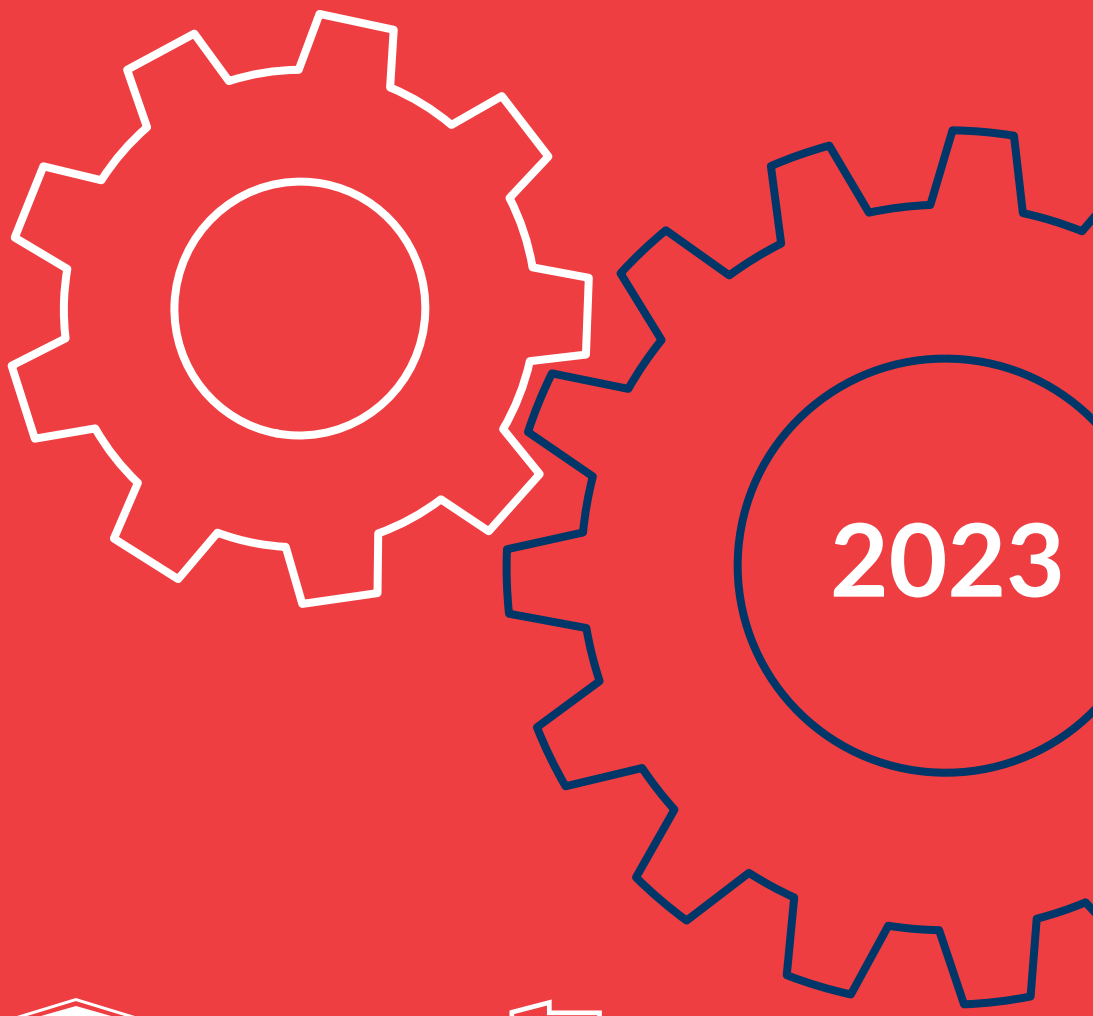
REPORT

of the Commissioner for Human Rights on the Activities of the National Preventive Mechanism



COMMISSIONER FOR HUMAN RIGHTS

NATIONAL PREVENTIVE MECHANISM

Report of the Commissioner for Human Rights on the activities of the National Preventive Mechanism in Poland 2023

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Report of the Commissioner for Human Rights on the Activities of the National Preventive Mechanism in Poland in 2023

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Part I Organization of work of the NPM – Katarzyna Kopystyńska
Part II Methodology and scope of work of the NPM – Katarzyna Kopystyńska, Aleksandra Nowicka, Klaudia Kamińska, Magdalena Laskowska
Part III Difficulties in the implementation of the NPM mandate – Mikołaj Kidoń
Part IV Situation in places of detention
Border Guard units – Magdalena Laskowska
Police detention facilities – Klaudia Kamińska
Penitentiary establishments – Aleksandra Osińska
Detention of juveniles – Justyna Jóźwiak, Ph.D.
Nursing facilities and residential care and treatment facilities – Dorota Krzysztoń
Psychiatric hospitals – Anna Grabowska
Sobering-up centres – Karina Balicka
Follow-up visits – Paulina Wróbel
NPM visits in 2023: tables by type of establishment – Julian Wasiński

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Contents

FOREWORD

To realise the vision of a state in which the risk of torture and other inhuman or degrading treatment is minimised, many elements are required. The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) recalls in its preamble that the effective prevention of torture requires education and a combination of various legislative, administrative, judicial and other measures.

The National Preventive Mechanism has been taking such measures in Poland with consistency and determination for 15 years. The anniversary of the Commissioner's mandate as the NPM, celebrated in 2023, provided an opportunity to summarise the activities of the Mechanism at an international conference organised by the Office of the Commissioner. The achievements of over 1,500 preventive visits were discussed, and the educational, training and advisory activities of the National Mechanism were highlighted.

Many recommendations of the National Mechanism have been implemented. However, some have not yet been realised. Two of them are of particular importance for me as Commissioner for Human Rights because they are fundamental to the prevention of torture: legally guaranteed access to a lawyer from the outset of detention for every person, and the introduction of torture as a separate crime into the Criminal Code. These and other postulated measures will remain on the agenda of the National Mechanism in the coming years. Our work will take into account, among others, the issues of: medical examinations for all persons detained by the police; documenting injuries of persons deprived of their liberty in a manner set out in the Istanbul Protocol; the legality of placement in private long-term care facilities of persons who are not legally incapacitated but whose health condition makes it impossible for them to conclude a care provision contract; the use of non-standard forms of protecting residents against injuries in care facilities; the lack of effective identification of victims of torture before placing migrants in guarded centres for foreigners, or the lack of specialised centres providing adequate care and assistance to juveniles with mental disorders and addictions. The mission of the NPM in these and other areas is and will be pursued.

In presenting the report of the CHR on the activities of the National Preventive Mechanism in the anniversary year 2023 I would also like to express my deep gratitude to all those who have dedicated their professional careers to the prevention of torture over the years and have devoted their time, creativity and energy to understanding and fulfilling this demanding mandate.

Marcin Wiącek
Commissioner for Human Rights

Part I
Organization of work of the NPM

COMPOSITION OF THE DEPARTMENT OF THE NATIONAL PREVENTIVE MECHANISM

The National Preventive Mechanism constitutes one of the departments within the CHR Office. In 2023, direct supervision over the activities of the department was exercised by Deputy Commissioner for Human Rights Wojciech Brzozowski, Ph. D. Hab., professor of the University of Warsaw. The composition of the NPM changed over time and in 2023, the NPM duties were carried out jointly by 19 specialists and an employee working as a secretary. The NPM department was composed of persons with education in the fields of law, sociology, psychology, political science and criminology. The NPM team was supported by employees of the CHR' regional representative office in Katowice who took part in NPM's two preventive visits[1].

Team Members of the National Preventive Mechanism in 2023:

Przemysław Kazimirski – Director of the NPM Department, lawyer
Marcin Kusy – Deputy Director; lawyer;
Łukasz Bębenista – lawyer;
Paweł Borkowski – lawyer;
Magdalena Dziedzic – lawyer;
Justyna Jóźwiak, Ph.D. – sociologist;
Grażyna Kalisiewicz – employee of the NPM office, lawyer;
Klaudia Kamińska – lawyer;
Ewa Kownacka – intercultural psychologist;
Dorota Krzysztoń – political scientist;
Rafał Kulas – lawyer;
Aleksandra Nowicka – criminologist, internal security specialist;
Michał Olczak – lawyer, pedagogist;
Aleksandra Osińska – psychologist;
Oliwia Rybczyńska – lawyer;
Paulina Wróbel – psychologist;
Justyna Zarecka – political scientist, internal security specialist;
Michał Żłobecki – lawyer, specialist in international migrations;
Tomasz Żółtek – psychologist.

[1] Visits to the remand prison in Mysłowice and the Social Care Home of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (ul. Podgórki Tynieckie 96).

EXPERT COMMITTEE

Since 2016, the Commissioner for Human Rights has been supported by the Expert Committee on the National Preventive Mechanism. In 2023, a new composition of the Committee, gathering experts in various areas, was appointed[2]. In 2023, the committee had the following members:

1. Marcin Kusy – CHR Office employee, co-chair of the Committee;
2. Patrycja Grzebyk, Ph.D., professor of the University of Warsaw, co-chair of the Committee;
3. Klaudia Kamińska - CHR Office employee, secretary of the Committee ;
4. Aleksandra Chrzanowska;
5. Łukasz Dembiński, M.D., Ph.D;
6. Maciej Duszczyk, Ph.D., professor of the University of Warsaw;
7. Radosław Grabowski, Ph.D., professor of the University of Rzeszów;
8. Witold Klaus, Ph.D., professor of the Institute of Law Studies, Polish Academy of Science;
9. Agnieszka Lewicka-Zelent, Ph.D. Hab., professor of the UMCS University in Lublin;
10. Janina de Michelis;
11. Lt. Col. Lidia Olejnik;
12. Sebastian Sykuna, Ph.D., professor of the University of Gdańsk;
13. Marcin Szwed, Ph.D.

FINANCING OF THE NPM

Expenditures on the activities of the NPM are covered from the state budget allocation to the CHR Office. According to the Annual Report on the Activity-Based Expenditures of the State Budget and of the European Funds Budget, in 2023 the CHR Office disbursed 4 816 243,88 PLN for the activities of the National Preventive Mechanism.

[2] By internal regulation no. 25/2023 of the Commissioner for Human Rights of 7 June 2023 setting out the composition of the NPM Expert Committee that supports the Commissioner for Human Rights.

Part II
Methodology and scope of work of the NPM

The powers of the NPM are laid down in Article 19 of the OPCAT. The conducting of preventive visits to places of detention is, according to OPCAT, only a part of the complex process aimed at improving the treatment of persons deprived of their liberty. In order to prevent torture and inhuman treatment it is also necessary to take other measures including education, training and activities increasing public awareness, as well as advisory activities such as the issuing of recommendations concerning changes in the legislation and law and of opinions on draft legislative acts.

METHODOLOGY OF THE VISITS

The NPM may visit all places where people are deprived of liberty[3]. Such places include all establishments (public or private ones) where persons are or may be deprived of their liberty either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence[4].

NPM is not an investigative body. It does not consider complaints either[5]. The aim of the NPM visits is to identify factors increasing the risk of torture and ill-treatment of persons deprived of liberty and to propose solutions to eliminate the risk. NPM visits are not announced.

During the visits, the NPM representatives may record sound and image with the consent of individuals who are going to be recorded, as well as hold meetings with persons deprived of their liberty without the presence of other parties and meet individuals who, at their discretion, may provide significant information[6]. The findings made by the NPM during the visits are therefore based on various sources, including the Mechanism's own observations, conducted interviews, analysis of documents and video surveillance footage. When visiting the premises and rooms of places of detention NPM employees use measuring and recording devices such as e.g. multimeters, laser rangefinders and cameras.

In all the visited establishments, the NPM follows the same core methodology. The first stage is to establish the composition of the visiting team[7]. The visiting team consists of several persons, with one person performing the role of the coordinator who is responsible for drawing up a visit report. Two persons, including the team coordinator, inspect the premises and buildings of the establishment, while others have individual conversations with persons deprived of their liberty. External experts (e.g. physicians) may also participate in the visits and draw up expert opinions on the functioning of the visited establishment; such opinions are incorporated in the visit report.

The duration of a specific visit depends on the size of the visited establishment and is between several hours and 5 days. An NPM visit comprises the following stages:

- conversation with the establishment's managers,
- inspection of all rooms used by persons deprived of their liberty,
- individual and group conversations with detainees,
- conversations with the personnel,
- analysis of documents and video surveillance footage,
- formulation of preliminary post-visit recommendations,
- listening to the establishment managers' opinions on the presented recommendations.

If a person deprived of his/her liberty reports an unlawful event during the visit, and expresses the desire to have it investigated, he/she has the opportunity to lodge an official complaint. The complaint is then forwarded to the competent team within the Office of the Commissioner for Human Rights. If the content of the complaint reveals grounds for notifying the prosecutor's office about a suspected crime, the decision in this regard is taken by the Commissioner for Human Rights.

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3 Article 19 OPCAT.

4 Article 4 OPCAT.

5 See: Ninth Annual Report of the SPT of 22 March 2016, CAT/OP/C/57/4, Annex thereto, part II, point 6. See also the publication of the Office of the United Nations High Commissioner for Human Rights entitled „Preventing Torture. The Role of National Preventive Mechanisms. A Practical Guide", Professional Training Series No. 21, United Nations High Commissioner for Human Rights, New York and Geneva 2018, p. 4-6.

6 Article 13(1a) of the Act on the Commissioner for Human Rights of 15 July 1987 (Dz. U. [Journal of Laws] of 2024, item 1264 as amended).

7 According to the OPCAT provisions, experts of national preventive mechanisms should have the required capabilities and professional knowledge.

Yet, if the person does not consent to addressing the issue officially, the visiting team shall only use the information for the purposes of analysing the operation of mechanisms intended to protect persons deprived of their liberty against degrading or inhuman treatment or punishment as well as from torture at a given establishment, and for the purpose of presenting relevant recommendations.

During every visit the establishment directors, staff members and persons deprived of liberty are informed of the prohibition of reprisals, provided for in Article 21(1) of the OPCAT.

According to Article 21 (1) OPCAT, no authority or official shall order, apply, permit or tolerate any sanction against any person or organization for having communicated to the national preventive mechanism any information, whether true or false, and no such person or organization shall be otherwise prejudiced in any way.

When the visit is completed, a report is drawn up which describes all the findings and conclusions, as well as recommendations for the body managing the visited establishment and for its supervisory authorities. When formulating its conclusions and recommendations, the NPM takes into account international human rights standards, in particular those set out by the UN[8], and recommendations of international bodies. If the establishment's managers do not agree with the recommendations, the NPM representatives request the supervisory body to issue their opinion and position on the matter. Such a dialogue is conducted to strengthen the protection of the rights of persons deprived of their liberty at the visited place.

NPM VISITS

In 2023, representatives of the NPM carried out a total of 76 preventive visits, a list of which is included in the closing part of this report. The National Mechanism carried out monitoring visits to:

- 17 penitentiary establishments (12 prisons, 1 remand prison and 4 prison ward branches);
- 12 rooms for detained persons within police organizational units;
- 3 police establishments for children;
- 4 youth care centres;
- 3 district youth care centres;
- 1 juvenile detention centre;
- 8 private long-term care facilities;
- 6 social care homes;
- 2 residential care and treatment facilities;
- 4 guarded centres for foreigners and a remand prison for foreigners;
- 9 Border Guard posts;
- 2 sobering-up centres;
- 4 psychiatric hospitals;
- 1 post-penal detention facility.

EDUCATIONAL ACTIVITIES

■ Social campaign "State without torture"

In 2023, representatives of the NPM continued training activities within the campaign "State without Torture". The aim of the campaign is to increase the awareness of what torture is, who may become its victim and how to prevent it. The campaign also aims at building a culture of non-acceptance of torture. It is addressed to officers and employees of places of detention, as well as school and university students.

In 2023, representatives of the NPM conducted a total of 19 training courses. They trained:

- Police officers from voivodeship police units of Podlaskie, Kujawsko-Pomorskie, Warmińsko-Mazurskie, Lubelskie, Małopolskie and Wielkopolskie voivodeships and Warsaw police unit;
- students of secondary schools, including students of uniformed service classes from schools located in Mazowieckie and Łódzkie voivodeships;
- university students: the training was conducted for students from the Faculty of Political Science

[8] Article 19(b) OPCAT.

and International Relations of the University of Warsaw and from Clinic 42 operating at the Department of Criminology and Criminal Policy;
- employees of social care homes and private long-term care facilities: two training sessions in the form of webinars were held in cooperation with the TZMO foundation *Razem Zmieniamy Świat* (Together We Change the World).

Conferences, study visits and meetings

In 2023, representatives of the National Preventive Mechanism took part in numerous international and national conferences and meetings and hosted participants of study visits from other countries. The main aim of the events was to exchange experience in the prevention of torture and the activities undertaken to this end by the national mechanisms.

One of the main events of 2023 was the celebration of the 15th anniversary of the existence of the National Mechanism in Poland. On this occasion, a conference was organised to summarise the activities of the NPM, both in the context of its over 1,500 preventive visits to places where people are deprived of their liberty, as well as the National Mechanism's achievements and challenges still ahead. The educational, training and advisory activities[9] of the NPM representatives were also highlighted.

Deputy CHR Wojciech Brzozowski and managers of the National Mechanism took part in a conference organised by the Subcommittee on Prevention of Torture to mark its 15th anniversary and the 20th anniversary of OPCAT[10].

NPM Director Przemysław Kazimirski represented the NPM Department as a panellist at the conference entitled *Prevention of torture and ill-treatment: International and European standards and good practice*, organised by the Council of Europe. He gave a presentation on the experience of the National Preventive Mechanism of Poland, gained over the past 15 years[11]. He also took part in the Warsaw Human Dimension Conference, in a panel devoted to the Mendez Principles[12]. The event is an annual meeting of representatives of National Preventive Mechanisms and civil society organisations from the OSCE region, organised e.g. by the Council of Europe and the European Association for the Prevention of Torture (APT). The theme of the last edition was mental health monitoring in places of detention and mental well-being of representatives of the National Mechanisms[13]. Deputy CHR Wojciech Brzozowski and the NPM Director took part in a workshop organised by the Voivodeship Police Headquarters in Katowice, devoted to police techniques and tactics of detention (regarding identification and apprehension of people under the influence of psychoactive substances or with mental disorders, and bringing them to rooms for detained persons[14]).

The National Mechanism directors took part in a webinar organised by the UN Subcommittee on Prevention of Torture (SPT) entitled "Strengthening the role of National Preventive Mechanisms in the prevention of torture". The meeting focused on two subjects of key importance for the prevention of torture: the role of National Mechanisms in protecting persons contacted by them against reprisals related to such contacts, as well as strengthening measures to verify the implementation of the Mechanisms' recommendations[15].

Deputy CHR Wojciech Brzozowski and the National Mechanism directors also took part in a meeting on the occasion of the launch of the Polish version of the OSCE/ODHIR publication "Preventing and addressing sexual and gender-based violence in places of deprivation of liberty: standards, approaches and examples from the OSCE Region". The event was organised by the OSCE Office for Democratic Institutions and Human Rights in Warsaw[16].

Magdalena Dziedzic from the NPM represented the Department during two events. The first one was the conference entitled *Instance nationale pour la prevention de la torture* (INPT), at which discussion was held on monitoring the treatment of people deprived of their liberty, coming from vulnerable groups[17]. The second event was the 14th Congress of Youth Care Centres, held in Goniądz, which was devoted e.g. to the functioning of the centres after the amendment of the *Act on support and social rehabilitation of juveniles*[18].

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9 See: https://bip.brpo.gov.pl/pl/content/konferencja-15-lat-kmpt-relacja.

10 The conference took place on 9 February 2023 in Geneva, see: https://bip.brpo.gov.pl/pl/content/konferencja-20-lat-opcat-2023.

11 The conference took place on 20 April 2023 in Almaty, see: https://bip.brpo.gov.pl/pl/content/kmpt-konferencja-almaty-rada-europy.

12 See: https://bip.brpo.gov.pl/pl/content/kmpt-zasady-mendeza-konferencja.

13 The meeting took place on 9 - 10 November 2023 in Copenhagen, see: https://bip.brpo.gov.pl/pl/content/kmpt-spotkanie-krajowe-mechanizmy-prewencji-obwe-2023.

14 See: https://bip.brpo.gov.pl/pl/content/zrpo-ptrpo-katowice-warsztaty.

15 See: https://bip.brpo.gov.pl/pl/content/webinar-spt-osoby-pozbawione-wolnosci.

16 See: https://bip.brpo.gov.pl/pl/content/odihr-spotkanie-przemoc-seksualna-plec-miejsca-detencji.

17 See: https://bip.brpo.gov.pl/pl/content/kmpt-konferencja-tortury-monitorowanie-grupy-wrazliwe.

18 See: https://bip.brpo.gov.pl/pl/content/brpo-kmpt-xiv-kongres-mow.

During the conference organised by the National Association of Private Long-Term Care Facilities and the Senior-Care foundation, Justyna Zarecka from the NPM presented the methodology of the National Mechanism's visits and the most frequent irregularities found in long-term care establishments[19].

Michał Żłobecki represented the NPM at the annual meeting of the Visegrad Group Ombudsmen[20] and a three-day training course entitled "Identification of victims and documentation of torture in the light of the Istanbul Protocol", focused on the identification of migrants who have experienced violence, have been detained by the Border Guard and seek international protection in Poland. The event was organised by the Helsinki Foundation for Human Rights[21].

■ Study visits by the Macedonian and Slovak Preventive Mechanisms

In 2023, the NPM Director and his deputy hosted delegations of employees of the National Mechanisms from Macedonia[22] and Slovakia[23] conducting study visits to Poland. The aim of the meetings was to exchange experience in the operation of the National Preventive Mechanisms and their working methods.

As part of international cooperation in the specialist area of work of the NPM Magdalena Dziedzic, a representative of the Mechanism met with Brigade Commander of the Tunisian National Guard's central unit that specializes in prosecuting offences such as violence against women and children and in combating crime. During the visit, practical aspects of the implementation of basic anti-torture guarantees and the protection of the rights of persons deprived of their liberty were discussed[24].

