inspection in the Closed Reception Center of Karec, there were complaints from aliens about their treatment as detainees in Albania, by placing them in a closed center and not giving the opportunity to leave the territory of Albania, such practice was already familiar in some of the Region countries.

Another complaint which was raised during meetings of inspection group with aliens was the lack of an interpreter in their language (Arabic) which made communication, information on their rights as well as daily communication difficult for different activities. Daily communication was made in English with foreigners who could speak the language and would then serve as interpreters for others. To address this concern, the director of the institution tried to provide the staff with a list of 60 words and basic sentences in English, written in the way they are pronounced with the respective Albanian translation.

In relation to treatment in the Center, main concerns were about the amount of food, the way of cooking and the variety of food ingredients used (in conflict with their religion). This concern was addressed by hiring a new cook, which was seen the second day of the monitoring visit, however the amount of food remained the same (350 gr of bread per day).

Another concern was related to clothes, covers and hygiene items which, despite all efforts of staff of the institution, were not enough to meet the needs of the aliens housed there. To address these problems the institution had requested donations, and the aliens were offered the opportunity to make a list of items which were given to the psychologist of the institution who would buy them outside the institution with the money of the aliens, and give them the receipt.

Due to the lack of rechargeable telephones, phone calls were made possible through rechargeable credit from the personal mobile of the psychologist. She made her phone number available to aliens, upon approval of the Director of the institution, but they complained about the amount of credit they could use, because price per minute with their origin countries was very high.

Other complaints were about their inability to find out what was happening outside the center, in their origin countries due to lack of televisions and satellite devices.

There were also complaints about lack of cultural, entertaining and sport activities. The only activity was playing with a ball on a field appropriate only for such games. There were no activities for minors, older children and women.

Safeguards

According to the regulation for establishment and functioning of Closed Center, aliens are not allowed to benefit personal medical, legal and social assistance, but in the organization chart of the center with 24 hour staff, there was no doctor, lawyer or psychologist. To some level the Director of the institution carried out the job of the legal officer, charge nurse acted also as doctor, whereas for the function of a psychologist a sociologist was hired who was appreciated and trusted from all the aliens, because she helped meeting basic needs of the aliens and served as a mediator between parties in this institution.

The system for receipts and physical checks was functional, there were specialist deployed for receptions and interviews. In the center were located personal files of detainees, registers of admissions in the center, register of meetings, register of the center, register of shift handover as well as logbooks of personal items and cash. The facility were money and personal items were stored was working according to the regulation. From the verification and inspection of documentation no irregularity was identified. Everything was recorded in the relevant register.

With regards to surveillance, Closed Reception Center for Aliens had surveillance cameras installed in the outdoor and indoor facilities, but not in the living spaces. None of the outdoor cameras was functional. Camera system was monitored by surveillance staff in the command and control room.

Visits of family members, defense attorneys and diplomatic representatives were carried out according to the regulation.

Security measures for isolation were issued by the Director of the Institution not longer than 24 hours and such measures were applied in the isolation rooms. In the day of the inspection there were no aliens subject to such measure. Measures would normally be issued except when they had joint activities.

There was a specific sector for females and minors, separated from male sector. In the event of families the aliens would be accommodated together with their relatives.

In relation to complaints/request system, the latter would be verbally done from aliens to psychologist or shift officer who would then take measures to inform the director of the institution. The director would reply within 24 hours.

There were five facilities in the institution foreseen for meetings with family members, but they were empty and didn't function as such.

Material conditions

The center consisted of a two- storey building, with a part foreseen for administrative offices and the rest made of 24 residential rooms, 4 seclusion rooms, library, laundry, showers, recreation environment, warehouse and outdoor space.

Inspection group visited rooms which were furnished with basic furniture and had bathrooms each. Rooms were foreseen for 2, 4 and 8 persons respectively. Residential rooms had natural and artificial light. No cases of persons sleeping on the floor were observed and neither presence of insects and rats.

Artificial lighting was a problem indoor and outdoor. The generator of the center needed maintenance. Ventilation was possible, but heating remained a problem, because the heating system was not put in use because it would cost 24 liters per hour.

Humidity was visible throughout the regiment, mainly due to terrace isolation problem and lack of heating.

Showering was possible in two common showers equipped with boilers for hot water. Showers were done based on a schedule, but they were not enough to meet the capacity of the Center.

In general, from all interviews it emerged that there were no lacking of covers, but there was a need for sheets, blankets and towels. The institution supplied them with shampoos, soaps and razors, but there were problems with clothing including shoes as well as other items for the common hygiene.

A washing machine was serving as a laundry for all detained aliens, while drying of clothes was done in the recreational area of minors and adults which had lost its primary function.