PROFESSIONAL DEVELOPMENT

In 2023, NPM employees participated in training on interviewing clients and dealing with difficult situations. They also developed their knowledge of psychosocial and legal aspects of transgenderism during training organised by the Trans-Fuzja Foundation.

Officers from the Voivodeship Police Headquarters in Katowice organised a two-day workshop for CHR Office employees on police techniques and tactics of detention. The workshop consisted of a theoretical part introducing the subject and a practical part consisting in the simulation of the detention procedure[25].

NPM STATEMENTS

Since 2017, the National Mechanism has been using a communication tool in the form of NPM statements[26]. The statements present the NPM's position on events significant from the point of view of torture prevention. In 2023, the NPM issued statements regarding the International Day in Support of Victims of Torture and the judgment in the case of detainees tortured by police officers from Olsztyn.

ADVISORY ACTIVITIES

■ CHR's general intervention letters drawn up at the initiative of the NPM

In 2023 the Commissioner for Human Rights, acting as the National Preventive Mechanism, sent to public authorities six general intervention letters concerning: the conditions in the remand prison for foreigners, the access of NPM representatives to medical records of detainees, the need to publish the CPT report on the visit to Poland in 2022, the need for provisions regulating the placement in residential care and treatment facilities of persons who are not legally incapacitated, the uniforms of officers working in police establishments for children and the legal regime of suspending the operation of private long-term care facilities. The key postulates set out in the intervention letters are discussed below.

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19 See: https://bip.brpo.gov.pl/pl/content/kmpt-konferencja-senior-care.
20 See: https://bip.brpo.gov.pl/pl/content/szczyt-ombudsmanow-panstw-v4-2023.
21 See: https://bip.brpo.gov.pl/pl/content/kmpt-szkolenie-identyfikacja-ofiar-tortur.
22 See: https://bip.brpo.gov.pl/pl/content/kmpt-spotkanie-delegacja-macedonia.
23 See: https://bip.brpo.gov.pl/pl/content/wizyta-studyjna-ombudsman-slowacja-kmpt.
24 See: https://bip.brpo.gov.pl/pl/content/kmpt-spotkanie-gwardia-narodowa-tunezja.
25 See: https://bip.brpo.gov.pl/pl/content/zrpo-ptrpo-katowice-warsztaty.
26 See: https://bip.brpo.gov.pl/tagi/o%C5%9Bwiadczenia-krajowego-mechanizmu-prewencji-tortur.

1. Procedure of placement in the remand prison for foreigners and living conditions therein[27]

In connection with the findings of NPM representatives visiting the only remand prison for foreigners operating in Poland, the CHR informed the Minister of the Interior and Administration of the systemic problems identified there.

Firstly, the representatives of the NPM pointed out that the living conditions in the remand prison did not meet the international standards of the protection of the rights of persons held in administrative detention. There were no toilets adjacent to bedrooms. The bedrooms were under constant surveillance and some furniture items were fixed to the floor. The living conditions in the visited remand prison for foreigners showed many similarities to those in prisons or even in prison wards for dangerous prisoners. There existed no grounds for these people being placed in such conditions as placement in the remand prison for foreigners takes place in connection with administrative proceedings conducted with regard to a given person. The persons placed there have not been convicted of any crime, and their isolation in the establishment is not a form of penalty for an offence committed or suspected.

In the opinion of the CHR, the conditions in which foreigners with unregulated status are detained should reflect the nature of their detention, in particular in terms of restrictions imposed on them and access to various forms of activity. Given that foreigners placed in administrative detention are not prisoners, any elements that increase the similarity of their place of detention to penitentiary establishments should be eliminated. The CHR also raised objections to the procedure of placing foreigners in the remand prison, in particular where the measure is applied immediately after their detention, without first using a less severe measure i.e. the placement in a guarded centre for foreigners. Under the current regulations, a person may be placed in a remand prison for foreigners solely on the grounds of the risk that the person would not comply with the rules in force in guarded centres for foreigners. The term "risk" is vague. The lack of the requirement to assess the risk based on the findings concerning the facts of a given case may lead to overuse of the measure of detention in the remand prison. In the opinion of the Commissioner, the risk of non-compliance with the rules of the guarded centre for foreigners should be real and should be assessed on a case-by-case basis, based on the actual behaviour of the person concerned. In making such an assessment, it should be of particular importance to determine how the migrant behaved during his or her apprehension and immediately afterwards. Therefore, the Commissioner found it necessary to make more detailed the requirements set out in Article 399(1) of the Act on Foreigners with regard to people's placement in a remand prison for foreigners. In view of the above, the CHR requested the Ministry of the Interior and Administration to take legislative steps to improve the living conditions and ease the regime in the remand prison for foreigners and requested a response to his comments from the ministry.

The Minister replied that ensuring adequate living conditions for foreigners placed in administrative detention facilities, including in the remand prison for foreigners, was a matter of constant attention for him. Activities aimed at improving the living standards are carried out systematically, within the limits of the ministry's capabilities and financial resources, including those available under international funds allocated to the improvement of the internal and external infrastructure managed by the Border Guard. In the context of the comments included in the CHR's intervention letter with regard to the living conditions of migrants placed in the remand prison for foreigners the Minister informed that the conditions meet the requirements of the national law, as specified in the Regulation of the Minister of the Interior of 24 April 2015 on guarded centres and remand prisons for foreigners. Nevertheless, given the ongoing systematic modernisation of the infrastructure of detention establishments the improvement of the conditions in the facility in question is included in the list of works planned to be carried out in the period 2021-2027.

As regards the procedure for placing migrants in the remand prison for foreigners, the Minister pointed out that the decision to place a person in the remand prison is taken by the district court competent for the place of the person's current residence, which issues a relevant decision. He emphasised that the risk of non-compliance with the rules of stay in a guarded centre for foreigners, referred to in the legal regulations, is always proportionate to the probability of such non-compliance and is assessed, as a rule, based on the behaviour of the person concerned by the application for placement in the facility. It is also of importance that the preventive measure in the form of placement in the remand prison for foreigners, and the related restrictions on access to various activities available in guarded centres for foreigners, are applied only for a short term.

2. Access of NPM representatives to medical records of detainees[28]

During one of the visits carried out in 2022, representatives of the NPM encountered difficulties in conducting their work, caused by the attitude of Prison Service officers. The visiting team requested access to selected medical records of several inmates held in the prison. The officers informed that access

[27] General intervention letter of the CHR to the Ministry of the Interior and Administration of 16 February 2023 (ref. no. KMP.572.1.2023); see: https://bip.brpo.gov.pl/pl/content/rpo-cudzoziemcy-areszty-mswia-odpowiedz.

[28] General intervention letter of the CHR to the Director General of the Prison Service of 18 February 2023 (ref. no. KMP.571.1.2023); see: https://bip.brpo.gov.pl/pl/content/rpo-osadzeni-dokumentacja-medyczna-kmpt-dostep-sw.

to the records may only be provided upon the inmates' written consent. Therefore, in order to conduct the visit as effectively as possible and to obtain the necessary information while staying in the establishment the NPM representatives provided to the inmates for signature written forms with consent to access to their medical records. However, only the prisoners with whom the NPM representatives had spoken consented to the access. In the described situation, the access of the National Preventive Mechanism employees to information about the persons deprived of their liberty was significantly restricted, which constituted a violation of the NPM mandate.

In the context described above, the CHR emphasised that prisoners' access to medical care as well as documentation on possible injuries that may prove the use of torture and other cruel, inhuman or degrading treatment or punishment are elements that are always assessed during NPM visits. The same standard applies to visits carried out by the UN Subcommittee on Prevention of Torture (SPT) and the European Committee for the Prevention of Torture (CPT), as confirmed by the reports of the two institutions which in recent years have visited penitentiary establishments also in Poland.

Representatives of the NPM act pursuant to the provisions of the *Act on the Commissioner for Human Rights* and the provisions of the OPCAT. The protocol was ratified by the Republic of Poland on 2 September 2005, following prior consent granted by way of an Act of Parliament, and thus forms part of the Polish legal order and is directly applicable, according to Article 91(1) of the Polish Constitution[29]. Article 20(2) of the OPCAT provides that "In order to enable the national preventive mechanisms to fulfil their mandate, the States Parties to the present Protocol undertake to grant them access to all information referring to the treatment of those persons as well as their conditions of detention." Undoubtedly, the standard applies also to data on the provision of medical care and the documentation of any injuries. In order to carry out a comprehensive and reliable assessment of the situation in these areas of importance for torture prevention, access to complete medical records is essential. Furthermore, the processing of personal data by employees of the Office of the Commissioner for Human Rights is done based on a written authorisation by the CHR, granted on condition that the authorised person maintains confidentiality of the processed data (Article 17c(3) of the *Act on the Commissioner for Human Rights*). Such an authorisation, together with the employee's professional identity card, is shown to the managers of the visited establishments during every visit.

There is, therefore, no doubt that according to the provisions of the OPCAT and of the *Act on the Commissioner for Human Rights*, representatives of the NPM have ex officio access to all necessary information and documents regarding people deprived of liberty, including their medical records. In view of the above, the Commissioner requested the Director General of the Prison Service in writing to remind directors of penitentiary establishments as well as medical personnel in prisons and remand prisons of the powers of the NPM and the rules of providing access to medical records of prisoners to the Mechanism's representatives.

In his response to the CHR, the Deputy Director General of the Prison Service stated that the procedure followed by the prison administrators had been correct. In the event proceedings are initiated pursuant to Article 9(1) of the Act of 15 July 1987 on the Commissioner for Human Rights, i.e. at the request of a person deprived of liberty, the person implicitly consents to access to all documentation concerning him or her, including documentation concerning his or her health. In such cases, access to medical records should be granted to employees of the CHR Office immediately. However, in cases where employees of the CHR Office take action in a penitentiary establishment pursuant to Article 9(3) of the Act of 15 July 1987 on the Commissioner for Human Rights, i.e. on the initiative of the Commissioner, the prison administration should, in the opinion of the Deputy Director General of the Prison Service, make access to medical records of persons deprived of liberty conditional on prior consent of those persons. This arises directly from the provisions of the Act of 6 November 2008 on Patient Rights and the Patient Ombudsman.

In view of the position presented in the response, the CHR wrote again to the Director General of the Prison Service regarding access by representatives of the National Preventive Mechanism to medical records of people placed in penitentiary establishments. In his letter, he pointed out that representatives of the NPM work on the basis of the provisions of the *Act on the Commissioner for Human Rights* and of the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The Optional Protocol, as an international agreement ratified following prior consent contained in an Act of Parliament, forms part of the Polish legal order and is directly applicable, taking precedence in the event of a conflict with the Act. Acting directly on the basis of the OPCAT, representatives of the National Mechanism are authorised and required to verify how persons deprived of their liberty are treated and to check the safeguards developed to ensure their appropriate treatment, taking account of the applicable standards of the United Nations. To this end, OPCAT grants to representatives of the Mechanisms access to all necessary information on the number and location of places of detention, the number of detainees as well as their treatment and conditions in which they are detained. The NPM representatives are therefore empowered to obtain information on how prisoners are treated, on their medical care and treatment as well as documentation on their injuries, including such

[29] The Constitution of the Republic of Poland of 2 April 1997 (Journal of Laws No. 78, item 483, as amended).

information on individual detainees. Since the information is contained in patients' medical records, the NPM's preventive mandate covers also the related parts of medical records. It is not possible to assess the manner of treatment of persons deprived of their liberty and the safeguards in place to protect them against torture and other forms of cruel, inhuman and degrading treatment or punishment without assessing the availability and quality of medical care in the establishment and the manner in which injuries found by medical personnel are documented. Medical examinations and correct documentation of prisoners' injuries constitute a fundamental safeguard against torture. However, for this to be possible, NPM representatives must have full access to medical records of prisoners. It should be noted that the Optional Protocol does not differentiate between information carriers. The access to information and documentation therefore means access to both analogue information (in the paper form) and electronic information (e.g. electronic records and images). Furthermore, OPCAT does not impose any additional restrictions on NPM representatives, including making the disclosure of medical data conditional on the patient's consent. The Commissioner noted that even assuming that such consent is required under the relevant Act of Parliament, any conflict between the Act and the international agreement ratified with the consent expressed in the form of an Act of Parliament should be resolved in favour of the international agreement. OPCAT also provides that information obtained by the Mechanism's representatives should remain confidential: "Confidential information collected by the national preventive mechanism shall be privileged. No personal data shall be published without the express consent of the person concerned." OPCAT thus guarantees the possibility to obtain confidential and sensitive data and the possibility to conduct, in confidence, interviews with selected persons, including medical personnel, who can provide information necessary to assess the situation of persons deprived of their liberty. It is natural that such interviews concern organisational issues, needs of the professionals, as well as individual medical cases (i.e. information covered by medical confidentiality). It is not possible to effectively monitor the treatment of prisoners and medical care provided to them without being able to discuss individual cases, emerging problems and their causes with medical personnel responsible for providing the care. The OPCAT provisions therefore leave no doubt that NPM representatives have ex officio access to medical records of detainees, regardless of their individual consent.

Furthermore, regardless of the powers arising from OPCAT, representatives of the NPM are authorised to process all necessary information pursuant to Article 17c of the *Act on the Commissioner for Human Rights*. According to the provision, they may, for the purpose of performing their statutory duties, process all necessary information, including personal data and data referred to in Article 9(1) and Article 10 of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). The purpose of data collection and processing is to fulfil the statutory obligation to prevent torture and other inhuman or degrading treatment or punishment, and thus to protect human and civil rights and freedoms.

The Commissioner therefore requested that the issue be re-examined in light of the above arguments and that measures be taken to make it possible for representatives of the NPM to obtain the legally required access to medical records of detainees. After further analysis of the regulations, the Deputy Director General of the Prison Service shared the Commissioner's position on the matter.

3. Publication of the CPT report on the visit to Poland in 2022[30]

From 21 March to 1 April 2022, a delegation of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) carried out its seventh periodic visit to Poland. The report on the visit was approved by the CPT at its plenary session held on 24-28 October 2022. When over a year had passed since its approval, the report was still not published in Poland, which caused concern of the CHR. This was the longest time of waiting for the publication of a CPT report, as compared to the Committee's other reports on the visits to Poland.

The situation posed a significant problem from the point of view of torture prevention, as CPT reports constitute an important preventive measure. Their publication makes it possible for the public to become aware of the Committee's comments and opinions on the situation in places of detention. This, in turn, promotes public debate on the issue and provides an opportunity develop optimal legislative solutions. The Committee's reports also have an important educational function. They should be included in training programmes for officers and staff members responsible for the supervision and care of persons deprived of liberty, and should serve as a point of reference for the inspection and supervision bodies. The CPT reports play a key role in the activities of the Commissioner for Human Rights, including the NPM. They highlight systemic problems and areas that require urgent improvement, and thus lead to determining priorities, adjusting conducted activities to new challenges and revising the CPT recommendations. They therefore contribute to increasing the quality of work and the consistency of the torture prevention

[30] General intervention letter of the CHR to the Minister of Justice of 18 September 2023 (ref. no. KMP.571.14.2023); see: https://bip.brpo.gov.pl/pl/content/rpo-miejsca-detencji-wizytacja-cpt-raport-ms-odpowiedz.

process. In view of the above, the Commissioner wrote to the Minister of Justice requesting him to order the publication of the CPT report on the visit to Poland in 2022 together with the response of the Polish authorities, the translation of the report into Polish and the publication of the translated version on the website of the Ministry of Justice, in line with the practice followed in the previous years. The Ministry of Justice published on its website the Polish translation of the CPT report on the visit to Poland in 2022, together with the response of the Polish authorities. Poland also agreed to the automatic publication of future reports and responses to them.

4. Admission to residential care and treatment facilities of persons who are not legally incapacitated but whose health condition makes it impossible for them to conclude a contract[31]

For years, the CHR has pointed to a legislative gap consisting in the absence of a regulation setting out the rules of admission to residential care and treatment facilities of adult persons who are not incapacitated but whose somatic health condition makes it impossible for them to conclude a contract and who have no appointed legal representatives to do this for them. There is no clear and unambiguous legal basis for placing a patient in a non-psychiatric residential care institution pursuant to a court decision.

The current legislation does not clearly permit direct application of Article 32 of the Act on the Professions of Physician and Dentist, which makes unclear the situation of adult patients who are not legally incapacitated but are unable to express informed consent to their placement in a residential care and treatment facility. This, in turn, may lead to abuse of their personal freedom as their rights are not sufficiently protected by law. It cannot be excluded that in extreme cases, a decision to place a patient in a residential care and treatment facility can be taken against the patient's interests, e.g. in order to gain access to the patient's apartment or other assets. It is therefore essential for the placement of patients in residential care and treatment facilities without their consent to be subject to effective judicial review.

The lack of adequate statutory regulations specifying the rules of admission to residential care and treatment facilities of adults who are not legally incapacitated but are unable to give informed consent to the admission still remains a problem. The lack of adequate regulations does not mean that no other solutions are used when placing patients in such facilities. The experience gained during the visits of the NPM shows that it is a common practice that applications for placement in such facilities are signed by the patient's family member or close person. Directors of the facilities, motivated by the patient's good, accept the practice, which may expose them to legal consequences.

Unfortunately, the Ministry of Health has not proposed any legislative solution other than incapacitation as an option to be used by directors of residential care and treatment facilities and patients' families to legalise the placement of people who are not legally incapacitated but are unable to give informed consent to their placement. However, the patient's inability to give informed consent to their placement in the facility does not mean that the conditions for the patient's full legal incapacitation are met. In the opinion of the CHR, the application of the legal solution proposed by the Ministry of Health i.e. full legal incapacitation of the patient solely for the purpose of placing him or her in residential care and treatment facility would constitute an excessive interference with the patient's personal freedoms.

The CHR pointed out that courts issue, on regular basis, decision on people's placement in the facilities, despite the lack of a clear legal basis. The currently binding legislation does not clearly provide that Article 32 of the Act on the professions of physician and dentist is applicable to people's placement in residential care and treatment facilities. This causes major discrepancies in the practices and, consequently, an unclear situation of the patients. The application of the existing regulations raises doubts as to how the court's decision should be worded. The question arises whether placement in a residential care and treatment facility is a health care service in itself, or whether the court should issue a consent to specific health care services to be provided in the facility. It should also be noted that consent to the placement of a patient in a residential care and treatment facility does not automatically constitute consent to the provision of health care services in that facility. In the jurisprudence, a uniform position has not been developed on whether proceedings regarding a person's placement in a residential care and treatment facility should be conducted ex officio or upon application.

The Commissioner emphasised that in the case of such far-reaching interference with the patient's personal freedoms there should be no doubt as to the legal basis for the decision. It would therefore be useful to regulate the matter in commonly applicable legislation, for example by introducing solutions analogous to the consent of a guardianship court to health care service provision, granted under Article 32 of the Act on the professions of physician and dentist, or consent to placement in a psychiatric hospital, granted under the Act on mental health protection[32]. The adoption of a separate regulation would make it possible

[31] General intervention letter of the CHR to the Minister of Health of 3 October 2023 (ref. no. KMP.573.18.2018); see: https://bip.brpo.gov.pl/pl/content/rpo-nieubezwlasnowolnieni-placowki-opieki-przyjmowanie-mz.

[32] Act of 19 August 1994 on Mental Health Protection (Journal of Laws of 2024, item 917).

to unify the practice of courts in the discussed area and to remove ambiguities regarding the wording of the judgments, so as to ensure the best possible protection of the rights and interests of the patients.

The solutions should also regulate the issue of authorising family members of such persons, or other entities (e.g. representatives of municipal social welfare centres) to apply to a court for placement of a person in an institution. Effective judicial oversight of the placement of patients in residential care and treatment facilities would strengthen their status and ensure better respect for their rights and freedoms. With this in mind, the Commissioner requested the Minister of Health to take a position on the matter and to consider taking action to regulate the problem by way of an Act of Parliament. The Minister replied that an analysis of the regulations is underway in connection with subjects indirectly related to the issue raised by the Commissioner.

5. Uniforms of officers in police establishments for children[33]

During preventive visits to police establishments for children, conducted in 2018, NPM employees drew attention to the clothing worn by officers on duty there. The decision not to wear uniforms, taken by officers from one of the establishments, was considered by the NPM to be a good practice. Unfortunately, during the follow-up visit in 2023 the Mechanism's employees noticed that the officers had abandoned the positive practice. The report on the visit recommended switching back to civilian clothing. In response, the NPM was informed that the implementation of the recommendation would require a change of the regulations. Officers serving in police establishments for children are required to wear a uniform according to Article 60 of the *Act on the Police*[34] and to Regulation no. 5 of the Police Commander-in-Chief of 11 January 2019 specifying situations in which a police officer may not wear a uniform when performing official duties.

Departure from wearing uniforms by officers who work in police establishments for children could bring positive effects in the form of reduction of emotional tensions in the children placed there and, consequently, of their potential aggression.

The NPM encourages staff of police establishments for children not to wear uniforms so as to avoid any association with penitentiary facilities. Police establishments for children have educational, caretaking, diagnostic and preventive functions. They can be more difficult to carry out when officers on duty wear uniforms. Their wearing may cause unnecessary anxiety in minors placed in the establishment and make it more difficult for them to maintain contact with the officers.

There is no doubt that it is the duty of a police officer to wear the uniform and equipment as specified by law. A person wearing a uniform is associated with professionalism and reliability, which contributes to building the society's trust in the uniformed service. As rightly pointed out in the response to the report, departure from wearing the uniform is possible only in clearly defined cases, including police officers serving in criminal, investigative, internal affairs and cybercrime units, the National Criminal Information Centre and preventive intelligence units.

However, the CHR also noted that a police officer may be exempt from the duty to wear the uniform "if so justified by the needs of the service or health condition" (Article 2 of the above-mentioned Regulation). This means that, apart from the cases specified therein, there may be other situations in which police officers perform their duties without wearing their uniforms. This is decided by the heads of police organisational units and other entities listed in Article 1(1) of the Regulation.

The departure from wearing uniforms by officers in the establishments for children could be introduced by their managers as one of the exceptions provided for in Article 2 of the Regulation. However, it would depend on their individual opinion and understanding of "justified needs of the service". This, in turn, would lead to differences in the situations of minors in various police establishments for children.

The lack of clear and consistent regulations could also have a negative impact on the solution's assessment by police officers. They may be reluctant to apply the solution as an exception because, as a rule, exceptions should be applied only in extraordinary situations rather than as a regular practice, even a positive one.

In the opinion of the CHR it would be optimal to regulate the issue separately from others in the Regulation, by the addition therein, in Article 1, of point 3 providing that police officers in police establishments for children are not required to wear the uniform when performing their official duties. The Commissioner requested the Police Commander-in-Chief to introduce such a provision but his argumentation was not accepted. The Deputy Commander replied that the regulations provide for the application of practices that are adequate to the purpose of placing minors in police establishments for children. Thus, the legislative initiative aimed at amending the regulations governing the wearing of police uniforms by officers serving in police establishments for children is not grounded.

In view of the negative approach of the Police Commander-in-Chief, the Commissioner, acting pursuant to Article 1(2a) of the *Act on the Commissioner for Human Rights*, requested the Ombudsman for Children to consider supporting the position taken by the Commissioner. The Ombudsman for Children

[33] General intervention letter of the CHR to the Police Commander-in-Chief of 28 November 2023 (ref. no. KMP.573.19.2023); see: https://bip.brpo.gov.pl/pl/content/rpo-izby-dziecka-policjanci-ubior-kgp-rpd-odpowiedz.

[34] Act of 6 April 1990 on the Police (Journal of Laws of 2024, item 145, as amended).

expressed her will to cooperate on the matter. She pointed out that the issue was of great importance and activities were need to prevent secondary traumatisation of children. She stated that the matter would be discussed with experts in psychology and violence prevention and with young people in order to develop solutions that are best for children.

6. Suspension of operations by private long-term care facilities[35]

In 2023, during an unannounced preventive visit to one of the private long-term care facilities, NPM employees were informed upon arrival that the owner of the facility had temporarily suspended its operations. The entity was entered in the register of facilities that provide long-term care to persons with disabilities, chronically ill persons and elderly persons (hereinafter referred to as the "register"), which includes also facilities operating pursuant to regulations on sole trader businesses. The information on the suspension of the facility's operations was not entered in the register and thus the facility was visible there as normally running its activities.

When clarifying the reasons for the situation it was established that neither the *Act on Social Welfare* nor the *Regulation of the Minister of Family, Labour and Social Policy of 28 August 2020 on issuing and withdrawing permits to operate a sole business in the form of a private long-term care facility* contain provisions relating to the suspension of the operation of private long-term care facilities and do not require the head of the voivodeship government to record such suspension in the voivodeship register of private long-term care facilities.

In the opinion of the CHR, the lack of provisions on suspending the operations of private long-term care facilities and of the requirement to record this fact in the voivodeship register constitutes a legislative gap that requires amendment of the Act on Social Welfare. First of all, attention should be paid to the well-being of people staying in long-term care facilities. The suspension of the operations by such a facility entails the need for the families to look for care for the residents in other similar establishments. The lack of regulations on the suspension of the facilities may lead to irregularities that can directly affect the health of residents and their sense of security, and expose them to unnecessary stress. In the opinion of the Commissioner, the legislator should develop clear and detailed regulations on the process of transferring residents in a way ensuring respect for their human dignity. Any necessary changes related to the transfer should cause as little discomfort as possible to the residents and their families.

Running a private long-term care facility is also a very specific form of business activity. The legislator should ensure that such facilities offer the highest standards of service and that the regulations on their work are transparent and detailed, given the purpose of their operation and the circumstances that cause the need to use their services.

In view of the above, the registers of private long-term care facilities, kept by heads of voivodeship governments, should be as transparent as possible and should contain all necessary information, which undoubtedly includes that on temporary suspension of their operations. People who need to ensure long-term professional care for themselves or their family members, in particular in an emergency situations, should not find themselves wasting time on trying to contact a facility that does not actually operate. The availability of information on the suspension of operations of such facilities is also important from the point of view of planning and carrying out visits by the National Preventive Mechanism. Due to the fact that the visits are unannounced the Mechanism may not contact the facility in advance to make sure that its work is ongoing. With this in mind, the Commissioner requested the Minister of Family and Social Policy to take a position on the matter.

In response, the Minister of Family and Social Policy informed that under the current regulations, an entity operating a private long-term care facility is not required to notify the head of the relevant voivodeship government of the temporary suspension of its activities. As a result, the information is not recorded in the voivodeship register of private long-term care facilities. The Commissioner was also assured that the issue, as well as the need for detailed regulations on the procedure of transferring residents of private long-term care facilities, would be taken into account during the next amendment of the *Act on Social Welfare*.

■ Issuing opinions on legislative acts

Issuing opinions on legislative acts is a form of preventing torture and other cruel, inhuman or degrading treatment or punishment. The power of National Preventive Mechanisms to present their opinions and comments on legislative solutions to the authorities is provided for in Article 19(c) of the OPCAT.

In 2023, the NPM submitted detailed comments on four draft legislative acts:

[35] General intervention letter of the CHR to the Minister of Family and Social Policy of 20 December 2023 (ref. no. KMP.573.12.2023); see: https://bip.brpo.gov.pl/pl/content/rpo-placowki-opieki-zawieszanie-dzialalnosci-mrips-odpowiedz.

1. Opinion on the draft regulation amending the regulation on the living conditions of detainees in prisons and remand prisons[36]

The rationale of the draft stated that the regulation should be amended due to the need to ensure that female prisoners receive bras as part of their clothing sets.

According to Article 111(1) of the Act of 6 June 1997 – Executive Penal Code[37], penitentiary establishments are required to provide convicts with clothing, underwear and footwear appropriate for the season of the year, unless they use their own clothing items. Pursuant to Article 249(3)(2) of the Executive Penal Code, the Regulation of the Minister of Justice of 19 December 2016 on living conditions of detainees in prisons and remand prisons was issued[38]. In the regulation, a bra was not included in the clothing set that is provided to convicted female prisoners according to Annex 1, Table 3, heading: "underwear". The CHR has requested for years to extend the list of underwear items by a bra[39]. The National Mechanism expressed its positive opinion on the amending regulation.

A bra, as part of women's underwear, was added as part of the clothing set for female prisoners by way of the Regulation of 12 July 2023 amending the regulation on the living conditions of detainees in prisons and remand prisons[40].

2. Opinion on the draft regulation amending the regulation on rooms for detained persons or intoxicated persons brought to sober up, on transitional facilities and police establishments for children as well as rules and regulations on the stay in such facilities and procedures regarding image recording there[41]

The draft regulation provided for a number of changes addressing the need for gradual adaptation of rooms for detained persons and of police establishments for children to the needs of persons with disabilities. The changes were based on the arrangements between the Police and the National Preventive Mechanism. The objectives of the draft and its direction were assessed positively.

In a letter to the Ministry of the Interior and Administration[42] the CHR drew attention to the wording of one of the provisions[43]. It covered a broad group of people with permanent or temporary difficulties in communicating with others. The group included people who are deaf, deaf and blind, hearing-impaired and hard-of-hearing. The situation of deaf people who have hearing aids or implants and communicate using Polish sign language, or Polish sign system, or oral communication supported by phonic gestures, and the situation of deaf people who communicate using spoken language, is very different from that of people who have no such aids and skills. When interacting with people who have communication difficulties, it is important to pay attention to their needs and abilities that vary between them.

The said draft regulation included the term "sign language". *The Act of 19 August 2011 on the sign language and other means of communication*[44] contains legal definitions of Polish sign language, Polish spoken-and-sign language, methods of communication used by deaf and blind people, and means of supporting their communication. As regards communicating with deaf people, a distinction is made between Polish sign language Polish sign system. Polish sign language is the natural language of deaf people, which has its own visual and spatial grammar other than that of the Polish language. The sign system, on the other hand, is an artificial communication system that combines Polish sign language and the Polish language. For a person using Polish sign language, translation into Polish sign system can be a problem. Unfortunately, many public institutions offer the latter due to lack of awareness[45]. For these reasons, the CHR expressed the opinion that references should be made to the definitions contained in Article 3 of the *Act on the sign language*. The opinion emphasised that the term "sign language" used in the draft may raise doubts both on the side of the persons using such communication and the public institutions required to provide the translation.

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36 Entered in the agenda of legislative works under number B656.
37 Journal of Laws of 2024, item 706 (hereinafter: the Executive Penal Code).
38 Journal of Laws of 2024, item 1406.
39 See: https://bip.brpo.gov.pl/pl/content/kobieta-w-wiezieniu-dostanie-komplet-bielizny-skuteczna-interwencja-rpo.
40 Journal of Laws, item 1519.
41 Entered in the agenda of legislative works under number 871.
42 KMP.022.1.2023.
43 Article 1(7)(a) of the draft.
44 Journal of Laws of 2023, item 20.
45 More information on the subject can be found in the report by the Expert Committee on Deaf People, entitled Osoby głuche w Polsce 2020, wyzwania i rekomendacje *[Deaf People in Poland 2020, Challenges and Recommendations]*; see: https://www.rpo.gov.pl/sites/default/files/Osoby_Gluche_w_Polsce_2020_Wyzwania_i_Rekomendacje.pdf.

3. Opinion on the draft regulation amending the regulation on the manner and procedure of cooperation between district youth care centres, juvenile detention centres and juvenile shelters with the police[46]

The opinion submitted to the Ministry of Justice[47] pointed out that the proposed regulation weakens the protection of the rights of minors placed in such establishments. This is because the president of the district court, as an entity independent of the police, the establishment and the Ministry of Justice supervising the establishment is removed from the process of information flow and decision-making related to measures planned and implemented to counteract threats to the security of the establishment.

It was also pointed out that as a safeguard, a provision should be introduced according to which, if police officers are called to enter the establishment, their entry should be reported to the court supervising the establishment, the Commissioner for Human Rights and the Ombudsman for Children. Furthermore, similarly as with regard to cooperation between the police and the establishment (Articles 5 and 13 of the regulation), the implementing act should set out the method of communication between those bodies, in order to ensure the effective flow of information.

4. Opinion on the draft regulation on the procedure of admitting children of mothers deprived of liberty to mother and child homes at specific prisons and on the system of organisation and operation of such facilities[48]

The opinion sent to the Ministry of Justice, drawn up jointly with the Penalties Enforcement Department of the CHR Office[49], pointed out, first of all, that the draft regulation did not set any time limit (even an approximate one) for conducting the first medical examination of the child after its admission to the mother and child home. The first medical examination, as stressed in the opinion, makes it possible to assess the health condition of the child and to give medical recommendations if needed for the time until the next quarterly assessment (referred to in Article 11 of the draft regulation) of the child's situation, including health condition.

Secondly, the draft regulation (Article 8) listed the personnel positions at a mother and child home but without their qualifications or experience required. According to the rationale of the draft regulation, the personnel should have the same qualifications as nursery carers. Detailed specification of the requirements for personnel in contact with children of mothers deprived of their liberty is particularly important in the context of the proposed Article 5. According to it, if the mother is temporarily unable to provide constant and direct care of her child, the child shall be under the care of a staff member designated by the home manager. It was also emphasised that the provision should be extended to add that the personnel member designated to provide care for the child should not perform any other official duties when providing the care.

Thirdly, the draft regulation referred to many organisational issues connected with meeting the child's living, health and education needs but disregarded one aspect of key importance for the child's psychological development, namely contact with the outside world, in particular with the child's father and relatives. The child's right to have contact with both parents arises e.g. from Article 9 of the Convention on the Rights of the Child. Also contact with other relatives undoubtedly contributes to the child's social development and should be ensured to the greatest extent possible.

MONITORING OF COURT JUDGMENTS

In addition to its standard activities connected with visiting places of detention, the NPM also analyses court judgments on cases involving torture, inhuman and degrading treatment or punishment. Every year, the NPM requests information from the Ministry of Justice on final judgments issued in cases involving offences under Articles 246 and 247 of the Criminal Code. The Polish Criminal Code still does identify torture as a separate crime and does not contain a definition of torture, which could assist in imposing adequate penalties for such offences. Offences that meet the definition of the Convention against Torture are most often considered in Poland under Articles 246 and 247 of the Criminal Code.

In 2023, the NPM analysed judgments that became final in 2021 and 2022 in cases involving acts under Article 246 of the Criminal Code[50]. According to the information from the Ministry of Justice, in those years, five judgments on cases under Article 246 of the Criminal Code became final. They included

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46 Entered in the agenda of legislative works under number B754.

47 KMP.022.3.2023.

48 Entered in the agenda of legislative works under number A504.

49 IX.022.2.2023.

50 The analysis did not cover judgments on crimes under Article 247 of the Criminal Code because all of them were committed by the victims' inmates not by Prison Service officers.

three convicting judgments and two judgments that conditionally dismissed the proceedings. In those five cases, 12 police officers in total were presented with charges.

Notably, the analysed proceedings under Article 246 of the Criminal Code were related to the use of violence by police officers in order to extract confessions or statements. The definition contained in the Convention against Torture states that violence against a person deprived of liberty can also be used "*for punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind*". Such acts should be considered, among others, under Article 247 of the Criminal Code, as the term "person deprived of liberty" means not only a person serving a sentence in a penitentiary establishment but also a person detained by the police or placed in another closed facility such as a juvenile detention centre or a psychiatric hospital.

■ What was the nature of violence that had features of torture, inhuman and degrading treatment or punishment?

In most of the analysed cases, physical violence was used. It involved hitting with a hand or an object (a folder with paper documents, or a cable), beating with a rubber baton or kicking all over the body. In most proceedings, the acts of the officers were described as violence, and in one of the judgments the court used the term "abuse".

In one of the proceedings, the court stated that the accused officer: '[...] *physically and emotionally abused the detainee [...] by using words commonly considered offensive and by using physical violence: by hitting him on the head, kicking him on the thigh and beating his feet with a black cable with a metal handle*'.

In all the cases, the victims were individuals suspected of committing so-called common crimes such as theft. An example is the case in which police officers apprehended a man suspected of burglary. He refused several times to admit to the charges against him but the officers demanded him to state that he was the perpetrator of the crime. One of the officers *'struck [...] the man on the ear and the right cheek with his right hand, from behind*, and another officer *"kicked the chair on which the victim was sitting [...]; as a result, the victim fell off the chair and hit his head against a wooden cabinet"*. The police officers then kicked the man all over his body, mainly on his legs and ribs. This lasted for about 3-4 minutes. As a result, the man admitted to the charges against him.

In each of the cases, violence was used in the police officers' rooms. In none of the cases were the detainees examined by a doctor upon detention. Their interrogation was not recorded and the detainees did not have access to a lawyer[51].

All the crimes were considered under Article 246 of the Criminal Code and their common element was the intention to obtain confession, explanations, information or statements. In most cases, the use of violence led to detainees making the statements demanded by the officers.

The analysis of the proceedings revealed that some of the violent acts were not just single incidents during the officers' period of service.

In one of the analysed cases, the detainee was taken to an officers' rooms where two police officers were present. One of them, pointing to the other officer, allegedly said to the detainee that his situation was really bad because the other officer "*likes to beat people*". Then, according to the court findings, the officer *"knocked the detainee off the chair and started beating him on the feet with a baton. [The detainee] asked the officer to stop beating him. When a third police officer entered the room, the officer [...] stopped beating the man. He placed the chair between the detainee's legs and sat on it in such a way that the man could not move his legs. The third police officer started beating the victim on the feet. [The detainee] shouted asking them to stop, and told them to write down whatever they wanted and to leave him alone*". The man then signed the statement.

■ Penalties imposed for the crimes that have features of torture, inhuman or degrading treatment or punishment

The least severe penalty imposed in the analysed cases was one year of imprisonment with a conditional suspension of the sentence for a probationary period of three years. The same court convicted a perpetrator of seven acts constituting a crime referred to in Article 246 of the Criminal Code and imposed on him a joint penalty of five years of imprisonment. In other proceedings analysed, the court imposed a penalty of one year and six months of imprisonment and conditionally suspended the sentence for a probationary

[51] The right to information (including the right to use an interpreter to ensure the proper exercise of the right to information by persons who do not speak Polish), the right to notify a selected person of the detention, the right of access to free legal aid and to a medical examination upon detention, and the right to lodge a complaint are fundamental anti-torture guarantees, the fulfilment of which strengthens the protection of detainees against torture.

period of four years[52]. In the third proceedings, the court imposed on each of the two defendants a joint penalty of one year and two months of imprisonment. In most of the cases, fines were also imposed on the perpetrators. In two of the three convictions, the courts ordered the perpetrators to pay compensation to the victims in the amounts ranging from PLN 1,000 to PLN 10,000.

Most of the described judgments as well as those from previous years[53] show that courts, when issuing judgments on cases involving crimes under Article 246 of the Criminal Code, usually impose penalties within the lower range of severity.

■ Conditional discontinuation of proceedings

In the case of both judgments that conditionally discontinued the proceedings, the statements of grounds for the judgments were not requested and, consequently, were not drawn up. Thus, it is not possible to fully understand the way of reasoning of the courts in the proceedings. Regardless of the findings in those specific cases, however, it is worth analysing the grounds for conditional discontinuation of proceedings in cases concerning the crime referred to in Article 246 of the Criminal Code.

Firstly, it should be recalled that for conditional discontinuation of proceedings, the following conditions have to be jointly met: the perpetrator's act and its social harmfulness have not been significant, the circumstances of the act raise no doubt, the perpetrator has not been convicted of an intentional crime, there is a positive expectation that the perpetrator will not commit a crime again, and the act in question is punishable by imprisonment for up to 5 years.

Due to the general nature of this publication the argumentation presented below is focused on the condition regarding social harmfulness of the committed act. Notably, even if the degree of social harmfulness of the committed act is found to be not significant, it does not mean that it is fully insignificant or negligible[54]. Nevertheless, only if the degree is found to be significant it is impossible to conditionally discontinue the proceedings.

According to Article 115(2) of the Criminal Code, "When assessing the degree of social harmfulness of an act, the court shall take into account the type and nature of the violated or threatened good, the extent of the actual or potential damage, the manner and circumstances of committing the act, the seriousness of the violation of his or her obligations by the perpetrator, the degree of intent, the perpetrator's motivation, the type of violated precautionary principles and the degree of their violation."

The legislator has included the crime provided for in Article 246 of the Criminal Code in the chapter on offences against the system of justice. Thus, the article protects the system of justice. The provision also constitutes the Polish legislator's response implementing the prohibition of inhuman and degrading treatment, as defined in Article 3 of the European Convention on Human Rights[55]. It is also worth noting that crimes which constitute torture or inhuman and degrading treatment or punishment, as confirmed by the judgments closing the analysed proceedings, are most often classified under more than one provision of the Criminal Code. In order to fully reflect the degree of unlawfulness of a given act, where it has features of more than one crime, the so-called cumulative classification is applied (Article 11(2) of the Criminal Code). In the analysed judgments, Article 246 was applied, for example, in conjunction with Article 157 that penalises causing moderate or minor bodily harm to an individual. In those cases, the other violated good was human health.

Furthermore, the crime provided for in Article 246 of the Criminal Code can be committed only intentionally i.e. with direct intent. This means that the perpetrator is aware of his or her actions and wants to commit the crime. One of the key elements in assessing the cases in question should be the fact that the crimes were committed by public officials - police officers who are designated to protect the good safeguarded by the provision. As persons familiar with the law and fully aware of the unlawfulness of their actions, they grossly violated their duties. It should not be forgotten that a public official who commits a crime referred to in Article 246 of the Criminal

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[52] Acting in line with Article 4(1) of the Criminal Code, the courts applied the regulations in force at the time of the offence, as more favourable for the perpetrators. They provided that a penalty of imprisonment for up to two years could be conditionally suspended. When suspending the sentences, the courts set the probation period close to the upper limit provided for by the legislator, as the maximum period was five years.

[53] See: M. Dziedzic, Przestępstwo tortur w Polsce - Omówienie wyroków w sprawach o przestępstwa z art. 246 oraz 247 k.k., które uprawomocniły się w 2020 r. [*The crime of torture in Poland – discussion of court judgments on cases concerning crimes under Articles 246 and 247 of the Criminal Code, which became final in 2020*], pp. 9–34; the report is available on the CHR Office website https://bip.brpo.gov.pl/sites/default/files/2022-12/Przestepstwo_Tortur_w_Polsce.pdf; see also: M. Dziedzic, Przestępstwo tortur w Polsce - analiza prawomocnych wyroków dotyczących przestępstw z art. 231, 246 oraz 247 Kodeksu karnego [*The crime of torture in Poland – analysis of final court judgments on cases concerning crimes under Articles 231, 246 and 247 of the Criminal Code*], pp. 13-26; The report is available on the CHR Office website https://bip.brpo.gov.pl/sites/default/files/Tortury_w_Polsce_Raport_KMPT_lipiec_2021.pdf.

[54] See: Supreme Court judgment of 26 May 1970, ref. no. Rw 450/70, OSNKW 1970, no. 9, item 102.

[55] Convention for the Protection of Human Rights and Fundamental Freedoms, drawn up in Rome on 4 November 1950, subsequently amended by Protocols nos. 3, 5 and 8 and supplemented by Protocol no. 2 (Journal of Laws of 1993, No. 61, item 284, as amended).

Code abuses the powers entrusted to him or her by the state and the advantage over the detained person. Furthermore, such actions adversely influence the image of the entire service and therefore the consequences of committing such a crime may go far beyond the relationship between the perpetrator and the victim.

In discussions on the harmfulness of using torture to extract information it is often argued that this method is not only morally reprehensible but also ineffective. A person subjected to such physical or psychological violence is often willing to make any statement or confirm any information in order to avoid further suffering. It is thus impossible to consider that, in such cases, the motivation of the perpetrator can be a mitigating circumstance.