There was a medical room (charge nurse room), clean but poor in medicaments for chronicle and acute diseases.

Monitoring group observed that there was an outdoor environment for activities, which was used for walking and ball games, but since there was grass and bushes it was not appropriate for football. There was no playground for children.

Closed Reception Center had a library which had only a Bible, Koran and a book on terrorism, etc with a total of 40 books. Neither the regulation for organization of the center nor internal regulations were displayed in the library.

There was a cult facility in the center which functioned as such.

Inspection group noticed that kitchen and canteen of the center were rather clean. The canteen had 16 tables and 44 chairs, but dishwasher and other appliances were missing. Daily menu was displayed. Food items were stored in a locked cabinet, but not in a fridge.

There was no shop in the institution to enable purchases. As it was described above these service was provided by the psychologist who bought them outside the institution.

Activities

Airing activity in this institution was the minimum of what it was foreseen, 2 hours per day from 11.00-13.00, including sportive activities.

Detained aliens had the opportunity to hold their religious rituals in the cult facility where an imam from Vlora would serve occasionally.

The library mainly worked for religious books, because the other books were in Albanian.

According to the organizational chart, the center had specialists only for admission and interviewing, but not considering very important posts by nature such as psychologists, educators and lawyers. Considering the fact that also families come to this center, the inspection group drew the conclusion that the center is understaffed, despite the fact the staff of institution was maximally engaged to meet all needs.

Health Care service

The structure of the institution had a full time charge nurse employed. There was no doctor foreseen in the organizational chart by making diagnosing and adequate treatment of health problems very difficult. Neither was a dentist foreseen in the organizational chart, so such service was not provided by the staff of center.

Cases of infectious diseases were handled by Hygiene Sector of Public Health Directorate of Durres.

The institution had no ambulance. In case of emergencies the vehicles of the institution were used to transport aliens in hospitals.

With regards to medication in this institution, they were not enough for treatment of chronicle and acute diseases.

When checking documentation of ass./doctor of the institution two registers were found, one for the visits and the other for medications, both properly filled out. Also, from all aliens in the institution, only three had medical files, one diagnosed with depressive neurosis and two others with neurotic state who were provided with appropriate medication with anxiolytics and hypno-

sedatives. In the second monitoring visit the group found the efforts had started from charge nurse to equip all aliens with health booklets.

As per above, it was recommended:

1. Taking measures to increase staff of the center with at least one social worker, psychologist, a translator from Arabic language, a lawyer and a doctor. The latter should at least be part time.
2. Taking measures to supply with covers, clothes and personal and common hygiene items all aliens accommodated in the center.
3. Taking measures to supply clothing per each season and age group of persons accommodated in the center.
4. Taking measures to furnish all rooms with closets and nightstands for personal items.
5. Taking measures to install phone booths as it is foreseen in the regulation of the institution.
6. Taking measures to supply recreational indoor and outdoor facilities with all necessary items for sportive activities for foreign citizens' minors and adults living in the center.
7. Taking measures to install televisions in common indoor facilities and connect them with satellite dish to inform foreigners on any events in their countries throughout the world in a language they can understand.
8. Taking measures to paint the building indoor and outdoor for disinfection purposes.
9. Taking measures to isolate the terrace to prevent humidity in the institution.
10. Taking measures to put in use cameras of the outdoor perimeter.
11. Taking measures to increase security of windows and perimeter wall.
12. Taking measures to store food items in fridges.
13. Taking measures to equip the kitchen of the institution with dishwasher and other appliances.
14. Taking immediate measures to include a doctor and a dentist in the organizational chart of the health sector of the institution to provide an efficient and proper health service.
15. Taking immediate measures to supply the institution with emergency medicine and medicine for chronicle diseases.

Annex 1

COOPERATION OF NPM
WITH CIVIL SOCIETY ORGANIZATIONS

National Mechanism for Prevention of Torture, pursuant to its legal obligations, for 2014 closely cooperated with active Civil Society Organizations specialized in the field. These NGOs have regularly supported NPM by providing qualitative expertise with doctors, psychologists, educational experts, etc. according to OPCAT standards, during regular visits in Institutions of executions of criminal decisions and Police Units. At the conclusion of monitoring visits, NGO experts prepared reports and recommendations about findings which they shared with NPM and respective institutions.