The above argumentation should lead to the conclusion that the commission of a violent crime by a public official during and in connection with the exercise of his or her official duties is characterised by significant social harmfulness. This view has been expressed by the courts in the proceedings in which the convicting judgments have been issued.

The use of violence by police officers should always meet strong opposition by the state and should be severely punished. This should be the case in particular in cases where the intensity of violence is so high that it can be described as inhuman or degrading treatment or torture.

The need to introduce a separate crime of torture into the Polish Criminal Code

As pointed out above, the Polish Criminal Code does not contain a definition of torture and does not refer to torture as a separate crime. For years, the NPM has been calling for the adjustment of the provisions of Polish law to the requirements of the Convention against Torture[56]. In its opinion on the need to include a definition of torture and the absolute prohibition of its use in Polish legislation, drawn up at the request of the Commissioner for Human Rights, ODIHR stated that Polish legislation does not meet the requirements of the Convention against Torture[57].

The Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), in its report on the visit to Poland in 2018, also recommended that legislative work be undertaken so as to introduce a separate crime of torture in the Polish legislation. The SPT emphasised the necessity for the provisions of Articles 1, 2 and 4 of the Convention against Torture to be reflected in the new legislation which will enable a criminal-law based response proportionate to the gravity of the crime[58].

It is worth noting that Article 247(3) of the Criminal Code provides for the crime of abuse of a person deprived of liberty by a public official. Yet, such abuse is not sanctioned with more severe penalties than those imposed in cases of abuse committed by other people. Consequently, a prohibited act committed by a prisoner using violence against his prison inmate is punishable by the same penalty as such an act committed by a public official.

The ODIHR referred to the recommendations of the Committee Against Torture and pointed out that the penalty of imprisonment, provided for in the regulations criminalising torture, should reflect the seriousness of the crime and should be no less than six years. Furthermore, in the opinion of the ODIHR it is necessary to make torture exempt from the provisions on the statute of limitations.

[56] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the United Nations General Assembly on 10 December 1984 (Journal of Laws of 1989, No. 63, item 378)

[57] See: Opinion regarding the definition of torture and its absolute prohibition in Polish legislation: opinion no. CRIM-POL/325/2018[TO], ODIHR, Warsaw, 22 May 2018, paras. 20-37.

[58] See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, p. 7.

Part III
Difficulties in the implementation of the NPM mandate

In 2023, representatives of the NPM experienced cases of violation of the OPCAT and of obstruction of the NPM mandate. The situations occurred at the visited places during the visits and in the periods following them. The difficulties were encountered in the facilities described below.

PRIVATE LONG-TERM CARE FACILITIES

During a visit to "Pogodna Jesień" private long-term care facility in Odrowąż, the NPM delegation was denied access to the rooms because the owner was not present. The NPM representatives were unable to carry out any activities on that date and had to visit the facility on the following day. As a result, the visit was not unannounced. On the following day, the NPM representatives were not, at first, allowed to enter the premises and had to wait for about 30 minutes for the arrival of the owner. The situation should be considered a violation of the Act of 15 July 1987 on the Commissioner for Human Rights[59] and Article 20 of the OPCAT[60].

Upon arrival at "Willa Chopina" private long-term care facility in Toruń, representatives of the NPM had to wait for about 40 minutes for the arrival of the owner. They could not start their activities at once because the owner had not consented to starting the visit in his absence. During the visit, the NPM representatives were not provided with a list of residents with their personal data (only a list containing the first name and the initial of the surname was made available). The civil-law contracts concluded between the facility and the residents (or their guardians or representatives), based on which the NPM delegation assesses the legality of their stay, were not made available to the NPM representatives despite their request and the legal grounds indicated. The owner of the facility stated that his refusal was caused by the lack of consent of the residents' families to access by third parties to the data contained in the agreements.

During the visit to a private long-term care facility called "Słoneczny Las [Sunny Forest] Family Home for Seniors" in Wierzbica, the co-owner informed the NPM delegation that, according to the permit held by the facility, it had places for 27 residents but only 16 were living there. She added that the residents lived only on the ground floor because the upper floors were out of use due to renovation works. During the visit, the visiting team found that on the other two floors, several residents were also present. The visiting team had the impression that both the staff and some of the residents were under pressure exerted by the facility's management and, as a result, they refused to provide information or denied facts previously established by the NPM representatives.

Despite its requests, the NPM were not provided access to a full list of residents and their documentation. The situation constituted a violation of the powers granted to the NPM under Article 20 of the OPCAT[61].

SOBERING-UP CENTRE

During the visit to the Diagnostics and Observation Unit of the Łódź Municipal Centre for Therapy and Prevention, representatives of the NPM requested access to documentation on the use of coercive measures in the facility, files on persons held there and surveillance system recordings. The facility manager informed that, in connection with the documentation archiving procedure, individual patients' files had been transferred to the headquarters of the Municipal Centre for Therapy and Prevention in Łódź. Thus, the NPM representatives requested the manager of the unit to inform the Centre of their intention to analyse selected documentation in the headquarters. Upon the arrival of the representatives there, the Centre managers questioned the NPM powers and refused access to the documentation.

[59] Journal of Laws of 2024, item 1264, as amended.
[60] See: NPM report on the visit to "Pogodna Jesień" private long-term care facility in Odrowąż, p. 5.
[61] See: NPM report on the visit to the private long-term care facility called "Słoneczny Las" Family Home for Seniors in Wierzbica, pp. 7–9.

The activities planned by the NPM representatives were finally not carried out on site. Thus, they sent a written request for access to the documents and the CCTV system recordings and for them to be sent to the Office of the Commissioner for Human Rights.

The attitude of the Centre managers and the forced suspension of work of the NPM representatives constituted a violation of the OPCAT provisions. On 8 May 2023, Deputy Commissioner for Human Rights Wojciech Brzozowski informed the Mayor of Łódź about the obstacles encountered in the implementation of the NPM mandate and requested that measures be taken to prevent such situations in the future. In response, the Deputy Mayor of Łódź expressed his regret, assured of his intention to cooperate and informed that the City of Łódź had taken supervisory measures with regard to the Centre[62].

YOUTH CARE CENTRE

During a visit to the Youth Care Centre in Skarżysko-Kamienna, representatives of the NPM encountered difficulties in performing certain tasks.

The head of the poviat (i.e. county) government, having learnt about the NPM's visit, questioned the Mechanism's powers to access personal data of minors placed in the centre and discontinued the activities of the NPM delegation. The head of the poviat government questioned the NPM's mandate and prohibited the staff of the centre to provide access to the requested documents (files of individual persons and their medical records). He even questioned the identity of the NPM representatives although they had shown to the director of the Youth Care Centre their official ID cards and letters of authorization to carry out the visit, issued by the Commissioner for Human Rights. The head of the poviat government agreed to restarting the NPM activities only after he had verified all the information provided.

The described situation raises concern, particularly in view of the fact that the NPM's powers were questioned by a representative of a public authority (local government authority). This undermined trust in the NPM and hindered the performance of its mandate. Any delay, even by several hours, in starting the NPM's activities can make it possible to conceal or remove signs of people's ill-treatment[63]. Deputy CHR Wojciech Brzozowski wrote a letter regarding the situation to the head of the poviat government.

ROOMS FOR DETAINED PERSONS OR INTOXICATED PERSONS BROUGHT TO SOBER UP

After the visits to the rooms for detained persons or intoxicated persons brought to sober up, located within Poviat Police Stations in Aleksandrów Kujawski, Strzyżów and Opoczno, the heads of the stations refused to send to the NPM copies of selected recordings made by the CCTV system. They stated that, according to the position taken by the National Police Headquarters[64], audio and video recordings may only be made available to the Commissioner on site, within the organisational unit of the police. It was pointed out that "the right to process information, including personal data, to the extent necessary for the performance of the Commissioner's duties set out in Article 17c(1) and (2) of the *Act on the Commissioner for Human Rights* is not the same as the right to request the provision or disclosure of, or the right to obtain, documents or materials, including audio-video, video or audio materials. This is because the right to request the provision or disclosure of, or the right to obtain, documents or materials, including audio-visual, video or audio materials from public authorities, including within the framework of the national preventive mechanism, is not provided for in Article 20 of the OPCAT or in Article 13 of the Act of 15 July 1987 on the Commissioner for Human Rights".

The NPM disagreed with the above statement and argued that Article 20(b) of the OPCAT provides a basis for the NPM delegations also to review archived materials relating to the treatment of detainees. The practice was applied until 22 February 2023 when it was questioned in a letter of the Deputy Commander-in-Chief of the Police. This resulted in significant difficulties in the performance of the NPM's mandate and affected the possibility of reliable and comprehensive verification of the living conditions and treatment of detainees in 2023.

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[62] See: NPM report on the visit to the Diagnostics and Observation Unit of the Municipal Centre for Therapy and Health Prevention in Łódź, pp. 4–6.

[63] See: NPM report on the visit to the Youth Care Centre in Skarżysko-Kamienna, pp. 4–6.

[64] Set out in the letter of the Deputy-Commander-in-Chief of the Police of 22 February 2023 (ref. no. Kpp-1993/623/2023), see: https://bip.brpo.gov.pl/sites/default/files/2024-03/Pismo_ZKGP_22_02_2023_0.pdf.

Part IV
Situation in places of detention

BORDER GUARD UNITS

In view of the migration crisis lasting since 2021, the NPM continued in 2023 its visits focused mainly on Border Guard posts and Border Guard-operated detention facilities. In 2023, the National Mechanism conducted in total: 4 visits to guarded centres for foreigners (GCF)[65] and the detention facility for foreigners (DF)[66], 8 visits to Border Guard posts near the Polish-Belarusian border as well as 2 pilot visits to Border Guard posts. The aim was to obtain information on the method of enforcing decisions on deportation of migrants to their country of origin pursuant to Article 329 of the Act on Foreigners and at verifying the presence of minimum safeguards against ill-treatment of expelled migrants[67].

Guarded centres for foreigners

In 2023, the NPM conducted 4 visits to guarded centres for foreigners (GCF) and the detention facility for foreigners (DC) and identified the problems described below.

■ Systemic problems

1. Lack of an effective tool for identifying victims of torture and other forms of violence

The NPM has been drawing attention for many years to the problem of the lack of an effective tool for identifying victims of violence, that would meet the requirements set out in the *Act on Foreigners*[68].

According to Article 400 of the *Act on Foreigners*, no decision on a foreigner's arrest or placement in a guarded centre shall be taken if the placement can pose a risk to the life or health of the foreigner or if his/her psychological or physical condition suggests the use of violence against him/her.

Due to the fact that, in practice, there is no mechanism under which people with experience of violence are identified after their detention but before their placement in a guarded centre for foreigners, all activities aimed at identifying victims of torture take place after foreigners' placement in the centre.

The guarded centres for foreigners still apply the *Border Guard Rules for dealing with foreigners in need of special treatment*. Despite its revision, in the opinion of the NPM they are still contradictory to Polish law, the standards set out in the Istanbul Protocol, and other international standards[69]. The rules permit placement of potential victims of violence in detention centres and do not require their "immediate release" from a guarded centre. The treatment and therapy available at the centres for identified victims of torture can even exacerbate their trauma.

The visits carried out by the NPM in 2023 confirmed that among migrants placed in GCFs there were people who could reasonably be considered victims of violence, including torture.

During the visit to the GCF in Kętrzyn the visiting team heard from one of the migrants that he had been subjected to torture in his country of origin and he still experienced psychological consequences of this traumatic experience (including nightmares and flashbacks) while living in the guarded centre. The man showed numerous long-shape scars on his body, which, according to him, had been caused by burning with a hot rod, and point scars from cigarette burns on his back, shoulders, chest, abdomen and thighs.

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[65] NPM visits to the Guarded Centres for Foreigners in: Lesznowola (KMP.572.3.2023), Kętrzyn (KMP.572.4.2023), Biała Podlaska (KMP.572.7.2023) and a visit to the Guarded Centre for Foreigners and the Detention Facility for Foreigners in Przemyśl (KMP.572.6.2023).

[66] NPM visit to the Guarded Centre for Foreigners and the Detention Facility for Foreigners in Przemyśl (KMP.572.6.2023).

[67] NPM visit to the Border Guard post in Warsaw and the Warsaw-Okęcie Airport Border Guard post (KMP.572.2.2023).

[68] See: Reports on the activities of the NPM in 2018 and 2021. See: NPM report entitled *Obcokrajowcy w detencji administracyjnej - wyniki monitoringu KMPT w strzeżonych ośrodkach dla cudzoziemców w Polsce*, [Foreigners in administrative detention – report on NPM monitoring visits to guarded centres for foreigners in Poland], 2021.

[69] See: Situation of foreigners in guarded centres at the time of crisis on the border between Poland and Belarus. Report on the visits of the NPM, 2022, pp. 27-31.

Foreigners referred to in the above-mentioned Border Guard rules were also placed in the GCFs in Biała Podlaska and Przemyśl.

2. Determination of chronological age

During two visits conducted by the NPM in 2023, two migrants were identified with regard to whom there were doubts as to whether they had achieved the age of majority[70].

Under Polish law, in cases of doubt regarding the age of a foreigner admitted to a guarded centre for foreigners or a detention facility for foreigners the age is determined by way of a medical examination[71]. However, according to the European standards, in order to increase the reliability of the assessment of chronological age, several different methods should be used as a basis for its determination[72].

The decision to apply specific methods of chronological age assessment should be taken with the awareness of the need to examine all relevant factors, including physical, psychological, developmental, social and cultural ones, so as to achieve the highest possible accuracy of the result. The experience of the NPM shows that in practice, chronological age is most often determined on the basis of an X-ray examination of the wrist. Although this is one of the most reliable and common methods, the literature points out that skeletal development may vary depending on race[73].

The NPM recommends that the procedure applied to determine the age of migrants be comprehensive and take into account psychological, developmental and social factors.

3. Bars in room windows

The Regulation on guarded centres and detention facilities for foreigners provides, in Article 6 point 2, that windows in bedrooms in a guarded centre for foreigners have to be secured either by bars made of round metal rods or flat metal rods, or by another structure ensuring safety and preventing escape from the establishment[74].

During the visit to the GCF in Przemyśl conducted in 2022, representatives of the NPM were informed that funds had been secured for dismantling the bars in bedroom windows there. In 2023, the NPM conducted another visit to the centre and found that the bars had not been removed.

The bars still present on the bedroom windows may create an impression that the centre is a penitentiary establishment, which may negatively influence the emotional condition of the migrants placed there and contribute to the emergence of conflicts. Therefore, the post-visit report reiterated the recommendation to remove the window bars at the guarded centre for foreigners.

4. Living conditions in the remand prison for foreigners

The NPM has already drawn attention to the problem of living conditions in detention facilities for foreigners in its previous annual report[75]. In 2023, the conditions did not improve, as the Commissioner for Human Rights also pointed out in his general intervention letter[76].

The living conditions there do not meet the international standards of the protection of the rights of persons held in administrative detention, despite the fact that they comply with the applicable national law[77]. One of the main problems is the lack of toilets adjacent to bedrooms. As a result, detainees (held

[70] NPM visits to Guarded Centres for Foreigners in Kętrzyn and Biała Podlaska.

[71] See: Article 397(4) of the Act on Foreigners.

[72] It is also important for the examination to be conducted by qualified specialists. Depending on the selected method, these may be social workers, paediatricians, general practitioners, radiologists, psychologists (child psychologists) or other qualified specialists with experience in child development assessment. See: European Asylum Support Office (EASO), Age assessment practice in Europe, 2014, p. 26.

[73] A study evaluating the value of the Greulich-Pyle method as a way of determining the bone age of healthy American children of European and African descent born after 1980 was conducted at the Department of Radiology at Children's Hospital in Los Angeles. X-ray images of hands and wrists of 534 children (265 boys and 269 girls) aged from several months to 19 years were analysed by two experienced paediatric radiologists who did not know the chronological age of the patients. It was proven that the skeletal maturation of American children of European descent is significantly delayed compared to that of children of African descent. The researchers confirmed that it is necessary to develop new standards for bone age assessment to enable the most accurate clinical decisions to be taken. See T. Matthews-Brzozowska, R. Flieger, Methods of bone age assessment and their significance in medicine and dentistry - a review of the literature, Nowiny Lekarskie 2009/2, pp. 165-167.

[74] Regulation of the Minister of the Interior and Administration of 24 April 2015 on guarded centres and remand prisons for foreigners (Journal of Laws of 2018, item 1576).

[75] Report of the Commissioner for Human Rights on the activities of the NPM in 2022, pp. 38-39.

[76] See: General intervention letter of the CHR of 16 February 2023 (ref. no. KMP.572.1.2023).

[77] See: Regulation of the Minister of the Interior of 24 April 2015 on guarded centres and remand prisons for foreigners (Journal of Laws of 2023, item 719).

there usually for several months) have to call the duty officer every time they need to use the toilet. With the large number of people in the facility, the time of waiting to be taken to the toilet is long. Moreover, the bedrooms are under constant surveillance and some furniture items are fixed to the floor. Even in penitentia ry establishments such solutions are used only in the case of particularly dangerous prisoners.

The CPT is of the opinion that, in the light of international standards, the conditions in which foreigners with unregulated status are detained should reflect the nature of their detention, in particular in terms of restrictions imposed on them and access to various forms of activity[78]. Importantly, foreigners in administrative detention should have 24-hour access to toilets[79] and to bathrooms with hot water[80].

■ Areas that require improvement

During the visits carried out in 2023, representatives of the NPM identified the following irregularities and areas that require improvement.

1. Right to information in a language one understands

During the visits to the GCFs in Biała Podlaska and Kętrzyn, situations were identified in which the files of individual foreigners contained written instruction forms in languages which, according to the other documents, were not known by the foreigners, or cases in which a foreigner had signed a statement drawn up in a language he or she did not understand.

The CPT emphasises that migrants with unregulated status who are deprived of their liberty should be clearly informed of the proceedings conducted with regard to them and of their rights. The information should be provided without delay and in a comprehensible manner, in particular in the language understood by the foreigner. The fact that the foreigner has understood the information should be confirmed by his or her signature[81].

There were situations in which migrants acted as interpreters for other persons at the centre when it was not possible to ensure the presence of an external interpreter.

The NPM notes that, given the lack of a formal framework defining the scope of service and the obligations (including confidentiality and due diligence) of persons providing interpretation, the above-mentioned situations should be limited to the necessary minimum and should take place only in urgent situations, at the request of a person who seeks the assistance.

2. Access to a psychologist

In two of the visited centres the NPM found that the number of psychologists was insufficient. The GCF in Biała Podlaska had only two psychologists working there. At the GCF in Kętrzyn two psychologists were on long-term sick leave and assistance was provided only by one psychologist who, apart from supporting foreigners at the centre, also performed other duties as member of the healthcare personnel of the Border Guard regional unit. Due to her workload she did not work at the centre within regular hours but on an ad hoc basis when called by social workers.

The NPM emphasises that access to psychological care adequate to the needs is particularly important for foreigners placed in detention, as the experience of migration, in particular forced migration is a factor that causes serious psychological strain, and deprivation of liberty as such is also a stressful circumstance.

3. Treatment

No instances of improper treatment of foreigners by personnel of the guarded centres were reported to the NPM representatives during the visits conducted in 2023. In September 2023, a protest by foreign-

[78] See: CPT Nineteenth General Report, CPT/Inf (2009) 27, para. 79.
[79] See: CPT report on the visit to Greece in 2011, CPT/Inf (2012) 1, para. 38.
[80] See: CPT report on the visit to Greece in 2013, CPT/Inf (2014) 26, para. 51.
[81] See: CPT reports on the visit to the Netherlands in 2007, [CPT/Inf (2008) 2], para. 36 and to Romania in 2006, [CPT/Inf (2008) 41], para. 61.

ers took place at the GCF in Przemyśl. However, the NPM representatives established that it was not related to the treatment of migrants placed there but to the lengthiness of administrative proceedings, which results in their continued deprivation of liberty[82].

The visiting team, however, had doubts as to the adequacy of care provided to migrants placed in the newly established unit for persons with physical disabilities at the GCF in Kętrzyn. Most of the residents there were men who had suffered serious injuries or bone fractures while trying to cross the barrier at the Polish-Belarusian border.

The NPM found that in some cases the injuries were so serious that patients required assistance with basic activities such as eating, personal hygiene or mobility. According to the representatives of the National Mechanism, the foreigners were not provided with such additional care. This, given their state of health, should be considered a risk of ill-treatment.

4. Medical examination upon admission and medical care

Some of the guarded centres did not use body maps which are recommended by the Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (Istanbul Protocol)[83]. In the GCF in Przemyśl, the NPM representatives noticed that comments regarding possible injuries of migrants, entered in their individual files, were too general or were not entered at all although they were confirmed by other documents.

The NPM emphasises that reliable and prompt assessment of the health of a foreigner newly admitted to a detention facility is in the best interests of both the foreigner and the centre's personnel. According to the case law of the European Court of Human Rights, in the event of allegations of ill-treatment the burden of proof lies with the state under whose authority the person deprived of liberty is detained[84].

5. Application and documentation of coercive measures

The surveillance system recordings analysed at the GCF in Przemyśl show a situation in which a man is brought to the isolation room and laid on the floor. After his handcuffs are taken off, his hands fell limply to the floor. The recording shows that the man's eyes are closed, which justifies the suspicion that he is unconscious at that time. The report on the use of coercion with regard to the man does not refer to any medical assistance provided to him in connection with the situation. In the post-visit report, the National Mechanism requested the Commander of the Bieszczady Border Guard Unit to explain the reason for the foreigner's possible loss of consciousness and to provide his medical records and full CCTV recordings covering the entire period of his stay in the isolation room.

At the same guarded centre there had been a situation of the use of tear gas on a foreigner. Afterwards, he was only given access to running water to wash his face, and a statement was included in the report that he did not require medical consultation.

The CPT has warned that tear gas is potentially dangerous and should not be used in enclosed spaces. If, in exceptional circumstances, it has to be used in an open space, there should be clearly defined safeguards in place. Persons exposed to the irritant should be provided with immediate access to a doctor and the possibility to quickly and effectively reverse the effects of the gas1[85].