Other cooperation

On 24 April 2014, Albanian Helsinki Committee (AHC) in cooperation with NPM delivered training of observers who would be engaged in monitoring in police commissariats, pre-trial institutions and prisons throughout the territory of the Republic of Albania. During the training delivered in the facilities of Hotel "Mondial" Tirana, observers of AHC were given updated knowledge about issues in this area drawn by AHC reports and national and international actors that act in this field; Albanian legislation about the rights of persons deprived of freedom in penitentiary institutions, in light of international and domestic standards of human rights; observation and reporting principles methodology; elements that must be considered before, during and after monitoring, etc. This activity was delivered in the framework of projects "More strengthening of human rights protectors in Albania", funded by Civil Rights Defenders and the project "Together against torture in the police and prisons of Albania" funded by European Commission in Tirana.

On 29 May 2014, a meeting was held in order to coordinate supportive activities that will be delivered by Association 'Përthyerje' and Association of Penal Lawyers of Albania in cooperation with Ombudsman in the framework of the project "Improvement of Human Rights and pre-trial institutions in Albania" funded by Danish Embassy in Albania. In this meeting organized in the conference room of the Ombudsman Institution, attended representatives from the Ombudsman respectively National Mechanism for Prevention of Torture (NPM), representatives of "Perthyerje" Association and Grant Manager of the Danish Embassy.

On 2 June 2014 NPM, in the conference room of the institution of Ombudsman, Perthyerje Association in cooperation with NPM organized a seminar with the staff of the Ombudsman Office about matters of Mental Health in prisons and pre-trial institutions. The seminar aimed at identifying management issues of Penitentiary Institutions in relation to activities for convicts and detainees with mental health problems, exploring these aspects of human rights and the need to take measures which protect mental health during imprisonment and introducing best practices in this area.

From 4 – 6 June and **12-13 June 2014**, Albanian Helsinki Committee (AHC) in cooperation with NPM, and representatives of State Police delivered training for prevention of torture and

maltreatment in police commissariats. There were about 172 participants of mid-level and basic level management nationwide. The goal of the training organized in 'Mondial' hotel in Tirana was awareness raising of police employees to respect human rights of detainees, arrested and accompanied persons, as well as increase their professionalism to fight effectively all forms of torture and maltreatments of these persons. The objectives of the training was to introduce to police employees with theory and case laws related to torture and maltreatment used by police towards escorted, arrested / detained persons as well as bringing into focus concrete cases identified during monitoring missions from institutions / independent monitoring organizations in this area. NPM made a presentation about the role of Ombudsman in the capacity of National Mechanism for Prevention of Torture as well as detention/arrest / escorting facilities according to legislation in force. A special contribution was given by General Directorate of State Police. These activities were delivered in the context of the project "Together against torture in police and prisons in Albania' funded by European Commission in Albania.

On 9 June 2014 in the conference room of the Institution of the Ombudsman, NPM, Përthyerje Association, Association of Penal Lawyers in Albania and the Grant Manager organized a joint meeting to discuss and share plan of inspections and joint monitoring visits in pre-trial institutions, prisons and police commissariats from June to December 2014.

On 24 October 2014, Përthyerje Association in close cooperation with Ombudsman in the capacity of NPM and training sector of Prisons Directorate, in the facilities of the training sector, delivered a training with managers of penitentiary institutions on "Human Rights in Prisons and Pre-trial institutions in Albania". The aim of the trainings was to inform about the role of National Mechanism for Prevention of Torture, identification of matters and challenges of human rights in prisons, national and international standards. NPM made a presentation about the work of the Ombudsman in the role of National Mechanism for Prevention of Torture as well as main findings and recommendations for 2013 and 2014. The activity was organized in the framework of the project "Improving Human Rights in Prisons and Pre-trial Institutions in Albania".

On 20-21 November 2014, Përthyerje Association in close cooperation with Ombudsman institution and training sector in the General Directorate of Prisons organized its first regional two days training in Tirana for 30 representatives from penitentiary institutions "Jordan Misja", "Ali Demi", "Mine Peza" and Vaqarr. This training aimed at enhancing knowledge in the field of human rights in prisons and pre-trial institutions in Albania. The training provided information about the importance of Ombudsman in the capacity of National Mechanism for Prevention of Torture as well as current issues and challenges were identified about human rights in prisons in order to improve knowledge on human rights in prisons according to national and international standards. The activity was organized in Penitentiary Institution of Elbasan, in the framework of the project "Improvement of Human Rights in prisons and pre-trial institutions in Albania" funded by Danish Embassy in Albania.

In 18-19 December 2014, Përthyerje Association in close cooperation with Ombudsman institution and training sector of General Directorate of Prisons organized a second two days regional training in penitentiary institution of Elbasan with 30 representatives from penitentiary institutions Elbasan, Drenovë, and Peqin. This training aimed at enhancing knowledge in the

field of human rights in prisons and pre-trial institutions in Albania. The training provided information about the importance of Ombudsman as a role of National Mechanism for Prevention of Torture as well as current issues and challenges were identified about human rights in prisons in order to improve knowledge on human rights in prisons according to national and international standards. The activity was organized in Penitentiary institution of Elbasan, in the framework of the project "Improvement of Human Rights in prisons and pre-trial institutions in Albania" funded by Danish Embassy in Albania.