During the same visit, certain irregularities were also found in the way of documenting the use of coercive measures. These included e.g. the indication of the reasons for using coercive measures or the failure to specify, in the documentation, all measures used and confirmed by other sources (e.g. CCTV recordings).

The NPM emphasises that reliable documentation of the use of coercive measures is particularly important, given the extent to which such measures interfere with a person's physical integrity. It is of key importance to be able to assess whether the use of coercive measures in a specific situation was justified and whether they were adequate and used in a correct manner.

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82 See: NPM report on the visit to the Guarded Centre for Foreigners in Przemyśl (KMP.572.6.2023).

83 See: NPM reports on the visits to GCFs in Kętrzyn and Przemyśl.

84 See: judgment of the European Court of Human Rights of 12 April 2007 in the case of Dzwonkowski v. Poland, application no. 46702/99.

85 See: CPT report on the visit to Poland in 2009, CPT/Inf (2011) 20, paras. 77 and 144, and CPT report on the visit to Georgia in 2014, CPT/Inf (2015) 42, para. 111.

6. Personnel

Due to the change of the profile of the GCF in Lesznowola and the related change of its capacity, the number of unoccupied places increased[86]. During the NPM visit, there were no foreigners at all at the centre. At that time, work was underway on hiring an appropriate number of staff members and acquiring the needed equipment.

The training offer for personnel of the centres visited in 2023 was, as a rule, assessed positively. However, at the GCF in Biała Podlaska, the NPM representatives received reports of insufficient response from the staff to threats or intimidation, used against some foreigners by members of another national group living in the centre. In view of this, it was recommended that measures be taken to develop appropriate mechanisms for responding to undesired behaviour of foreigners.

The personnel, in particular female employees also reported that they encountered unusual aggression from a specific national group. The information gathered during the visit showed that the change of the centre's profile from a centre for families to one for men had not been preceded by sufficient training of the personnel.

In order to increase the physical safety of the personnel it was recommended that additional self-defence training be conducted for them. In order to improve their psychological comfort, supervision by an external expert should be provided.

Border Guard posts

■ Method of conducting deportation operations

In February 2023, the NPM conducted pilot visits to the Border Guard Post in Warsaw and Warsaw-Okęcie Airport Border Guard Post[87]. The aim was to obtain information on the method of enforcing decisions on deportation of foreign nationals to their country of origin pursuant to Article 329 of the *Act on Foreigners* and at verifying the presence of minimum safeguards against ill-treatment of expelled foreign nationals.

The main problem identified by the NPM with regard to enforcing decisions that impose on foreign nationals the obligation to return to their country of origin was the lack of an effective mechanism for monitoring deportations[88]. The need to develop such a system has been highlighted by the Committee of Ministers of the Council of Europe[89]. The need to ensure an effective system for monitoring deportation operations by EU Member States also arises from Article 8(6) of the so-called Return Directive[90].

The Commissioner for Human Rights wrote three general intervention letters to the Ministry, calling for legislative action to enable full implementation of the Commissioner's mandate to monitor deportation operations. The request was not fulfilled so the Commissioner raised the issue with the Minister again and was assured that representatives of the Commissioner will be invited to participate in the works on the proposed solutions to improve the current system[91].

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86 Between the NPM visit (20 February 2023) and the date of the response to the post-visit report (17 May 2023), the number of staff increased from 127 to 130. As a result, the number of vacancies changed from 104 to 101.

87 NPM visits to the Border Guard Post in Warsaw and Warsaw-Okęcie Airport Border Guard Post (KMP.572.5.2023).

88 Article 333(1) of the Act on Foreigners provides that representatives of non-governmental organisations or international organisations involved in assistance provision to migrants may be present as observers during deportation operations. However, the provision, among entities authorised to monitor deportations, fails to mention the Commissioner for Human Rights who has the status of the National Preventive Mechanism of Poland. Unlike with regard to non-governmental organisations, the Act therefore does not regulate the procedure for the Border Guard to provide the CHR with information on planned deportations, or the organisational and financial aspects of CHR representatives' participation in deportation operations. The issue is not covered either by the provisions of the regulation issued pursuant to Article 333 of the Act on Foreigners, i.e. the Regulation of the Minister of the Interior of 18 April 2014 on the presence of representatives of non-governmental organisations in the course of activities related to bringing a foreigner to the border of the country or to an airport or seaport of the country, to which he/she has been ordered to be brought (Journal of Laws, item 534).

89 See: Twenty Guidelines on Forced Return, Guideline 20, Committee of Ministers of the Council of Europe, 2005.

90 See: Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals.

91 See: https://bip.brpo.gov.pl/pl/content/rpo-cudzoziemcy-deportacje-monitorowanie-mswia-odpowiedz.

NPM visits to Border Guard posts on the Polish-Belarusian border

Representatives of the NPM also conducted eight visits to Border Guard posts[92] located close to the Polish-Belarusian border. The visits were conducted jointly with representatives of the Department for the Rights of Migrants and National Minorities that forms a part of the Equal Treatment Department of the CHR Office. Deputy Commissioner for Human Rights Wojciech Brzozowski took part in some of the visits. The aim of the action was to check the practical application of the provisions[93] on returning to the borderline of the country foreign nationals who have crossed the Polish border in an irregular manner (so-called pushback).

In the opinion of the NPM, there is an urgent need to amend the provisions of the Act on Foreigners with regard to the treatment of persons crossing the border in an irregular manner and to repeal Article 3(2a) and (2b) of the Regulation of the Minister on temporary suspension or restriction of border traffic at specific border crossing points.

It was found that almost all foreign nationals apprehended by the Border Guard while crossing the border of the country in an unregulated manner were returned to the border line (immediately after apprehension) pursuant to a decision ordering them to leave the territory of the Republic of Poland, referred to in the *Act on Foreigners*, or pursuant to the above-mentioned regulation. The National Mechanism established that the only group of people who were formally detained and with regard to whom deportation proceedings were initiated were so-called couriers (i.e. persons who, in return for a fee, transport foreign nationals from the Polish-Belarusian border outside the territory of Poland, usually to Germany).

As regards detained foreign nationals, there are no standardised rules for determining whether a given person will be returned to the border of the country based on the provisions of the Act or of the Regulation. The decision in this regard is made on a case-by-case basis (depending on the practice adopted by a given post) by its commander or officers who have found and apprehended the foreign nationals. The lack of uniform practice in this field not only constitutes unequal treatment but also impacts the possibility to control the procedures. If a foreign national is returned to the border under the provisions of the regulation, the fact is not sufficiently documented as it is recorded only in the form of a brief note in the internal system of the Border Guard (Management Support System). If a foreign national is returned to the border pursuant to the Act, the legality his or her stay is verified and an appropriate decision is issued.

The NPM points out that neither of the procedures ensures the respect for the right of foreign nationals to apply for international protection in Poland. Thus, the procedures are in conflict with national law[94], including the Constitution of the Republic of Poland[95], and international law[96].

The provision of information to foreigners about their right to apply for international protection and the possibility to exercise this right also remains a problem. According to the findings of the NPM representatives, people who speak a language understood by the officers who have detained them have a better chance to effectively submit the application. In theory, officers can use electronic translation devices and applications on their phones. Yet, in practice, such devices were not available at most of the visited posts. This is particularly important as in the border areas there are problems with mobile internet access necessary to use the telephone applications that only work online.

The commander of one of the visited Border Guard posts admitted that his officers make an initial assessment of the situation when a foreigner states that he or she intends to seek protection in Poland. In practice, such statements are not formally received from persons whose appearance or documents suggest that the country they come from is not affected by war.

It should be emphasised that Border Guard officers are not empowered to make such subjective assessments and it is their duty to make it possible for any interested person to file an application for protection.

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92 Border Guard post in Lipsko, Border Guard post in Nowy Dwór, Border Guard post in Kuźnica Białostocka together with Border Guard facility for detained persons, Border Guard post in Bobrowniki with Border Guard facility for detained persons, Border Guard post in Narewka with Border Guard facility for detained persons, Border Guard post in Białowieża, Border Guard post in Dubicze Cerkiewne with Border Guard facility for detained persons, and the Foreign Nationals Registration Centre, and Border Guard post in Mielnik with Border Guard rooms for detained persons.

93 Article 303b of the Act on Foreigners of 12 December 2013 (Journal of Laws of 2024, item 769, as amended), hereinafter referred to as the Act on Foreigners, and Article 3(2b) of the Regulation of the Minister of the Interior and Administration of 13 March 2020 on the temporary suspension or restriction of border traffic at specific border crossing points (Journal of Laws of 2023, item 1403).

94 The Act on Foreigners and the Act of 13 June 2003 on granting protection to foreigners on the territory of the Republic of Poland (Journal of Laws of 2023, item 1504).

95 Article 56(2) of the Constitution of the Republic of Poland.

96 Convention relating to the Status of Refugees, signed in Geneva on 28 July 1951 (Journal of Laws of 1991, No. 119, item 515, as amended).

At the visited posts, the NPM representatives saw paper forms with statements of no intention to seek international protection in Poland. All the statements made available to NPM representatives indicated Germany as the destination country. At one of the visited posts, there were five foreign nationals whose files contained such statements. When interviewed individually, four of them declared their intention to apply for international protection in Poland. When asked why they had filed the statements of no intention to seek such protection they replied that they were not aware of their legal situation. They did not know that indicating 'Germany' as their destination would result in the necessity to return to Belarus.

The NPM representatives together with the foreigners spoke to the commander of the post. The foreigners informed him of their intention to apply for international protection. The commander confirmed in writing the acceptance of their statements and informed that the refugee procedure would be started.

POLICE DETENTION FACILITIES

In 2023, the NPM carried out visits to 11 rooms for detained persons (hereinafter: RDPs)[97] and persons brought to sober up, located within police organisational units. The problems found and the good practices identified are presented below.

■ Good practices

In one of the facilities[98], persons who wanted to pray could borrow a prayer rug or a rosary. The items were available only in that single facility, despite the fact that their presence was not required by any regulations.

The same facility had a non-monitored medical room. Although the requirement for such a room no longer existed under the regulations, it was used for conducting medical procedures that are intimate by nature and to ensure confidentiality for medical personnel (including paramedics performing resuscitation).

■ Systemic problems

1. Insufficient number of staff at RDPs

Under the current regulations, the unit commander is required to organize work in such a way so as to make sure that there is at least one police officer on duty in the RDP[99]. n the visited police units, supervision over detained persons was exercised by one officer, irrespective of the number of persons detained there[100].

In the opinion of the NPM, however, one person is not able to carry out procedural duties (completing documentation) and control tasks and at the same time make sure that detainees can exercise their rights (e.g. use a toilet). Under such circumstances, it may also be particularly difficult to respond to extraordinary incidents. This way of organising the service can also be dangerous for officers, as it excludes the possibility of mutual support.

The CPT points out that there would be many advantages to establishing a special group of officers responsible for supervising persons placed in police detention facilities. This, among others, would lead to

[97] RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023), RDP at the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023), RDP at the Poviat Police Headquarters in Rawicz (KMP.570.14.2023), RDP at the Poviat Police Headquarters in Kętrzyn (KMP.570.6.2023), RDP at the Poviat Police Headquarters in Strzyżów (KMP.570.3.2023), RDP at the Poviat Police Headquarters in Pułtusk (KMP.570.10.2023), RDP at the Poviat Police Headquarters in Aleksandrów Kujawski (KMP.570.4.2023), RDP at the Poviat Police Headquarters in Opoczno (KMP.570.13.2023), RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023), RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023), RDP at the Poviat Police Headquarters in Pabianice (KMP.570.15.2023) and RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023).

[98] RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023).

[99] See: Article 2(2) of Regulation no. 130 of the Police Commander-in-Chief of 7 August 2012 on the methods and forms of performing duties in rooms for persons detained or brought for sobering up (Journal of Regulations of the National Police Headquarters of 2012, item 42, as amended).

[100] RDP at the Poviat Police Headquarters in Aleksandrów Kujawski (KMP.570.4.2023), RDP at the Poviat Police Headquarters in Pułtusk (KMP.570.10.2023), RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023), RDP at the Poviat Police Headquarters in Rawicz (KMP.570.14.2023), RDP at the Poviat Police Headquarters in Kętrzyn (KMP.570.6.2023), RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023), RDP at the Poviat Police Headquarters in Strzyżów (KMP.570.3.2023), RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023), RDP at the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023), RDP at the Poviat Police Headquarters in Pabianice (KMP.570.15.2023), RDP at the Poviat Police Headquarters in Opoczno (KMP.570.13.2023) and RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023).

greater specialization, professionalism and efficiency of officers and would increase the sense of responsibility for persons in police custody. The practice could also contribute to preventing the misunderstood solidarity among police officers in cases of ill-treatment of detainees, and would strengthen the procedural safeguards against it. An officer could, for example, check on a person's admission to the RDP whether they have been informed about all their rights and whether it has been done in a manner understandable to them. The presence of such officers would also provide an opportunity for a detained person to file a formal complaint regarding the detaining officers, for example if excessive force was used during the detention[101].

2. Placement at RDPs of drunk people to sober up, of people who have taken other substances with effects similar to those of alcohol and people with mental health problems

A large group of people are brought to police rooms for detained persons (RDPs) for the purpose of sobering up[102]. There is also a growing number of people who have taken psychoactive substances with effects similar to those of alcohol, which are equally or even more dangerous to health.

The NPM emphasises that RDPs do not provide adequate conditions and security to such persons. Apart from a medical examination upon admission, there is no requirement at present to ensure permanent medical care for such persons. There are no doctors to supervise people brought to police stations for sobering up. The responsibility for the safety of such persons, therefore, falls on police officers who are not prepared for this role and, in situations of suspected deterioration of health, can only provide first aid and call a medical rescue team. Such a systemic solution does not ensure adequate protection of the health of detainees and thus needs to be changed.

According to the recommendation of the SPT, Poland should introduce a system of quick access to free-of-charge medical treatment (including psychiatric care) to people detained in RDPs[103].

The situation of intoxicated persons with mental disorders, with regard to whom police undertakes interventions, is also problematic. Officers at one of the visited facilities[104] informed the visiting team that psychiatric wards refuse to hospitalise such persons due to their intoxication and they have to remain in an RDP until they have sobered up. Yet, police RDPs are not medical facilities and have no human resources and conditions to provide optimal care, including psychiatric care, to such persons.

An example illustrating this opinion is the incident that took place on 18 September 2022 at one of the visited facilities[105]. A police patrol undertook intervention in a town where, according to a report, a 63-year-old man wanted to commit suicide by dousing himself with petrol and setting himself on fire. An ambulance was called to the place. After examining the man, the paramedics refused to take him to a psychiatric hospital due to his intoxication. Because of the fact that the man's behaviour posed a risk to the health and life of himself and other people and that he was intoxicated with alcohol, a decision was taken to take him to an RDP to sober up.

On 19 September 2022 the police officer taking over the shift at the RDP saw the man lying on the floor with his face down in a pillow. The officer entered the room and found that the man was not showing any signs of life and was unresponsive. The emergency medical team called to the place started rescue activities. The doctor, however, soon pronounced the man dead (the death certificate stated: 'death reason unknown').

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101 See: CPT Twenty-Eighth General Report, CPT/Inf (2019) 9, paras. 83-85.

102 RDP of the Poviat Police Headquarters in Aleksandrów Kujawski (KMP.570.4.2023), RDP of the Poviat Police Headquarters in Pułtusk (KMP.570.10.2023), RDP of the District Police Headquarters (KMP.570.1.2023), RDP of the District Police Headquarters in Rawicz (KMP.570.14.2023), RDP of the District Police Headquarters in Strzyżów (KMP.570.3.2023), RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023), RDP of the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023), RDP of the Poviat Police Headquarters in Pabianice (KMP.570.15.2023), RDP of the Poviat Police Headquarters in Opoczno (KMP.570.13.2023) and RDP of the Poviat Police Headquarters in Starachowice (KMP.570.11.2023).

103 See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, para. 54.

104 RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023).

105 RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023). The case was classified by the Poviat Police Headquarters in Starachowice as an extraordinary case within the meaning of Article 7(3) of Regulation no. 130 of the Police Commander-in-Chief of 7 August 2012 on the methods and forms of performing duties in rooms for persons detained or brought for sobering up.

3. Failure to conduct medical examinations of all detainees

Detainees are subjected to medical examinations prior to being detained in an RDP, in accordance with the principles set out in the applicable regulation of the Minister of the Interior[106]. It does not provide for the examination of all detainees. For this reason, some persons placed in RDP do not undergo such an examination.

In the opinion of the NPM, all persons detained by the Police should undergo a medical examination. This is because such an examination constitutes a basic guarantee for the prevention of torture and protects officers from allegations concerning the treatment of persons in their custody. Also, the awareness that any injuries will be found and documented by medical personnel is a deterrent and may prevent ungrounded or disproportionate application of coercive measures. The awareness that injuries will be disclosed and documented by medical personnel acts as a deterrent, which may also prevent unjustified or disproportionate use of coercive measures.

The SPT has recommended that Poland adopts a system of preventive medical examinations of all persons detained by the police[107].

According to the CAT recommendation, Poland should take effective measures to ensure that detainees undergo a confidential medical examination by an independent doctor within 24 hours of their arrival at the place of detention. They should also have the right to request an independent medical examination at any time[108].

The issue of mandatory medical examinations of detainees was also raised by the ECtHR. In the case of *Dzwonkowski v. Poland*[109], the Court judgment sets out a standard according to which a person under police supervision should, at the end thereof, be in a condition no worse than at the time when the supervision started. If, upon leaving the police station, the person has physical injuries she or he did not have at the time of admission, it is the duty of the state to establish the circumstances in which the injuries occurred. Only a mandatory medical examination upon admission of all persons detained by the police will make it possible to compare the state of their health at the time of admission to the police facility with that at the time of release.

4. Examination of persons with mental disorders by doctors with specialisation other than psychiatry

The NPM's experience shows that detainees reporting mental health problems are examined by doctors on duty in hospital emergency rooms. It is rare for a person deprived of liberty to be provided with a psychiatric consultation after the first medical examination.

In the opinion of the NPM, the examination of people with symptoms of mental disorders or reporting psychiatric problems by doctors with specialisation other than psychiatry may pose a risk to the health or even lives of such detainees if the diagnosis is not correct.

Notably, detention at a police station of people with mental disorders, who may pose a risk to themselves or others, means assigning to the police officers a particularly difficult task of ensuring the safety of those people during their stay at the RDP. For appropriate fulfilment of the task, a reliable assessment of the health of such persons by a doctor with the relevant specialisation is necessary.

5. Access to legal aid from the outset of detention

Poland does not have a system of legal aid that would enable any detainee to contact an attorney or a lawyer from the outset of detention. Yet, in the period immediately following detention the risk of torture and ill-treatment is the greatest.

Under Polish law, an application for appointment of a public defender may only be filed after the first interrogation as a suspect. Until the appointment of a public defender and their first contact with the client, officers carry out official procedures regarding the detainee (questioning, interrogation or other procedures). The lack of other safeguards (such as a mandatory medical examination upon detention or video and audio recording of questioning/interrogation) may be conducive to the use of torture. The situation of less well-off persons who cannot afford an attorney of their choice is particularly difficult. Such persons are in fact deprived of legal assistance during the initial stage of criminal proceedings.

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[106] See: Regulation of the Minister of the Interior of 13 September 2012 on medical examinations of persons detained by the police (Journal of Laws of 2012, item 1102, as amended).

[107] See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, paras. 53 and 55.

[108] See: Committee against Torture, Concluding observations on the seventh periodic report of Poland, 29 August 2019, CAT/C/POL/CO/7, para. 16.

[109] Judgment of the European Court of Human Rights of 12 April 2007 in the case of Dzwonkowski v. Poland, application no. 46702/99.

The NPM emphasises that contact with an independent professional attorney is an essential safeguard against the use of torture; it also facilitates access to the complaint mechanism and the possibility to exercise other rights of detainees, promotes fairness and quality of criminal proceedings and protects officers against slander regarding their working methods.

The problem has been identified by international institutions and has been the subject of recommendations issued to Poland by the CAT[110], SPT[111] and CPT[112].

Also, according to Directives of the European Parliament and the Council, Poland is required to provide free ex officio legal aid to European Union citizens residing in its territory, prior to their first interrogation by the police or another authority and prior to the performance of investigation or evidence-taking procedures[113].

6. Notification of detention

At the visited facilities, police officers, at the request of the detained person, notify a third party of the detention. However, this can be done only by an officer, regardless of the reason for the detention and the nature of the prohibited act of which the detained person is suspected. It is not possible for detained persons themselves to inform their relatives that they are under police supervision.

Importantly, the regulations in force do not allow detained people themselves to notify a person of their choice of the detention, and applicable acts of Parliament stipulate that such notification has to be made at the request of the detained person[114].

However, in the opinion of the NPM, detained persons themselves should have the possibility to notify a person of their choice about the detention. This would require a change in the legislation. Only in special situations, justified by specific circumstances (e.g. a justified fear of tampering with evidence or obstructing criminal proceedings, or serious alcohol intoxication that makes such notification impossible) should the information about the detention be communicated through a police officer. Not all reasons of detention justify the current precautionary solution and the lack of contact with a close person may cause an additional unnecessary hardship.

In accordance with international guidelines on interrogations and information gathering (the so-called Mendez Principles), the right to immediately notify a family member, friend or other person designated by the detainee of the fact and circumstances of the detention is a key safeguard for the observance of their rights. "The entity making the detention is responsible for enabling the detainee to contact a third party and is required to record who was notified of the detention and when this took place. Regardless of the fact that the above procedure is required by law, facilitating contact with the outside world is also an opportunity to build a relationship of trust between the detaining authority and the detainee"[115].

According to the UN principles, "Promptly after arrest and after each transfer from one place of detention or imprisonment to another, a detained or imprisoned person shall be entitled to notify or to require the competent authority to notify members of his family or other appropriate persons of his choice of his arrest, detention or imprisonment or of the transfer and of the place where he is kept in custody"[116].