On 19 December 2014, Albanian Helsinki Committee (AHC) in cooperation with National Mechanism for Prevention of Torture (NPM) organized an evaluation mission in pre-trial institution of Vlora, specifically in the juvenile sectors. The objective of this evaluation mission was to assess the new approach of working with juveniles in pre-trial, potential changes of the methodology of staff who worked with juveniles and potential changes of juvenile's behavior. Evaluation team met with director and other management staff of the institution of Vlora. This evaluation mission was in the framework of the project "Improvement of prisons conditions to reintegrate juveniles who are convicted and in pre-trial institutions in Albania, Macedonia and Kosovo' implemented from Dutch Helsinki Committee.

In 22-23 December 2014, Përthyerje Association in close cooperation with Ombudsman Institution and training sector of Prisons Directorate organized a third two days regional training in penitentiary institution of Kruja with 30 representatives of staff from penitentiary institutions Fushë Krujë, Shën Koll, Lezhë and Krujë. This training aimed at enhancing knowledge in the field of human rights in prisons and pre-trial institutions in Albania. The training provided information about the importance of Ombudsman in the capacity of National Mechanism for Prevention of Torture as well as current issues and challenges were identified about human rights in prisons in order to improve knowledge on human rights in prisons according to national and international standards. The activity was organized in penitentiary institution of Fushe Kruja, in the framework of the project "Improvement of Human Rights in prisons and pre-trial institutions in Albania" funded by Danish Embassy in Albania.

Annex 2

ACTIVITIES OF NPM

On 7 April 2014, NPM participated in the working group about reform in prisons chaired by Mr. Artur Zoto, Director General of Prisons and Mrs. Silda Anagnosti, OSCE Presence in Albania. Meeting was held in ICITAP offices in Tirana. During the meeting there was an introduction of updated daily activities of General Directorate of Prisons and participants discussed specific matters about the care of persons who suffer from mental health issues in penitentiary system.

From 9-10 April 2014, NPM participated in a meeting organized by APT and Swiss OSCE, as part of a representation with all NPM of the region, to discuss and prepare recommendations and technical suggestions on the needs and areas from which NPM could benefit through a deeper involvement with OSCE/ODIHR. Meeting was held in Hofburg Palace in Vienna, Austria. During the activity it was emphasized the importance of different models of NPM, legal basis, transparency and cooperation with CPT for ongoing exchange of experiences for prevention of torture, inhuman and degrading treatment in institution of deprivation of human rights and freedom. NPM, in this round of discussions and in cooperation with experts from APT, SPT and CPT approved 19 Recommendations which were presented to the Assembly and OSCE Ambassadors of relevant countries. Out of these 19 Recommendations, 5 of the approved Recommendations were an initiative of the NPM from Albania. Recommendations were also presented to high level of Council of Ministers of OSCE who met in Basel, in Switzerland in 2-3 December.

From 10-11 April 2014, NPM attended Supplementary meeting for Human Rights Dimension organized by OSCE/ODIHR with representation of member countries of OSCE/ ODIHR, MPT and respective NGOs. The meeting held in Vienna, Austria focused in the level of ratification and application of OPCAT in the participants countries. Another important part of this meeting was the role of NGOs and cooperation at a national level for prevention of torture.

On 22 April 2014, NPM held a meeting with wide participation of NGOs and interested parties where they presented Annual Report for 2013 about the activities of the Ombudsman Institution in the role of National Mechanism for Prevention of Torture. The meeting was held in the conference room of Ombudsman Offices. In the meeting were discussed findings, prepared recommendations, cases of violence and their management as well as cooperation with NGOs in order to achieve common goals.

On 8 May 2014, NPM participated in the working group meeting about the reform in prisons chaired by Mr. Artur Zoto, Director General of Prisons and Mrs. Silda Anagnosti, OSCE Presence in Albania. During the meeting held in facilities of ICITAP, Tirana, comments and recommendations were made about Mid-term Strategy of (2014-2017), as well as Action Plan was discussed.