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110 See: Concluding observations of the Committee against Torture on the seventh periodic report of Poland, CAT/C/POL/CO/7, paras. 15(a) and 16 (a).

111 See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, paras. 51-52.

112 See: CPT reports on the visit to Poland in 2017, CPT/Inf (2018) 39, para. 25 and in 2019, CPT/Inf (2020) 31, paras. 19 and 21-22.

113 See: Directive (EU) 2016/1919 of the European Parliament and of the Council of 26 October 2016 on legal aid for suspects and accused persons in criminal proceedings and for requested persons in European arrest warrant proceedings (OJ EU 2016 No. 297, p. 1 as amended) and Directive (EU) 2013/48/EU of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings, and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty (OJ EU. L .2013 No. 294, p. 1).

114 See: Article 261(1) in conjunction with Article 245(3) of the Act of 6 June 1997 – Code of Criminal Procedure (Journal of Laws of 2024, item 37, as amended); Article 46(3) of the Act of 24 August 2001 – Code of Procedure in Misdemeanour Cases (Journal of Laws of 2024, item 977); Article 40(11) of the Act of 26 October 1982 on upbringing in sobriety and counteracting alcoholism (Journal of Laws of 2023, item 2151, as amended).

115 See: Principles on Effective Interviewing for Investigations and Information Gathering, 2021, available at: https://bip.brpo.gov.pl/sites/default/files/Zasady_Mendeza_%20%28jez.angielski%29.pdf.

116 See: UN General Assembly Resolution 43/173 of 9 December 1988 – Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, Principle 16.1.

7. No walking areas in RDPs

According to current regulations, RDPs are not required to have a walking yard and detainees do not have the right to a walk outdoors.

The CPT recommended that Poland ensure that all persons detained in police custody for a period of 24 hours or more are given the opportunity to take daily outdoor exercise[117].

Also, the SPT recommended to Poland that all persons detained by the police are given the opportunity to spend time outside their cells, including exercise and access to fresh air, for at least one hour a day[118].

Walking yards should also be adequately equipped. It would be best if they had appropriate exercise equipment, benches and a roofed part to be used in bad weather and if they took into account the needs of persons with disabilities and with limited physical abilities. They should also be equipped with a video surveillance system to ensure security and officers supervising detainees should have body-worn cameras[119].

8. Officers' body-worn cameras

Not all of the visited posts had such equipment for their officers[120]. The situation encourages abuse and police officers have no additional protection in the event of allegations concerning irregularities during an intervention. In the opinion of the National Mechanism, body-worn cameras have also a preventive function with regard to misbehaviour on the part of officers as well as persons at whom police intervention is directed. The awareness that a given situation is recorded and the recording may be used in court may be a deterrent for aggressive individuals, which increases the safety of the officers, protects them against unsubstantiated allegations and contributes to improving the quality of their work. If the grounds for applying coercion have been questioned the recording can help assess the situation, draw conclusions, discuss mistakes and draw consequences for its ungrounded and/or disproportionate use. Therefore, the recommended solution is to use body-worn cameras as much as possible.

It is worth noting that the SPT recommended the use of body-worn cameras by law enforcement officers whenever possible[121].

The CPT, in turn, recommends their use to Council of Europe member states, emphasising that they provide additional protection against irregularities on the part of officers as well as protection against unfounded allegations against them[122].

9. Lack of guidelines of Police Commander-in-Chief on dealing with transgender and non-binary persons

In the opinion of the NPM, the National Police Headquarters should develop guidelines for officers on how to deal with transgender and non-binary persons and should provide police officers with appropriate training.

Gender identity, i.e. the inner sense of belonging to a given gender is a personal right of the individual. Although gender identity is not defined in Polish law, it is considered an unacceptable ground for unequal treatment under the parliamentary act that relates to equal treatment. The prohibition of discrimination on the grounds of gender relates also to gender identity, and the prohibition of discrimination against transgender persons is part of EU law. The constitutional prohibition of discrimination covers discrimination on the grounds of gender identity and is further reinforced by the principles of human dignity and equal treatment.

The UN Subcommittee on Prevention of Torture points out that that lesbian, gay, bisexual, transgender and intersex persons are included in the design, implementation and evaluation of measures adopted to

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117 See: CPT report on the visit to Poland in 2017, CPT/Inf (2018) 39, para. 33.

118 See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, paras. 66–67.

119 See: NPM thematic report entitled "Human rights in places of isolation. How Poland implements the recommendations of international bodies for the prevention of torture (CPT and SPT) in practice", published in 2022, p. 35.

120 RDP at the Poviat Police Headquarters in Pułtusk (KMP.570.10.2023), RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023), RDP at the Poviat Police Headquarters in Aleksandrów Kujawski (KMP.570.4.2023), RDP at the Poviat Police Headquarters in Strzyżów (KMP.570.3.2023) and RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023).

121 See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, para. 47.

122 See: CPT report on the visit to Romania in 2021, CPT/Inf (2022) 06, para. 16; CPT report on the visit to Germany in 2020, CPT/Inf (2022) 18, para. 16 and CPT report on the visit to Spain in 2020, CPT/Inf (2021) 27, para. 19.

prevent torture and ill-treatment against them[123]. In the case of this group, the authorities must recognize specific risks, identify those who are in a vulnerable situation, and protect them in ways that do not leave them isolated. Special attention should be paid to ascertaining the reasons for arrest, and specific policies must be developed in relation to searches, intake and interrogation. The specificity of the needs of transgender persons makes the involvement e.g. of experts in transgender persons particularly desirable[124].

The SPT has also made recommendations on providing to police officers training and awareness--raising on international human rights standards and principles of equality and non-discrimination, including in relation to sexual orientation and gender identity. Those measures should include training on how to communicate effectively and professionally with lesbian, gay, bisexual, transgender and intersex detainees and how to identify and respond to their legitimate need[125].

■ Areas for improvement

1. Treatment

At one of the visited facilities[126], a situation was identified of a woman under the influence of alcohol who attempted suicide. An analysis of the CCTV footage showed that at 7:45 p.m., the woman took off her underwear and wrapped it around her neck into a noose which she tightened. For about 15 minutes she remained in the room by herself although it was monitored. At around 8:00 p.m. two officers entered the room and found the woman unconscious. The police officers checked her vital signs. They detected no pulse or breathing so they began resuscitation. An ambulance was also called. After several dozen chest compressions, the detainee's vital functions were restored and when a few more minutes passed she regained consciousness. The detainee was taken to a hospital for a psychiatric consultation and was ultimately placed back in the room for detained persons as she was still under the influence of alcohol. An investigation regarding the case was conducted both by the police[127] and the prosecutor's office[128]. No irregularities in the actions of the police officers were found[129]; the involvement of third parties or incitement of the detainee to attempt suicide was excluded[130].

The National Mechanism drew attention to the officers' long period of inaction after the suicide attempt. Approximately 15 minutes passed between the attempt by the female detainee and the reaction of the police officers at the RDP, although the incident was visible on CCTV footage. In the opinion of the NPM, CCTV is only an additional method of surveillance. The responsibility for the safety of detainees rests with police officers.

At another RDP[131] the visiting team noted that although it was cold inside, the detainees were dressed in their trousers and T-shirts. They had blankets but their sweatshirts that were in the storage room were not given to them. Some of the detainees did not know if they could have them. The interviewed detainees were not aware either whether they could take a shower at the RDP. One of them stated he had asked an officer about this but received no answer.

At one of the facilities[132], the analysis of the documentation made available to the vising team showed that a detainee was admitted to the RDP in the evening. The detention took place at 7:35 p.m. and thus the detainee did not get breakfast on the following day. The detainee was present during the visit and did not receive lunch either by the end of the visit (the visit ended in the afternoon).

In the context of the treatment of detainees it should also be noted, based on the observance of the work of officers, that they addressed the detainees informally using their first names[133].

An analysis of a CCTV recording at one of the RDPs[134] showed that detainees had no access to the toilet at night. The recording, made during the night between27 and 28 August 2023 shows that a plastic bucket was brought to a cell with two detainees. On 28 August 2023, at 12:59 p.m., just before the NPM team arrived, the bucket was taken away from the cell by one of the detainees.

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123 See: Ninth Annual Report of the SPT, CAT/C/57/4, para. 71.
124 Ibid., p. 76.
125 Ibid., p. 79.
126 RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023).
127 Investigation pursuant to Article 134(4) of the Act on the Police of 6 April 1990.
128 Proceedings pursuant to Article 308 of the Code of Criminal Procedure.
129 See: Report of 4 July 2023of the Poviat Police Headquarters in Otwock on the investigation, ref. no. KPP-W-I-2286/23.
130 See: Decision of 7 June 2023 of the Office of the District Prosecutor in Otwock to abandon the investigation without its commencement, ref. no. 4 Ds. 747.2023.
131 RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023).
132 Ibid.
133 RDP at the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023).
134 Ibid.

At another facility[135] disciplinary proceedings were conducted which confirmed a disciplinary offence by one of the police officers on duty in the room for detained persons. The officer did not fulfil his duties and, three times, he refused to provide access to the toilet to detainees. Instead, he gave them a plastic cup into which they were supposed to pass urine. The police officer committed also other disciplinary offences consisting in the failure to properly perform his duties. He frequently stayed in the officers' room that is not equipped with monitoring devices for observing the RDP. He did not monitor the behaviour of persons placed there, did not register five situations when they left the RDP and were taken to the toilet, and did not lock the security gate leading to the RDP. The officer was given a reprimand.

The NPM is of the opinion, in the context of the above-described situations, that a person placed in a room for detained persons should have unrestricted access to sanitary facilities, including at night time.

2. Use of coercive measures

During its visits[136] the NPM observed preventive use of handcuffs with regard to detainees. It was also noted that detainees remain handcuffed during procedures with the participation of medical staff[137].

One of the detainees reported that he and other detainees had their hands handcuffed in front during their apprehension and had to sit outdoors in snow for about an hour and a half, waiting for the officers to finish the search of the premises. If the detainee's statement is true the practice constituted degrading treatment[138].

According to the NPM, the use of handcuffs is not always proportionate to the actual threat posed by the detained person, in particular when he or she does not resist detention, is not aggressive, is accompanied by several police officers and/or is in a safe place (e.g. a police car or a police station where security solutions exist). Often, handcuffs are used automatically as means of prevention, without case-by-case assessment of the risk, even if their use is not necessary and is not adequate to the actual threat posed by the detained person.

The NPM emphasises that handcuffs are an invasive means of direct coercion. They can be used as a tool of repression and intimidation, and their use can even be a form of torture. They can also stigmatise people in the society if the detention takes place in front of bystanders. Furthermore, in some situations, their use can be dangerous[139].

In the opinion of the NPM, handcuffs should not be used as a preventive measure on all detainees but only when fully justified by the results of a risk assessment conducted on case-by-case basis. In situations where their use is necessary, they should not be fastened too tightly and should be removed as soon as possible. The use of handcuffs fastened behind the back and combination handcuffs, as well as handcuffs during transport, should also be avoided. Detainees should be transported by secure vehicles, which reduces the need to use this coercive measure. Police officers should develop appropriate tactical solutions and techniques of mutual support in the event of aggression or an attempt to escape by a detainee, so as to limit the preventive use of handcuffs and use them only in exceptional cases.

The issue was also notified to Poland by the SPT[140] and the CPT[141].

3. Body search and preventive checks

During its visits, the NPM came across cases where all detainees placed in a given RDP were subjected to body search[142]. The NPM also encountered a situation where body check was carried out in a monitored room (the area where the check was conducted was blurred on the CCTV recording)[143].

During its visits, the NPM also saw that some officers on duty at the RDPs had difficulties distinguishing between a body search and a preventive check[144].

The NPM is of the opinion that body search should not be carried out routinely on detainees, but only in exceptional cases, justified by the specificity of the situation and after the individual risk assessment carried

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135 RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023).

136 RDP at the Poviat Police Headquarters in Aleksandrów Kujawski (KMP.570.4.2023) and RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023).

137 RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023) and RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023).

138 RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023).

139 The NPM's opinion on the issue has been set out in detail in its annual report for 2022, p. 54.

140 See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, paras. 68 and 69.

141 See: CPT report on the visit to Poland in 2019, CPT/Inf (2020) 31, para. 17 and footnote 17.

142 RDP of the Poviat Police Headquarters in Pułtusk (KMP.570.10.2023), RDP of the Poviat Police Headquarters in Turek (KMP.570.16.2023), RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023).

143 RDP at the Poviat Police Headquarters in Rawicz (KMP.570.14.2023).

144 RDP at the Poviat Police Headquarters in Pułtusk (KMP.570.10.2023), RDP at the Poviat Police Headquarters in Kętrzyn (KMP.570.6.2023) and RDP at the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023).

out. The only mandatory measure[145] at RDPs should be preventive check that consists of fast external manual check of the person's body, their clothes and items on their body and in their possession[146].

Body search should be conducted in stages[147]. Persons subjected to such search should be informed of their right to file a complaint regarding the grounds for the search, its legality and correctness, as well as the right to request that a report be drawn up on the body search conducted[148].

Body search should always be conducted in a place that ensures privacy and is not accessible to persons other than those conducting the procedure. Furthermore, body search should be carried out in stages – after removing one clothing item (top or bottom), the person searched should be allowed to put it back on and only then should be required to take off another clothing item. During body search, two officers of the same sex as the person searched should be present to ensure mutual support and safety[149].

4. Taking away of glasses and orthopaedic equipment items

At the police units visited[150], there were instances where detainees held at RDPs had their glasses taken away. The practice was said to be based on security considerations. According to the NPM, the measure is excessive, causes discomfort to the detainees and is potentially humiliating. The lack of glasses makes it difficult for them to find out about their basic rights and to read information such as the RDP regulations, a list of human rights institutions, a list of lawyers and legal advisors and the instructions received.

In its judgment in the case *Slyusarev v. Russia*, the ECtHR pointed out that certain forms of legitimate treatment or punishment – for example, a deprivation of liberty – may involve an inevitable element of suffering or humiliation. However, under Article 3 of the Convention the States must ensure that a person is detained in conditions which are compatible with respect for his human dignity, and that, given the practical demands of imprisonment, his health and well-being are adequately secured. The Court also pointed out that after taking the applicant's glasses he could not read or write normally, and, besides that, it must have created a lot of distress in his everyday life, and given rise to a feeling of insecurity and helplessness. The Court thus considered that the applicant's situation constituted degrading treatment and thus a violation Article 3 of the Convention[151].

5. Right to contact a defence counsel

At some of the visited RDPs there were no lists of lawyers and legal advisors who provide services within the area of jurisdiction of the police unit[152]. There was also a unit where, despite the presence of such a list in the officers' room, no information about it was provided to persons placed at the RDP[153]. In another unit[154], the list of lawyers providing legal assistance was out of date. It included the names of persons who no longer provided legal assistance in that area or had been removed from the register of attorneys.

According to the NPM, the presence of such a list facilitates access to professional legal representatives for detainees, which is of fundamental importance from the point of view of preventing torture and ensuring the right to defence. It can also contribute to improving interpersonal relations with officers and alleviate tensions caused by the fact of detention. The police, in consultation with the bar association should draw up a list of defence counsels ready to provide legal assistance to detainees, which should be available in every RDP and at all police units where detainees are held and interrogated.

The CPT takes the view that the provision of access to a lawyer to people detained by the police is a fundamental safeguard against ill-treatment, as it discourages persons inclined to use violence

[145] See: Article 5(2) of Annex 1 to the Regulation of the Minister of the Interior of 4 June 2012 on rooms for detained persons or intoxicated persons brought to sober up, on transitional facilities and police establishments for children as well as rules and regulations on the stay in such facilities and procedures regarding image recording there (Journal of Laws of 2023, item 2672, as amended).

[146] The full scope of preventive checks is set out in Article 15g(1) and (3) of the Act on the police of 6 April 1990.

[147] See: Article 15d(2) of the Act on the Police of 6 April 1990.

[148] See: Article 15d(2) of the Act on the Police of 6 April 1990.

[149] See: CPT report on the visit to Latvia in 2016, CPT/Inf (2017) 16, para. 37.

[150] RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023).

[151] See: ECtHR judgment of 20 April 2010 in the case of Slyusarev v. Russia, application no. 60333/00.

[152] RDP at the Poviat Police Headquarters in Kętrzyn (KMP.570.6.2023), RDP at the Poviat Police Headquarters in Aleksandrów Kujawski (KMP.570.4.2023) and RDP at the Poviat Police Headquarters in Pabianice (KMP.570.15.2023).

[153] RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023).

[154] RDP at the Poviat Police Headquarters in Opoczno (KMP.570.13.2023).

from applying it against detainees. Furthermore, a lawyer is able to take appropriate action if he or she receives information about ill-treatment of his or her client[155].

The NPM has noted cases where detainees were allowed to contact their lawyers only in a monitored room[156].

According to Article 245(1) of the Code of Criminal Procedure[157], a detainee shall, upon request, be allowed to contact an attorney without delay in an accessible form and to speak with him or her directly. In exceptional cases, justified by special circumstances, the detaining officer may inform that he or she will be present during the meeting.

In the opinion of the NPM, the presence of a camera in the room in which a detainee meets with his or her lawyer does not guarantee full confidentiality of the meeting (thus reducing the minimum safeguards of the prevention of torture) as well as undermines the legal professional privilege and the right of defence.

The view has been shared by the bar association which, in its letters to the Commissioner for Human Rights, has pointed out that the presence of a camera in the room in which a meeting with a lawyer takes place may result in a violation of the legal professional privilege and of the right to defence, including the right to unlimited contact with a defence counsel and the right to a fair trial. The legal professional privilege should be understood as broadly as possible. It covers not only conversations but also materials exchanged between the client and the lawyer in the form of notes or documents. Monitoring of meetings with a defence counsel violates the confidentiality of the exchanged information, undermines the relationship of special trust between the defence counsel and the client, and thus influences the effectiveness of the legal aid provided[158].

According to point 33 of Directive 2013/48/EU of the European Parliament and of the Council of 22 October 2013 on the right of access to a lawyer in criminal proceedings and in European arrest warrant proceedings, and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty, "Confidentiality of communication between suspects or accused persons and their lawyer is key to ensuring the effective exercise of the rights of the defence and is an essential part of the right to a fair trial. Member States should therefore respect the confidentiality of meetings and other forms of communication between the lawyer and the suspect or accused person in the exercise of the right of access to a lawyer provided for in this Directive"[159].

According to information from one of the visited units[160], detainees who are in need of legal assistance and do not have a legal representative are provided with a list of lawyers. However, according to the information provided by the officers, there are situations in which lawyers refuse to arrive to the RDP or inform that they would be willing to provide legal assistance only when the detainee leaves the facility and meets them at their office.

In the opinion of the NPM, such an attitude makes it impossible for the lawyer to assess the actual physical and mental condition of the detainee, may affect the effectiveness of legal assistance (as procedural activities at the RDP are conducted in the absence of the lawyer) and create conditions conducive to the use of torture. Access to a lawyer is a minimum safeguard for the prevention of torture.

6. Medical care and documentation of injuries

The NPM has always emphasised that medical examinations aimed at identifying any signs of torture should meet two basic criteria: they should be carried out as soon as possible after the incident and in accordance with the rules ensuring effective documentation of torture.

The SPT emphasises that the examination should be conducted in conditions of confidentiality (only medical personnel should be present) and should be aimed at identifying any cases of torture and ill-treatment[161].

At one of the visited RDPs[162], based on the documentation available on site the visiting team found that one of the detainees, examined by a doctor, had visible injuries on his face, reported suicidal thoughts and could be under the influence of alcohol or other substances with similar effects. The file concerning

[155] CPT Twentieth General Report, CPT/inf (2011), para. 28.
[156] RDP at the Poviat Police Headquarters in Rawicz (KMP.570.14.2023), RDP at the Poviat Police Headquarters in Aleksandrów Kujawski (KMP.570.4.2023), RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023) and RDP at the Poviat Police Headquarters in Strzyżów (KMP.570.3.2023).
[157] Act of 6 June 1997 – Code of Criminal Procedure.
[158] See: Letter of the President of the Supreme Bar Council of 25 February 2019 (NRA.56.1.2019); Letter of the Chair of the Human Rights Committee of the Supreme Bar Council of 2 July 2021 (NRA.56.3.2021).
[159] Official Journal of the European Union, 2013, no. 294, p. 1.
[160] RDP at the Poviat Police Headquarters in Opoczno (KMP.570.13.2023).
[161] SPT report on the visit to Ukraine, 18 May 2017, CAT/OP/UKR/3, paras. 57–61.
[162] RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023).

the person did not contain any mention of the injuries that were present upon his admission to the RDP, which may raise doubts as to the circumstances and time of their occurrence.

In the report on its visit to Poland, the CPT set out the standards for documenting injuries of persons detained by the police[163]. The standards, however, have not been implemented, which is of concern from the point of view of effective prevention of torture.

Among the irregularities, the NPM also came across situations where healthcare services or initial medical examinations were provided in the presence of police officers[164]. The practice may prevent the detection of signs of ill-treatment, affect the assessment of the patient's health and pose a risk of violating the detainee's privacy, dignity and medical confidentiality.

The issue was highlighted by the CAT[165], SPT[166] and CPT[167], which recommended that Poland ensure confidentiality during medical examinations of detainees.

7. Documentation

The NPM pointed out, with regard to medical documentation, that the information entered by some doctors in medical certificates issued for the purpose of confirming that a given person can be placed in an RDP was too brief[168]. As a result, it could be difficult for police officers to react appropriately to any symptoms of illness of a person whose condition at the time of the examination allowed for placement at the RDP but whose situation changed over time. The review of the documentation carried out by the visiting team revealed that doctors do not always enter all precise data required, i.e. some of the certificates failed to indicate the hour of the examination, and a legible stamp and signature of the doctor.