On 17 October 2014, NPM in cooperation with General Directorate of Prisons organized a symbolic ceremony in penitentiary institution “Mine Peza” in order to start installation process of mail boxes for complaints of all prisoners in all penitentiary institutions nationwide. In this

activity participated Ombudsman Mr. Igli Totozani, Director of National Mechanism for Prevention of Torture Mrs. Jorida Rustemi, Deputy/General Director of Prisons Mr. Bledar Skënderi, Director of penitentiary institution “Mine Peza”, as well as representatives from General Directorate of Prisons. This cooperation is in the context of respecting constitutional and legal obligations related to activities of both institutions, Ombudsman Institution and General Directorate of Prisons respectively. Installment of one of mail boxes to file complaints was made in airing space of Penitentiary Institution “Mine Peza”, as a facility for prisoners to use it any time during airing or other activities. All these boxes will be placed in the internal regime as another tool which could increase transparency of General Directorate of Prisons for the rights of the prisoners to send requests or file different complaints addressed to Ombudsman of Albania or any other institution or organization that works in the area of human rights.

In 20 and 21 October 2014, in Skopje Macedonia was held the next working meeting of medical groups within the Network of Mechanisms for Prevention of Torture focusing in the enforcement of European Convention for Prevention of Torture in psychiatric institutions. In this working meeting, NPM of Albania reported the latest findings of inspections in psychiatric institutions, as well as structures which provide such services in Albanian penitentiary institutions. In this meeting, Albanian NPM has officially received the one year period Presidency of NMP of South-East Europe.

On 22 October 2014, NPM organized a press conference with the presence of the media about the one year presidency of Network of NPM of Southeast Europe. This network was created in 2013 pursuant to Statement of Cooperation signed by Ombudsmen of Albania, Austria, Bulgaria, Croatia, Macedonia, Montenegro, Slovenia, Serbia, Bosnia and Herzegovina, Hungary, Greece and Rumania in order to increase cooperation, exchange experiences and organize other joint activities to fulfill the mandate of NPM in the region, as it was provided in “Optional Protocol of Convention against Torture and Cruel, Degrading and Inhuman Treatment or Punishment (OPCAT).

From 27 to 28 November 2014, in the Palace of Serbia in Belgrade, the Ombudsman of the Republic of Serbia in the capacity of National Mechanism for Prevention of Torture in cooperation with OSCE Mission in Serbia, held a two days event “First OPCAT forum of Southeast Europe” which was followed by a conference for prevention of torture and other forms of maltreatment and punishment”. In these events attended Chairman of Sub-Committee for Prevention of Torture (SPT), Deputy President of Committee for Prevention of Torture, Chairman of Division of Migration and Human Rights of Council of Europe, leaders and representatives of Mechanisms of Southeast network, NGOs, etc. The aim of these meeting was to establish direct contacts between protection actors and promotion of human rights and NPM in the region, as well as assess needs and necessary tools in the fight for protection of rights of people deprived of freedom, pursuant to “Optional Protocol of Convention against Torture or Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Albanian NPM was represented by two members. During the OPCAT forum, Head of Albanian Mechanisms for Prevention of Torture gave a welcoming speech in the role of Chairman of Network of Mechanisms of Southeast Europe.

On 27 November 2014, in the penitentiary institution of Kavaja, National Mechanism for Prevention of Torture attended an activity "Round Table on transparency and cooperation in civil society" organized by General Directorate of Prisons with the support of UNICEF. The activity had as a goal strengthening of cooperation and transparency with civil society, as well as presentation of joint priorities paper for 2015. In this meeting took part representatives of UNICEF, EU Delegation in Albania, deputy Ambassador of Great Britain, Head of State Agency for Protection of Child's Rights, etc. which also held an welcoming speech. The representative of NPM took the floor about the role of the institution of Ombudsman in increasing transparency and recent findings about the situation in penitentiary institutions.

On 5 December 2014, the Ombudsman attended an international conference on "Mental health in penitentiary institutions in Albania and best practices in Europe, as a reflection of positive obligation of the country in the context of Human Rights. In this conference, the Head of National Mechanism for Prevention of Torture, Mrs. Jorida Rustemi held an welcoming speech, and she gave information about current situation of mental health in prisons and pre-trial detention as well as congratulated the initiative of such project that aims at improving treatment of mental health and respect of human rights for prisoners with mental health problems in the penitentiary system in Albania.

Annex 3

TABLE OF INSPECTIONS CONDUCTED BY THE NPM IN COOPERATION WITH CIVIL SOCIETY ORGANIZATION DURING 2014 BASED ON ANNUAL INSPECTION PLAN

Name of institution	**Date of inspection**	**Organization joining the monitoring**
Penitentiary Institution Rrogozhinë	01.02.2014	__
Penitentiary Institution Peqin	11.02.2014	__
Penitentiary Institution Zahari, Krujë	03.04.2014	European Institute of Tirana
Detention Institute for Juveniles Kavajë	16.04.2014	__
Police Commissariat Krujë	22.04.2014	__
Police Station Fushë-Krujë	22.04.2014	__
Police Commissariat Durrës (RPD)	23.04.2014	__
Police Commissariat Shijak	23.04.2014	__
Police Commissariat Kavajë	23.04.2014	__
Police Commissariat Rrogozhinë	23.04.2014	__
Penitentiary Institution 325	30.04.2014	European Institute of Tirana
Penitentiary Institution Vaqar	07.05.2014	European Institute of Tirana
Penitentiary Institution Kosovë, Lushnjë	14.05.2014	European Institute of Tirana
Police Commissariat Peqin	18.05.2014	__
Police Commissariat Gramsh	18.05.2014	__
Police Commissariat Cërrik	18.05.2014	__
Police Commissariat Librazhd	19.05.2014	__
Police Commissariat Elbasan (RPD)	19.05.2014	__
Police Commissariat Lezhë (RPD)	23.05.2014	Association of Penal Lawyers of Albania
Police Commissariat Kurbin	23.05.2014	Association of Penal Lawyers of Albania
Police Commissariat Mirditë	23.05.2014	Association of Penal Lawyers of Albania
Police Station Mamurras	23.05.2014	Association of Penal Lawyers of Albania
Police Station Shëngjin	23.05.2014	Association of Penal Lawyers of Albania
Penitentiary Institution Peqin	13.06.2014	Përthyerje Association Albanian Helsinki Committee
Penitentiary Institution Shën Koll, Lezhë	16.06.2014	Përthyerje Association Albanian Helsinki Committee
Police Commissariat Peshkopi (RPD)	18.06.2014	__
Police Commissariat Burrel	18.06.2014	__
Police Commissariat Bulqizë	18.06.2014	__

Name of institution	Date of inspection	Organization joining the monitoring
Penitentiary Institution Kukës	19.06.2014	Përthyerje Association
Police Commissariat Kukës (RPD)	19.06.2014	__
Police Commissariat Has	19.06.2014	__
Police Commissariat Tropojë	20.06.2014	__
Penitentiary Institution Tropojë	20.06.2014	Përthyerje Association
Psychiatric Hospital Elbasan	23.06.2014	__
Pre –trial detention institute Elbasan	23.06.2014	Përthyerje Association
Penitentiary Institution Jordan Misja (313)	30.06.2014	European Institute of Tirana Përthyerje Association
Penitentiary Institution Durrës	31.07.2014	Përthyerje Association
Penitentiary Institution Durrës	29.09.2014	Përthyerje Association
National Shelter of Asylum Seekers	03.09.2014	__
Penitentiary Institution Fushë-Krujë	01.10.2014	Përthyerje Association
Penitentiary Institution Burrel	06.10.2014	Përthyerje Association
National Shelter for Victims of Trafficking	08.10.2014	__
Police Commissariat Kuçovë	13.10.2014	__
Police Commissariat Çorovodë	13.10.2014	__
Police Commissariat Berat	14.10.2014	__
Penitentiary Institution Berat	14.10.2014	Përthyerje Association
Penitentiary Institution Mine Peza	17.10.2014	Përthyerje Association
Police Commissariat No. 1, Tiranë	22.10.2014	__
Police Commissariat No. 5, Tiranë	22.10.2014	__
Police Commissariat No. 3, Tiranë	24.10.2014	__
Police Commissariat No. 2, Tiranë	24.10.2014	__
Regional Police Directorate, Tirana	24.10.2014	__
Police Commissariat Ersekë	28.10.2014	__
Police Commissariat Devoll	28.10.2014	__
Penitentiary Institution Drenovë	29.10.2014	Përthyerje Association
Police Commissariat Korçë	30.10.2014	Përthyerje Association
Police Commissariat Tepelenë	10.11.2014	__
Police Commissariat Përmet	10.11.2014	__
Penitentiary Institution Tepelenë	10.11.2014	Përthyerje Association
Police Commissariat Gjirokastër	11.11.2014	__
Police Commissariat Delvinë	11.11.2014	__