An analysis of the documents available at one of the visited facilities[169] revealed the following situations:

- a detention report on a detainee failed to indicate who had conducted his sobriety test and found the presence of alcohol in his body (the police officer or the doctor);
- a detainee's state of intoxication was mentioned by the doctor in the medical certificate issued for the detainee but was not mentioned in the detention report;
- there were no reports on detainees' sobriety tests (no printouts from the device were attached); in all cases, on the reverse side of the medical certificates there was handwritten information on the test results;
- there was no sobriety test report for a detainee despite the statement that is was attached to the detainee detention report;
- there were discrepancies between the police officer's record of detention and the full detention report (e.g. according to the record, the person had visible scratches around the mouth as well as stitches on both lips, while according to the report, he had only visible abrasions on the skin around the mouth; the medical certificate mentioned no visible injuries at all); furthermore, the officer's record relating to the detainee's injuries contained two different names of the detainee;
- a detainee's file contained no medical certificate while the detention report contained information that a medical examination of the detainee had been conducted (the report stated that the detainee had been examined by a doctor who found no contraindications to the placement of the detainee at the RDP);
- records of injuries of detainees, drawn up by police officers, did not mention the circumstances in which they occurred, and the medical certificates concerning the detainees did not contain any information on the injuries;
- there was no mention in a detainee's file of why he had not signed the deposit collection form upon release;
- many handwritten entries were difficult to read.

The discrepancies in the documentation raise doubts as to the actual condition of people deprived of liberty at the police unit visited. From the point of view of preventing ill-treatment in places of detention, such shortcomings are undesirable and every effort should be taken to avoid them.

[163] See: CPT report on the visit to Poland in 2022 (CPT/Inf (2022) 56, para. 17).
[164] RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023).
[165] See: Concluding observations of the Committee against Torture on the seventh periodic report of Poland, CAT/C/POL/CO/7, para. 16, point e.
[166] See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, paras. 53 and 55.
[167] See: CPT reports on the visits to Poland: in 2022, CPT/Inf (2022) 56, para. 17; in 2019, CPT/Inf (2020) 31, para. 24; and in 2017, CPT/Inf (2018) 39, para. 27.
[168] RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023).
[169] RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023).

8. Material conditions

Material conditions in the individual RDPs were generally good or even very good. However, some rooms for detainees were stuffy and had an unpleasant odour (in one of the RDPS[170], it was not possible to open the windows to let fresh air in).

In one of the cells, there were just pieces of paper sheets with internal rules of the facility and a list of institutions protecting human rights[171]. In other RDPs[172], in some cells the covers on mattresses and pillows of detainees were torn. Some RDPs[173] had items that were old and used or were not available in sufficient amounts (mattresses or towels)[174]. The NPM also recommended that renovation work be carried out in cells in which the floor paint was damaged[175].

In the RDPs, the rooms were generally well lit. At one of the police units[176] the RDP was dim although the visit took place during the day. In the opinion of the NPM, such poor lighting may make it difficult and in some cases impossible (for older or visually impaired persons) to read, e.g. the internal regulations of the RDP.

Not every RDP[177] had replacement underwear to be provided to female detainees whose private bras were taken due to security reasons. In one of the RDPs[178], the NPM also recommended that personal hygiene products be available and placed in the women's toilet so that female detainees do not have to ask for them every time they need them, especially that all the staff were male. At other RDPs[179] it was noticed that the showers had no curtains to ensure a minimum of level of privacy to detainees, and the shower trays were dirty. There was no soap in the dispensers and, instead, there were dirty lumps of partly used soap on the edges of shower trays. In the storage room for clothes of people with infections there were dirty clothes. Not every RDP provided access to newspapers for detainees[180].

9. Training for officers

The NPM recommended that the training programmes for officers of the visited facilities[181] include issues related to international human rights standards for prevention of torture, conflict de-escalation techniques, the Istanbul Protocol, interpersonal communication, methods of coping with stress, counteracting burnout, provision of first aid, methods of documenting course of service at RDPs, and the application of coercive measures.

The SPT points out that training of officers is a mechanism for preventing torture. For this reason, training programmes for all police officers should cover international human rights standards aimed at preventing torture and ill-treatment[182]. Furthermore, all people who supervise detainees and draw up documentation and investigate cases relating to torture and ill-treatment should be trained in the application of the Istanbul Protocol[183]. In the SPT's view, it is an essential tool for detecting, documenting, reporting

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170 RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023).
171 RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023).
172 RDP at the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023).
173 RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023).
174 RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023).
175 RDP at the Poviat Police Headquarters in Pabianice (KMP.570.15.2023).
176 RDP at the Poviat Police Headquarters in Rawicz (KMP.570.14.2023).
177 RDP at the Poviat Police Headquarters in Kętrzyn (KMP.570.6.2023), RDP at the Poviat Police Headquarters in Strzyżów (KMP.570.3.2023), RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023), RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023) and RDP at the Poviat Police Headquarters in Pabianice (KMP.570.15.2023).
178 RDP at the Poviat Police Headquarters in Kętrzyn (KMP.570.6.2023).
179 RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023).
180 RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023) and RDP at the Poviat Police Headquarters in Pabianice (KMP.570.15.2023).
181 RDP at the Poviat Police Headquarters in Rawicz (KMP.570.14.2023), RDP at the Poviat Police Headquarters in Kętrzyn (KMP.570.6.2023), RDP at the Poviat Police Headquarters in Pułtusk (KMP.570.10.2023), RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023), RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023), RDP at the Poviat Police Headquarters in Strzyżów (KMP.570.3.2023), RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023), RDP at the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023), RDP at the Poviat Police Headquarters in Pabianice (KMP.570.15.2023) and RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023).
182 See: SPT report on the visit to Mexico in 2008, CAT/OP/MEX/1, para. 95.
183 See: SPT report on the visit to the United Kingdom in 2019, CAT/OP/GBR/ROSP/1, para. 71, SPT report on the visit to Portugal in 2018, CAT/OP/PRT/1, para. 34.

and deterring torture and ill-treatment[184]. Not only does it help in the early identification of victims and the documentation of trauma but also in assessing the needs and adjusting the care to them as appropriate[185].

The CPT, in turn, recommends that in the system of training for officers, particular emphasis be placed on developing interpersonal communication skills based on respect for human dignity[186].

Due to the noticeable increase, in recent years, in the number of police interventions with regard to people with mental disorders and people under the influence of psychoactive substances, the NPM also recommended that RDP personnel:

- be regularly reminded of the principles of professional ethics, with particular emphasis on issues related to respect for human dignity and human rights;
- undergo practical training on conducting police intervention, with particular emphasis on the use of coercive measures with regard to persons with mental disorders and persons under the influence of psychoactive substances;
- be made familiar with the expert report commissioned by the NPM and entitled *Police interventions with regard to persons with mental disorders* and with the information brochure drawn up on its basis. The brochure is a practical and accessible source of information that can help police officers to properly assess the condition of a detained person and follow procedures aimed at increased protection of their health and life during a police intervention.

In some of the visited police units[187], officers had stun guns as part of their equipment. In the opinion of the NPM, the use of stun guns may, in certain situations, help to avoid the use of firearms. However, if used incorrectly they can pose a danger both to the officers and to persons detained.

The NPM recommended that the training programme on the use of stun guns include issues related to:

- international standards for the use of stun guns, in particular those set out by the UN[188] and CPT[189] (including the recommendations for Poland included in the CPT report on the visit held in 2017[190]);
- potential effects of their use on human health;
- situations of risk to human health and situations where the use of a stun gun may be ineffective (e.g. in people with mental disorders or people who do not react to pain)[191];
- action methods alternative to coercive measures (e.g. de-escalation of conflict situations, mediation and effective communication);
- first aid provision.

The 2017 report of the UN Special Rapporteur on Torture, focused on the use of force by state officials[192] points out that States must take effective measures to prevent acts of torture and other cruel, inhuman or degrading treatment or punishment from occurring within their jurisdiction. This means that States must regulate the extra-custodial use of force and establish other adequate mechanisms to ensure that State agents are trained, equipped and instructed so as to prevent torture and other cruel, inhuman or degrading treatment or punishment in law enforcement operations[193].

The UN Special Rapporteur recommends that law enforcement officials be provided with mandatory initial and recurring training and instructions for all law enforcement officials concerning the lawful

[184] See the SPT's observations and recommendations in its reports on visits to Poland [CAT/OP/POL/ROSP/1, para. 55], the United Kingdom [CAT/OP/GBR/ROSP/1, paras. 69 and 71], Portugal [CAT/OP/PRT/1, paras. 34, 89, 93] , Spain [CAT/OP/ESP/1, para. 46, 63-64, 70] and Brazil [CAT/OP/BRA/3, paras. 20-22, 34, 89, 93].

[185] See: Statement of CAT, SPT, the Special Rapporteur on Torture and the Board of Trustees of the United Nations Voluntary Fund for Victims of Torture of 25 June 2019, available at: https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24739&LangID=E

[186] See: CPT Second General Report, CPT/Inf (92) 3, para. 60.

[187] RDP at the Poviat Police Headquarters in Aleksandrów Kujawski (KMP.570.4.2023), RDP at the Poviat Police Headquarters in Strzyżów (KMP.570.3.2023), RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023), RDP at the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023), RDP at the Poviat Police Headquarters in Pabianice (KMP.570.15.2023) and RDP at the Poviat Police Headquarters in Starachowice (KMP.570.11.2023).

[188] See: United Nations Human Rights Guidance on Less-Lethal Weapons in Law Enforcement, dated 2020, available at: https://www.ohchr.org/en/publications/policy-and-methodological-publications/unitednations-human-rights-guidance-less.

[189] See: Document entitled 'Electric weapons': Extract from Twentieth General Report, CPT/Inf (2010) 28 - part, available in Polish at: https://www.coe.int/en/web/cpt/EDW.

[190] See: CPT report on the visit to Poland in 2017, CPT/Inf (2018) 39, paras. 21–22.

[191] See: United Nations Human Rights Guidance on Less-Lethal Weapons in Law Enforcement, dated 2020, paras. 7.4.5–7.4.10.

[192] See: Report of the UN Special Rapporteur on Torture entitled „Extra-custodial use of force and the prohibition of torture and other cruel, inhuman or degrading treatment or punishment", 20 July 2017, A/72/178.

[193] Ibid., para. 58.

use of force, weapons and other equipment, as well as in the effective implementation of alternative, non-violent methods and tactics, with a particular focus on preventing any act of torture or other cruel, inhuman or degrading treatment or punishment[194]. Furthermore, it recommends regular monitoring of the effectiveness of such training in preventing torture and other cruel, inhuman or degrading treatment or punishment and other human rights violations[195].

10. Legality of placement

The aim of every NPM visit is to assess the observance of the rights of detainees in terms of the legality of their placement in the facility. At one RDP only[196] there were irregularities in this regard. A person released from the DRP had to wait for about 15-20 minutes for an ambulance after his formal release. While waiting for the ambulance the person was formally deprived of liberty for a period longer than that recorded in the documentation on his detention. According to Article 4(2) of the OPCAT, deprivation of liberty means 'deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority'[197].

11. Right to information and a complaint mechanism

In most of the visited RDPs[198] foreign nationals were given for signature documents that were drawn up in Polish (including detention reports, statements of being informed of their rights and deposit receipts). The documents contained no mention that they had been translated for a given detainee. In most cases, there was no information either about the language barrier, the language spoken by the detainee or the language into which the documents were translated. Therefore, it is not certain whether the foreign nationals understood the content of the documents they signed and to what extent.

In one of the visited RDPS[199], the visiting team had doubts concerning a person born in China. All the documentation shown to the team members was drawn up in Polish and contained no mention that it had been translated for the detainee. The detention report and the information on the detainee's rights in criminal proceedings were not signed by him (the file contained information by the officer on the detainee's refusal to sign the documents). The information sheet given to the detainee for signature was in English not in Chinese. It is therefore uncertain whether the detainee understood English, and the police documentation does not indicate the language in which the police officer communicated with the detainee and whether there were any communication difficulties.

In another RDP[200] there was a Moldovan citizen placed for sobering up. The officer on duty in the room assured the NPM representatives that the detainee understood and could communicate in Polish. However, during an interview with the detainee the team found that the man could communicate only in his native language and in Russian. The NPM delegation found that the man signed documents which he did not understand because they were in Polish (including the RDP regulations). The detainee did not have access to an interpreter upon admission. He also signed a statement in Polish that he understood the language (the statement was probably written by an officer).

The NPM recommends that all statements signed by foreign nationals be translated into a language they understand. In the event of communication problems, the assistance of a translator should be used, regardless of the grounds for detention. The translations of documents should be certified (by the translator's signature and stamp placed on it). The NPM also recommends that any communication difficulties, information on the language spoken by the detainee and whether translation was provided and how be entered in the documentation.

The right to information is a fundamental safeguard against torture. Access to understandable and up-to-date information on important issues such as one's rights, applicable procedures and complaint

194 Ibid., para. 66(a).
195 Ibid., para. 66(b).
196 RDP at the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023).
197 See: Article 4(2) of the OPCAT.
198 RDP at the Poviat Police Headquarters in Rawicz (KMP.570.14.2023), RDP at the Poviat Police Headquarters in Kętrzyn (KMP.570.6.2023), RDP at the Poviat Police Headquarters in Strzyżów (ref. no. KMP.570.3.2023), RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023), RDP at the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023), RDP at the Poviat Police Headquarters in Pułtusk (KMP.570.10.2023), RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023), RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023), RDP at the Poviat Police Headquarters in Pabianice (KMP.570.15.2023) and RDP at the Poviat Police Headquarters in Opoczno (KMP.570.13.2023).
199 RDP of the Poviat Police Headquarters in Pruszków [located at the police station in Piastów] (KMP.570.2.2023).
200 RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023).

filing methods increases their sense of security, makes it possible for them to actively exercise their rights, provides access to complaint mechanisms and thus constitutes a measure preventing violence.

The detention report on one of the persons brought to the RDP[201] contained the phrase 'not able to place a signature'. The report was signed by three officers taking part in the detention procedure. The reason for not being able to place a signature was not mentioned. In the box for the detainee's statement on his state of health the following text was entered: 'I am healthy, I do not undergo any medical treatment, I do not need to contact a doctor; the detainee has not been examined by a doctor'. The documentation drawn up in connection with the detention did not mention why the detainee was unable to sign the report. The duty book contained a mention by an officer of all standard procedures carried out with regard to every detainee: 'I received items for deposit, he signed the list of the items. I presented the RDP regulations to the detainee and showed him the call button. He behaved calmly and made no comments about his state of health.'

The entry shows that, unlike in the case of the detention report, the deposit document was signed by the detainee. Given that the detention report contained no other comments apart from that on the detainee's inability to place a signature, the visiting team could not determine the reason for it. The discrepancy regarding the two documents raises doubts as to the condition of the man during the time spent at the police station. From the point of the prevention of people's ill-treatment in places of detention such doubtful situations are undesirable and every effort should be made to avoid them.

According to CPT recommendations, all persons detained by the police should be fully informed of their fundamental rights as from the outset of their deprivation of liberty (that is, from the moment when they are obliged to remain with the police). Particular care should be taken to ensure that detained persons understand their rights; it is incumbent on police officers to ascertain that this is the case [202].

The SPT recommended that Poland adopt the necessary legislative and administrative measures to ensure that all persons deprived of their liberty are informed of all their rights and the reasons for their detention from the outset of detention and, as soon as possible after their detention, of the charges against them. Such information should first be provided verbally in a clear manner in a language that the person understands, if necessary with the assistance of an interpreter, and then provided to the person in writing[203].

According to the Directives of the European Parliament and the Council of the EU, information about applicable procedural rights should be given by means of a written letter of rights drafted in an easily comprehensible manner so as to assist those persons in understanding their rights. Such a letter of rights should be provided promptly to each arrested person when deprived of liberty[204]. Persons who do not speak Polish should have translated all documents relevant to ensuring their ability to exercise their right of defence and to challenge the legality of their detention[205].

The visiting team noted that in one of the visited RDPs[206] the file of a detainee contained an outdated list of rights of detained persons. Moreover, some of the detention reports at the facility contained information that the list of detainees' rights was attached to the detainee's documentation but in reality the list was not attached.

During the visits, NPM representatives check whether in the rooms for detainees there are materials with information of key importance for the prevention of torture, i.e. the RDP regulations and a list of human rights protection institutions and their contact details. The requirement to display the two information sheets is included in the relevant regulation of the Ministry of the Interior[207].

The conducted visits revealed irregularities in this regard. Representatives of the NPM noticed that at the visited RDPs[208] the information sheets were placed between the window bar and the window as such.

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201 RDP at the Poviat Police Headquarters in Kętrzyn (KMP.570.6.2023).

202 See: CPT report on the visit to Poland in 2017, CPT/Inf (2018)39, para. 28.

203 See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, para. 50.

204 See: Directive 2012/13/EU of the European Parliament and of the Council of 22 May 2012 on the right to information in criminal proceedings (OJ EU L 142, 2012, p. 1).

205 See: Directive 2010/64/EU of the European Parliament and of the Council of 20 October 2010 on the right to interpretation and translation in criminal proceedings (OJ EU L 280, 2010, p. 1).

206 RDP at the Poviat Police Headquarters in Opoczno (KMP.570.13.2023).

207 See: Article 16(2) of the Regulation of the Minister of the Interior of 4 June 2012 on rooms for detained persons or intoxicated persons brought to sober up, on transitional facilities and police establishments for children as well as rules and regulations on the stay in such facilities and procedures regarding image recording there (Journal of Laws of 2023, item 2672, as amended).

208 RDP at the Poviat Police Headquarters in Rawicz (KMP.570.14.2023), RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023) and RDP at the Poviat Police Headquarters in Pabianice (KMP.570.15.2023).

In the opinion of the police the aim was to prevent them from being destroyed by detainees. However, due to outdoor sunlight and poor lighting inside the room the text was practically illegible. The solution constitutes only an illusory implementation of detainees' right to information. In one of the RDPs[209] the list of human rights institutions was available only in the admission room. The list did not contain the contact details of the institutions. In some units, the list of institutions contained outdated contact details for the Helsinki Foundation for Human Rights[210].

12. No name tags on police officers' uniforms and balaclava wearing by police officers

In one of the visited RDPs[211], CCTV footage viewed by the NPM team showed that police officers in contact with a detainee (bringing him to the police station and performing initial duties in one of the officers' rooms) were wearing balaclavas that covered their faces, except for the eyes. They had no name tags and only the word 'POLICE' was visible on their uniforms. Other officers at the police station, including the RDP staff and the Criminal Department staff did not cover their faces when in contact with the detainee (on the day of his detention and on the following day).

The requirement to wear a uniform is set out in legal regulations[212], according to which 'A police officer on duty is required to wear the official uniform and equipment'[213]. The parts of the uniform as well as rank insignia, name tags and their wearing rules are laid down in the Regulation of the Minister of the Interior and Administration of 20 May 2009 on police uniforms[214] and apply to every police officer in accordance with the requirements set out therein.

In the opinion of the National Mechanism, the identification of officers of combat and operational units that take part e.g. in securing public demonstrations is contrary to the standards and recommendations of international institutions operating within the human rights protection systems of the United Nations and the Council of Europe.

In the opinion of the CPT, officers should not wear balaclavas while performing their duties, mainly because it hinders identification of the responsible person in the case of allegations of misconduct. Only in exceptional situations should face covering by police officers be permitted[215].

In its judgments, the European Court of Human Rights draws attention to situations in which masked officers of uniformed services, under the pretext of performing their official duties, commit acts of violence against persons deprived of their liberty. The ECtHR criticised the anonymity of the officers. In one of its judgments, the ECtHR pointed out as follows: "The Court considers that, by allowing the special-unit officers to cover their faces with balaclava masks and not requiring them to wear any distinctive signs on their clothing, the domestic authorities knowingly made futile any future attempts to have them identified by the victims. The impossibility for the victims to tell the identically clad rank-and-file unit officers apart was invoked as the main ground for discontinuing the criminal proceedings against those officers (see paragraph 47 above), whereas the proceedings against their commander Mr B. – the only person whose face had not been covered – were discontinued on the charge of abuse of power because he had not beaten anyone himself (see paragraph 49 above). Given that the reports on the use of rubber truncheons did not list the name of the officer who administered the blows, the Court finds that the domestic authorities deliberately created a situation of impunity in which any identification of the officers suspected of inflicting ill-treatment was impossible and an investigation inadequate"[216].

13. Audio and video recording of police interrogations

Interrogations conducted at the visited police stations[217] are, as a rule, not recorded although the regulations on criminal proceedings provide for the possibility of image or sound recording[218]. Unrecorded interrogations in the absence of a third party (e.g. a defence counsel) entail a significant risk of torture.

The CPT underlines that audio and video recording of interrogations is an important additional safeguard against ill-treatment of detainees. Such recording can provide a complete record of the co-

[209] RDP at the Poviat Police Headquarters in Opoczno (KMP.570.13.2023).
[210] RDP at the Poviat Police Headquarters in Rawicz (KMP.570.14.2023), RDP at the Poviat Police Headquarters in Lubliniec (KMP.570.9.2023), RDP at the Poviat Police Headquarters in Pułtusk (KMP.570.10.2023) and RDP at the Poviat Police Headquarters in Otwock (KMP.570.1.2023).
[211] RDP at the Poviat Police Headquarters in Turek (KMP.570.16.2023).
[212] See: Article 60(1) of the Act on the Police of 6 April 1990.
[213] Exceptions to the rules are precisely defined and relate e.g. to officers of the Central Investigation Bureau of the Police, who are required to show their ID cards instead of wearing badges; this, yet, is not relevant to the case discussed.
[214] Journal of Laws No. 90, item 738, as amended.
[215] See: CPT report on the visit to Slovenia in 2000, CPT/Inf (2001) 29, para. 19.
[216] See: Judgment of the ECtHR of 15 May 2008 in the case of *Dedovskiy and others v. Russia*, application no. 7178/03.
[217] RDP at the Poviat Police Headquarters in Strzyżów (KMP.570.3.2023).
[218] See: Article 147 of the Act of 6 June 1997 – Code of Criminal Procedure.

nversation with the detainee, thereby greatly facilitating the investigation of any allegations of ill-treatment, including psychological pressure. The CPT also recommends that initial questioning by operational officers be recorded and that police stations have special rooms with equipment ensuring audio and video recording of police interrogations[219].