Name of institution	Date of inspection	Organization joining the monitoring
Penitentiary Institution Sarandë	12.11.2014	Përthyerje Association
Police Commissariat Sarandë	12.11.2014	__
Police Station Himarë	13.11.2014	__
Penitentiary Institution Vlorë	13.11.2014	Përthyerje Association
Police Commissariat Vlorë	13.11.2014	Përthyerje Association
Psychiatric Hospital Vlorë	14.11.2014	__
Military Unit Bunavi, Vlorë	14.11.2014	__
Military Unit nr. 1200 Zall Herr, Tiranë	02.12.2014	__
Military Police Battalion Sauk, Tiranë	02.12.2014	__
Police Commissariat Rinas	02.12.2014	__
Facilities of the Deported persons Rinas	02.12.2014	__
Police Commissariat no. 4	03.12.2014	Përthyerje Association Association of Albanian Penal Lawyers
Police Commissariat no. 6	03.12.2014	Përthyerje Association Association of Albanian Penal Lawyers
Border and Migration Police Commissariat Rinas	4/ 17.12.2014	__
Special Health Institution of Prisons	09.12.2014	Përthyerje Association
Police Commissariat Pukë	10.12.2014	__
Military Unit nr.1010 Vau i dejës	10.12.2014	__
Police Commissariat Malësi e Madhe	11.12.2014	Albanian Helsinki Committee
Police Commissariat Shkodër (RPD)	11.12.2014	Albanian Helsinki Committee
Psychiatric Hospital Shkodër	11.12.2014	__
Penitentiary Institution Drenove	12.12.2014	__
Police Commissariat Lushnjë	16.12.2014	__
Police Commissariat Fier (RPD)	16.12.2014	__
Police Commissariat Mallakastër	16.12.2014	__
Penitentiary Institution Elbasan	16.12.2014	__
Penitentiary Institution Vlore	19.12.2014	Albanian Helsinki Committee
Penitentiary Institution Rrogozhinë	28.12.2014	__
Penitentiary Institution Rrogozhinë	30.12.2014	Përthyerje Association

Annex 4

TABLE OF RECOMMENDATIONS SENT BY NPM FOR 2014

No.	No. Doculive	Date it was sent	Subject of Recommendations	Institution that was sent the recommendation	Status of Recommendation Accepted/ Refused/ No answer	Implemented or not.
1	201400174	04.02.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Rrogozhinë	Accepted	Partially
2	201400237	14.02.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Peqin	Accepted	Partially
3	201401020	11.04.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Kosovë, Lushnjë	Accepted	Partially
4	201400765	14.05.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Juveniles' Penitentiary Institution in Kavajë	Accepted	Partially
5	201400843	14.05.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Durrës	Accepted	Partially
6	201400840	14.05.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Durrës	Accepted	Partially
7	201400842	14.05.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Durrës	Accepted	Partially
8	201400841	14.05.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Durrës	Accepted	Partially
9	201400926	15.05.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution "Ali Demi" (325)	Accepted	Partially
10	201401019	29.05.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Vaqar	Accepted	Partially
11	201401125	12.06.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate	Accepted	Partially

				Lezhë		
12	201401126	12.06.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Lezhë	Accepted	Partially
13	201401127	12.06.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Lezhë	Accepted	Partially
14	201401128	12.06.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Lezhë	Accepted	Partially
15	201401131	24.06.2014	Analysis of the case in Commissariat no 4, RPD Tiranë, with citizen A.B.	Director General of State Police; Regional Police Directorate Tiranë	Accepted	Completely
16	201401246	09.07.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Zahari Krujë	Accepted	Partially
17	201401263	17.07.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Kukës	Accepted	Partially
18	201401262	17.07.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Kukës	Accepted	Partially
19	201401261	17.07.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Kukës	Accepted	Partially
20	201401240	17.07.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Shën Koll, Lezhë	Accepted	Partially
21	201401260	17.07.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Dibër	Accepted	Partially
22	201401258	17.07.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Dibër	Accepted	Partially
23	201401259	17.07.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Dibër	Accepted	Partially
24	201401340	25.07.2014	Improvement of treatment conditions for persons kept in this institution	Ministry of Health; Minister of Social Wellfare and Youth; Director of Psychiatric Hospital of Elbasan	No reply from Minister of Health; Accepted by Minister of Social Welfare	Partially

					and Youth; and Accepted by Director of Hospital	
25	201401085	12.08.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Elbasan	Accepted	Partially
26	201401086	12.08.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Elbasan	Accepted	Partially
27	201401084	12.08.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Elbasan	Accepted	Partially
28	201401087	12.08.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Elbasan	Accepted	Partially
29	201401083	12.08.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Elbasan	Accepted	Partially
30	201401474	14.08.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Peqin	Accepted	Partially
31	201401359	14.08.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Kukës	Accepted	Partially
32	201401357	14.08.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Elbasan	Accepted	Partially
33	201401358	21.08.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Tropojë	Accepted	Partially
34	201401356	25.08.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution "Jordan Misja" (313)	Accepted	Partially
35	201401463	25.08.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Durrës	Accepted	Partially
36	201401200	28.08.2014	Upon initiative about the inspection of the return procedures of illegal emigrants from Schengen Zone	Director of Border and Migration Directorate	Accepted	Partially
37	201401744	13.11.2014	Improvement of treatment conditions for persons kept in this institution	National Receipt Center for Victims of Trafficking	Accepted	Partially
38	201401925	13.11.2014	Improvement of treatment conditions	Director General of State	Accepted	Partially

			for persons kept in this institution	Police; Regional Police Directorate Berat		
39	201401926	13.11.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Berat	Accepted	Partially
40	201401924	13.11.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Berat	Accepted	Partially
41	201401923	19.11.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Berat	Accepted	Partially
42	201401740	19.11.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Durrës	Accepted	Partially
43	201401745	19.11.2014	Improvement of treatment conditions for persons kept in this institution	National Shelter of Asylum Seekers	Accepted	Partially
44	201401999	04.12.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Korçë	Accepted	Partially
45	201402000	04.12.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Korçë	Accepted	Partially
46	201402001	04.12.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Korçë	Accepted	Partially
47	201402160	04.12.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Gjirokastër	Accepted	Partially
48	201402159	04.12.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Gjirokastër	Accepted	Partially
49	201402161	04.12.2014	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Gjirokastër	Accepted	Partially
50	201401977	17.12.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution "Mine Peza" (302)	Accepted	Partially
51	201401904	06.01.2015	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Fushë-Krujë	Accepted	Partially
52	201402370	06.01.2015	Improvement of treatment conditions	Director General of State	Accepted	Partially

			for persons kept in this institution	Police; Regional Police Directorate Tiranë		
53	201402374	06.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Tiranë	Accepted	Partially
54	201402372	06.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Tiranë	Accepted	Partially
55	201402371	06.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Tiranë	Accepted	Partially
56	201402369	06.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Tiranë	Accepted	Partially
57	201402312	06.01.2015	Improvement of treatment conditions for persons kept in this institution	Minister of Health; Minister of Social Welfare and Youth; Head of KKSHM; Director of Psychiatric Hospital Vlora	Accepted from Minister of Social Welfare and Youth	Partially
58	201402373	06.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Tiranë	Accepted	Partially
59	201402375	06.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Tiranë	Accepted	Partially
60	201400839	06.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Tiranë	Accepted	Partially
61	201400838	06.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Tiranë	Accepted	Partially
62	201402451	06.01.2015	On the situation of overpopulation in Regional Police Commissariats	Minister of Internal Affairs; Director General of State Police	Accepted	Partially
63	201402452	06.01.2015	On the situation of overpopulation in Penitentiary Institutions	Minister of Justice; Director of General Directorate of Prisons	Accepted	Partially
64	201402002	14.01.2015	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Drenovë	Accepted	Partially
65	201402366	14.01.2015	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Vlorë	Accepted	Partially
66	201402546	14.01.2015	Improvement of treatment conditions for persons kept in this institution	Minister of Health; Head of KKSHM; Director of PHD,	Accepted	Partially

				Head of Psychiatric Hospital Shkodër		
67	201401905	19.01.2014	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Burrel	Accepted	Partially
68	201402365	19.01.2015	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Tepelenë	Accepted	Partially
69	201402313	19.01.2015	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Penitentiary Institution Sarandë	Accepted	Partially
70	201402003	20.01.2015	Improvement of treatment conditions for persons kept in this institution	Closed Reception Center of Aliens, Kareç	Accepted	Partially
71	201402224	21.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Vlorë	Accepted	Partially
72	201402223	21.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Vlorë	Accepted	Partially
73	201402225	21.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Vlorë	Accepted	Partially
74	201402222	21.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Vlorë	Accepted	Partially
75	201500083	22.01.2015	Improvement of treatment conditions for persons kept in this institution	Director of General Directorate of Prisons; Director of Special Health Institute of Prisons	Accepted	Partially
76	201402528	26.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Fier	Accepted	Partially
77	201402526	26.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Fier	Accepted	Partially
78	201402527	26.01.2015	Improvement of treatment conditions for persons kept in this institution	Director General of State Police; Regional Police Directorate Fier	Accepted	Partially
79	201500026	17.02.2015	Improvement of treatment conditions for persons kept in this institution	Ministry of Defense; Commander of Military Police Battalion Sauk, Tiranë	Accepted	Partially
80	201500023	17.02.2015	Improvement of treatment conditions for persons kept in this institution	Ministry of Defense; Commander of Land Forces, Vau i Dejës Shkodër	Accepted	Partially
81	201500038	18.02.2015	Improvement of treatment conditions	General Director of Prisons;	Accepted	Partially

			for persons kept in this institution	Director of Penitentiary Institution Rrogozhinë		