International experts also emphasise that recording of police interrogations makes it possible to retain original evidence of verbal communication, reduces the number of complaints regarding police abuse and can be useful for training purposes[220]. It also reduces the risk of evidence being questioned on the grounds of doubt as to whether a given statement or explanation has been made voluntarily. The exclusion of evidence creates enormous costs for the justice system[221].

PENITENTIARY ESTABLISHMENTS

In 2023, the National Preventive Mechanism carried out monitoring visits to seventeen penitentiary establishments[222]. Two of the visits[223] were focused on verifying compliance with the prohibition of ill--treatment, set out in Article 21(1) of the OPCAT.

■ Good practices

- **The operation of the Prison Media television and radio station** via which information of various types is provided to inmates. The published content includes announcements from the Prison Service, educational spots on how to behave during the pandemic, information on healthy lifestyle or counteracting addiction and domestic violence[224].
- **Readaptation with the use of dog therapy - the "Help Me Out" programme:** several editions of the programme have already been conducted based on dog therapy as a recognised therapeutic method in social rehabilitation[225].
- **Study visits for teenagers** – the penitentiary establishment implements the national programmes entitled 'In Service of Law' and 'Penitentiary Class', addressed to students of high schools, upper secondary schools, vocational schools and higher grades of primary school in the region of Podkarpacie[226].
- **Charity campaigns** - artworks made as part of occupational therapy are sold during charity actions such as the annual finals of the Great Orchestra of Christmas Charity, Siepomaga Foundation and Pod Skrzydłem Anioła [Under Angel's Wings] Association[227].
- **Opportunity for inmates of various employment at the establishment's workshops**[228].
- **Possibilities of undergoing addiction therapy, also outside the establishment**[229].

■ Systemic problems

1. Small number of penitentiary establishments/wards for women

The annual statistical report for 2022, drawn up by the Prison Service Central Administration[230] indicates that as of 31 December 2022 there were 175 penitentiary establishments in Poland and 27 of them had

[219] See: CPT report on the visit to Lithuania, CPT/Inf (2018) 2, para. 24; CPT report on the visit to Azerbaijan, CPT/Inf (2018) 37, para. 42; CPT reports on the visits to Serbia: CPT/Inf (2018) 21, para. 16 and CPT/Inf (2016) 21, para. 30 and CPT report on the visit to Russia, CPT/Inf (2013) 41, para. 28, point 3.

[220] See: Seminar Report, Seminar on combatting torture during police custody and pre-trial detention, 22-23 March 2018 in Copenhagen, Denmark.

[221] See: Symposium on Procedural Safeguards in the first hours of police custody, Outcome Report, APT, 2017, p. 22.

[222] Prison in Barczewo (KMP.571.13.2022), prison in Łowicz (KMP.571.2.2023), prison in Włocławek (KMP.571.4.2023), prison in Potulice (KMP.571.5.2023), prison in Sztum (KMP.571.6.2023), prison in Chełm (KMP.571.8.2023), prison in Grudziądz (KMP.571.13.2023), prison in Tarnów (KMP.571.15.2023), prison in Rawicz (KMP.571.17.2023), prison in Rzeszów (KMP.571.18.2023), branch unit of the remand prison in Kraków-Nowa Huta (KMP.571.10.2023), Stawiszyn branch unit of the remand prison in Grójec (KMP.571.9.2023), Lubliniec branch unit of the prison in Herby (KMP.571.12.2023), Płońsk branch unit of the prison in Płock (KMP.571.20.2023).

[223] Prison in Potulice (KMP.571.5.2023) and prison in Grudziądz (KMP.571.13.2023).

[224] Prison in Włocławek.

[225] Prison in Rzeszów.

[226] Ibid.

[227] Ibid.

[228] Ibid.

[229] Ibid.

[230] See: Annual Statistical Information for 2022, Ministry of Justice, Prison Service Central Administration, BIS.0332.16.2022.MM, p. 3, available at: https://www.sw.gov.pl/strona/Statystyka.

wards for women (of these, 4 had wards for remand prisoners only). The number is insufficient given the need for penitentiary establishments appropriate for female prisoners, with the possibilities of individual approach referred to in Article 82 of the Penal Code and of contact with closed persons in the form of visits.

Nine penitentiary establishments[231] have open wards for women. Each of them has a ward for first-time offenders, 8 have wards for repeat offenders, and 5 have wards where juvenile offenders may be placed. 15 establishments have semi-open wards and 12 have closed-regime wards[232]. Few establishments have wards providing therapy for women: with non-psychotic mental disorders or mental disabilities (2 wards in Poland), alcohol addiction (3 wards) and addiction to psychoactive substances other than alcohol (1 ward).

The small number of prisons for women means that they are often placed in locations far from their place of residence. Already many years ago, the Commissioner drew attention to the problem of placing prisoners (both women and men) in establishments located far from their place of residence. He emphasised that current regulations do not provide for sentences to be served as close as possible to the place of residence[233].

The situation of women in this respect is more difficult due to the small number of women's wards. Moreover, the number of women deprived of their liberty has been increasing in the last years. In 2011, women accounted for 3.17% of the prison population in Poland (2,598 inmates[234]), in 2018 - 4.13% (3,017 inmates[235]) and in 2023 - 5.08% (3,811 inmates[236]).

The need to place prisoners in establishments as close as possible to their place of residence is mentioned by the European Prison Rules (Rules 17.1, 17.2, and 17.3)[237], the Nelson Mandela Rules (Rule 59)[238], and the Bangkok Rules (Rule 4)[239].

One of the key factors that helps inmates to reintegrate into society is their relationship with their families. Women's access to in-person meetings with their families is limited due to the small number of women's wards Thus, it is a duty of the authorities to take special effort to ensure that women are placed close to their place of residence. The choice of the establishment should be made after contacting the prisoner and taking into account her personal situation related to domestic violence and other forms of violence. Some women may not want to be placed close to their homes. They may prefer to stay away from their husband, partner or other person who was a perpetrator of violence against them prior to their imprisonment[240].

2. Access to hygiene products for female prisoners

Surveys on menstrual awareness show that women who live in poverty experience menstrual exclusion more frequently[241]. The situation of women in penitentiary establishments, most of whom come from low-income families, seems particularly difficult in this respect.

In one of the visited penitentiary estab lishments[242] women got one pack (20 pieces) of sanitary pads per month. Additional unpaid pads could be obtained based on a prescription from a gynaecologist or general practitioner. Inmates could also buy sanitary pads or tampons in the prison canteen shop.

The surveys also show that sanitary pads provided by the Prison Service are generally of low quality, are uncomfortable to wear, provide poor protection and pose a risk of soiling bedding. Other problems mentioned included: rationed availability of painkillers, problems with toilet availability (1 toilet per cell,

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231 The number includes the closed-regime ward in Lubliniec which, despite its status, never operated as an open ward.

232 See: Prisons and remand prisons 4by type of use as of 8 January 2024. Available at: https://www.sw.gov.pl/strona/statystyka-przeznaczenie-zk-i-as.

233 The requirement to place convicts in penitentiary establishments closest to their place of residence was abolished by the amendment to the Executive Penal Code of 2012 (Act of 16 September 2011 amending the Act - Executive Penal Code and certain other acts, Journal of Laws No. 240, item 1431).

234 As of 30 November 2011. See: Annual Statistical Information of the Prison Service Central Administration for 2011. Available at: https://www.sw.gov.pl/strona/Statystyka.

235 As of 30 November 2018. See: Annual Statistical Information of the Prison Service Central Administration for 2018. Available at: https://www.sw.gov.pl/strona/Statystyka.

236 As of 30 November 2023. See: Annual Statistical Information of the Prison Service Central Administration for November 2023. Available at: https://www.sw.gov.pl/strona/Statystyka.

237 See: Recommendation Rec (2006) 2 of the Committee of Ministers to member states of the Council of Europe on European Prison Rules.

238 See: United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), Resolution adopted by the UN General Assembly on 17 December 2015.

239 See: United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), Resolution adopted by the United Nations General Assembly on 21 December 2010.

240 The issue is described in more detail in the report on the visit to Lubliniec branch unit of the prison in Herby, pp. 5–10.

241 See: Menstruation. Report on a qualitative and quantitative survey by *Difference* company for the Kulczyk Foundation, Warsaw, February 2020, pp. 76–77. Available at: https://kulczykfoundation.org.pl/uploads/media/default/0001/05/0fbe618f4aa748170c8b3f096367e2c607888eb8.pdf.

242 Lubliniec branch unit of the prison in Herby.

which is a problem when more than woman has a period) and no conditions for reducing tensions (no possibility of staying by oneself to rest or relax)[243].

The national regulations are unclear about female prisoners' access to sanitary pads. The Regulation of the Minister of Justice of 19 December 2016 on living conditions of detainees in prisons and remand prisons[244] states that a female prisoner shall receive one pack of sanitary products upon reporting the need.

At the same time, Instruction no. 1 of the Director General of the Prison Service of 21 November 2018 on the treatment of female prisoners refers to the need to ensure proper hygiene conditions in penitentiary establishments for women, e.g. by broadening the offer of items available from canteen shops by selected hygiene products (Article 6(2) of the Instruction). However, it does not solve the problem of free access to hygiene products for women who do not have money and cannot count on anyone from outside.

There can also be problems related to access to hot water. According to the Regulation of the Minister of Justice of 23 December 2022 on organisational rules on serving the penalty of deprivation of liberty[245], a convicted woman shall have access to hot water at least once a day, and to a hot bath twice a week (Article 27(4)). Exceptions to this rule are possible only for pregnant women and breastfeeding women in prisons (Article 24).

The lack or insufficient amount of sanitary products and the lack of constant access to hot water during menstruation can have serious consequences, including health problems (urinary tract infections and pain), psychological problems (stigma and feeling of shame) and economic problems (due to limited ability to engage in professional work)[246].

The CPT emphasises that women's specific hygiene needs should be adequately addressed. Ready access to sanitary and washing facilities, adequate quantities of essential hygiene products, such as sanitary towels and tampons, and safe disposal arrangements for blood-stained articles, are of particular importance. The failure to provide women in prison with such items can amount, in itself, to degrading treatment[247].

The Bangkok Rules state that the accommodation of women prisoners shall have facilities and materials required to meet women's specific hygiene needs, including sanitary towels provided free of charge and a regular supply of water to be made available for the personal care of children and women, in particular women involved in cooking and those who are pregnant, breastfeeding or menstruating (Rule 5).

3. Presence of non-medical personnel during medical examinations

It is practically a standard practice of all the visited establishments that Prison Service officers are present during inmates' medical examinations conducted outside the prison (and, in some cases, also within it)[248]. In the opinion of the NPM, all medical examinations of inmates (upon admission and at a later stage) should be carried out of the hearing and out of the sight of Prison Service officers, unless the doctor requests their presence during the examination.

In one of the visited prisons[249] there was even a situation in which an inmate in a cell was restrained with a multi-part belt and, thus, could not pose any danger to himself or the doctor, yet as many as four officers were present in the cell. In the situation, there was also unacceptable interference on the part of the officers, as during the medical interview one of them started to add his comments, e.g. 'you don't look like you have any illness'. The inmate tried to continue his answer but the officer added: 'so I don't know the point of this all...'.

The CPT points out that the presence of custodial staff during medical examinations is detrimental to the establishment of a proper doctor-patient relationship and is usually unnecessary from a security point of view. The Committee encourages custodial staff to seek alternative solutions to reconcile

[243] Item, p. 75.
[244] Journal of Laws of 2024, item 1406.
[245] Journal of Laws, item 2847.
[246] See: Summary of the report entitled: 'A bloody problem: period poverty, why we need to end it and how to do it'. https://kulczykfoundation.org.pl/uploads/media/default/0001/05/63f40c6daa0e66cc61a60928481788dc936a6db0.pdf.
[247] See: Women in prison, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CPT/Inf (2018) 5, p. 4, available at: https://www.coe.int/en/web/cpt/women-in-prison.
[248] Prison in Potulice (KMP.571.5.2023), prison in Barczewo (KMP.571.13.2022), prison in Sztum (KMP.571.6.2023), prison in Tarnów (KMP.571.15.2023), branch unit of the remand prison in Kraków-Nowa Huta (KMP.571.10.2023), branch unit in Stawiszyn (KMP.571.9.2023), remand prison in Mysłowice (BPK.571.3.2023), prison in Chełm (KMP.571.8.2023), prison in Łowicz (KMP.571.2.2023) and prison in Grudziądz (KMP.571.13.2023).
[249] Prison in Sztum.

legitimate security requirements with the principle of medical confidentiality. One possibility might be the installation of a call system[250].

The SPT has also issued a recommendation that any medical examination, including examinations upon admission to prison, should strictly observe the right to privacy and confidentiality[251]. The Sub-committee is of the opinion that the performance of medical examinations in the presence of other officials, such as members of the convoy or guards on duty, infringes upon confidentiality and may discourage a discussion of injuries resulting from torture and ill-treatment[252].

The provisions of the Executive Penal Code, however, stand in opposition to the standards set out above. Paragraph 7a added to Article 115 of the Executive Penal Code provides that in the case of a convict who poses a significant threat to the society or the security of the establishment, or a convict who, during his or her stay in a remand prison or a prison has violated the disciplinary system and order of the establishment, medical services are, as a rule, provided in the presence of an officer who is not a medical professional.

Similar provisions apply to convicts serving a prison sentence in a closed prison if medical services are provided to them outside the establishment. This means that, for example, a convict who is not a repeat offender, is not aggressive and is serving a sentence in such establishment has to be handcuffed while waiting for a medical visit among other patients, undergoing medical examinations and communicating with medical personnel.

4. Protective measures

In 2022, changes were introduced in the field of security measures in penitentiary establishments[253]. The new measures relate mainly to professionals (psychologists, correctional officers and therapists) who conduct one-to-one meetings with prisoners in their official rooms. Currently, prisoners are handcuffed during such meetings (in some cases, a security officer is also present during the conversation). In the professional's room, the prisoner may not cross the line that is marked on the floor with yellow and black tape. The room is monitored through glass windows in the door. During the meeting prisoners stand or sit if permitted. The changes also require some staff members who previously did not wear uniforms (e.g. psychologists) to wear a uniform during their work.

In the opinion of the National Mechanism, the system described above reduces contact with every prisoner, regardless of the individual circumstances, to a potential threat. This, in turn, makes it impossible to establish a mutual relationship based on trust.

The Mechanism has also negatively assessed the requirement for prisoners to stand during meetings with correctional officers or psychologists (a prisoner may sit down only upon permission) and the identified practice of conducting several-minute conversations in the presence of other officers, with the prisoner standing and the door open.

In the opinion of the NPM, the requirement to stand is an unjustified difficulty. The lack of confidentiality of the conversation, in turn, may affect the possibility to communicate and build a relationship, which is an element of key importance for the effects of the meeting and further interaction. For this reason, all security measures should be individually adjusted based on a detailed risk analysis and should be proportionate to the actual degree of threat posed by a particular inmate.

5. Organisation of the election and referendum procedures

During general elections and referendums, the instruction of the Director General of the Prison Service of 5 October 2003[254] regarding their organisation has to be followed. According to the instruction, prisoners are required to be taken to the ballot points in handcuffs. Any exemption from the requirement has to be based on a decision of the establishment Director, issued pursuant to Article 19(7) of the Act on the Prison Service of 9 April 2010[255]. In one of the visited establishments[256] it was found that the exemption had been applied only with regard to two persons due to their physical disability.

As a result, about 1,000 inmates had to be handcuffed one by one and taken to the ballot point to vote in the handcuffs. This created a big organisational problem, especially that, despite the large number of voters, there was only one ballot point in the prison.

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[250] See: CPT report on the visit to Poland, CPT/Inf (2014) 21, para. 79.
[251] See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, para. 104.
[252] See: SPT report on the visit to Ukraine, CAT/OP/UKR/3, para. 53.
[253] See: Letter of the Director General of the Prison Service of 6 April 2022, ref. no. BDG.070.40.2022.KS.
[254] BO.070.35.2023.MD.
[255] Journal of Laws of 2023, item 1683.
[256] Prison in Rzeszów (KMP.571.18.2023.DK).

6. Medical examination of persons placed in penitentiary establishments and the absence of procedures to be followed in cases of reported torture in order to document injuries

The NPM visits have once again shown that not every person placed in a penitentiary establishment undergoes a medical examination. Only „newly detained" people are examined; inmates who are moved between penitentiary establishments are not[257]. The procedure is usually limited to a medical interview by a nurse who refers the detainee to a doctor if necessary. There is no requirement for obligatory physical examination of all first-time detainees, including body examination. The practice causes a large gap in the system of preventing torture and ill-treatment. Even if a prisoner has undergone a medical examination before being moved to another establishment, the lack of such an examination upon arrival to the place makes it impossible to discover signs of any potential violence used against the prisoner during his/her convoying.

The experience of the NPM shows that the examination by a doctor is often superficial and is limited to interviewing the patient, without checking his/her body (conducting a physical examination). The fact that medical personnel limit themselves to interviewing the patient, without examining his/her body, makes it impossible to discover signs of violence and, consequently, makes this minimum anti-torture safeguard ineffective.

The NPM has called in its subsequent annual reports, since 2016, for the adoption by the Prison Service of procedures to be followed when a prisoner has reported that he/she has been a victim of torture or violence or when the use of torture or violence against a prisoner is suspected, and the NPM's call is still valid[258]. The lack of a clear system leads to irregularities that are revealed during subsequent visits by the NPM to penitentiary establishments.

When analysing medical records of selected prisoners the NPM representatives came across extremely brief descriptions of injuries (e.g. 'skin abrasion'). There was no information on the possible reasons or size of the injury. Another shortcoming was the lack of information on the injuries of a detainee who, according to the personnel, had made cuts on his chest himself. There was no mention of this fact in the detainee's medical records. Thus, doubts occurred as to whether it was just an omission and negligence in keeping the medical records, or the inmate (after the self-mutilation) had not been taken to the medical room at all[259].

The method of documenting injuries also needs improvement. They are most often recorded in inmates' medical records or in the form of official notes. The prison staff do not take photographs of injuries and do not use the special medical form containing an outline of a human body (the so-called body map) to mark the examined person's injuries[260].

In the opinion of the NPM, prison staff (including medical staff) need professional support in identifying and documenting signs of torture and other forms of ill-treatment, including training in the Istanbul Protocol[261]. Another significant problem is the ability to detect traces of torture inflicted by certain methods (e.g. stun guns), especially in the context of granting the Prison Service the power to use such devices. In the opinion of the NPM, medical personnel in penitentiary units must be adequately prepared to reliably diagnose the effects of the use of this weapon and be able to detect and properly document any abuse.

The CPT called on the Polish authorities to put in place specific injury registers in every penitentiary establishment. The CPT also calls upon the Polish authorities to take steps to ensure that the record drawn up after the comprehensive medical examination of a newly-arrived prisoner contains: (i) an account of statements made by the person concerned which are relevant to the medical examination (including their description of their state of health and any allegations of ill-treatment); (ii) a full account of objective medical findings based on a thorough examination, and (iii) the doctor's observations, in light of (i) and (ii), indicating the consistency between any allegations made and the objective medical findings. The report should also contain the results of additional examinations carried out, the detailed conclusions of any consultations with specialists and a report of the treatment given for the injuries and any other procedure carried out[262].

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[257] Only the prison in Rzeszów was an exception as medical examinations were conducted both for prisoners admitted to the prison and those transferred there from other establishments.

[258] See: Reports of the Commissioner for Human Rights on the activities of the NPM in Poland in 2018, 2019, 2020, 2021 and 2022.

[259] See: NPM report on the visit to the prison in Potulice (KMP.571.5.2023).

[260] See: CPT report on the visit to Poland in 2022, CPT/Inf (2018) 56, para. 57; see also: CPT observations and recommendation included in the report on the ad hoc visit in 2019, CPT/Inf (2020) 31, para. 26.

[261] See: Istanbul Protocol. Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. The document is available at: https://bip.brpo.gov.pl/pl/content/rpo-protokol-stambulski-nowa-wersja-tlumaczenie-ms-odpowiedz-kolejna.

[262] See: CPT report on the visit to Poland in 2022, CPT/Inf (2022) 56, para. 57.

The SPT points out that initial physical examination of all the inmates should be carried out with the use of a standard questionnaire which, apart from general questions regarding health, should include descriptions of all recent acts of violence experienced by the inmate concerned. A doctor should carry out a full physical examination, including inspection of the whole body. If the doctor has reasons to suspect the prisoner has been subjected to torture or other forms of abuse, he should inform relevant authorities immediately. The same should apply to any injuries suffered in the penitentiary establishment. Moreover, the SPT recommends the adoption of procedures to ensure that any injuries reflecting the inmate's report about ill-treatment (or suggesting ill-treatment even if it has not been reported by the inmate), are reported to competent authorities regardless of whether the inmate has requested to report them or not. The results of the inmate's physical examination should be available to the inmate concerned, and to his/her lawyer[263].

7. Standard applicable to the number of penitentiary psychologists

The need to increase the number of psychologists employed in penitentiary establishments has been raised by the CHR in his general intervention letters to the Director General of the Prison Service[264] and has been mentioned in the NPM annual reports[265]. According to the current standard, one psychologist can conduct psychological assessment, provide psychological assistance and work with a group of up to 200 inmates[266]. In the opinion of the NPM, psychological support in prisons is insufficient and the existing standard does not ensure the effectiveness of the support.

In one of the visited prisons, according to the director's order on the organisational structure and list of positions in the establishment, there were six full-time positions for psychologists in the penitentiary wards and two full-time positions for psychologists in the therapy ward for inmates addicted to psychotropic substances other than alcohol. As a rule, individual psychologists from the penitentiary wards were assigned to specific wards. Detailed work schedules of the staff, available e.g. in the correctional officers' rooms, referred to five psychologists and included clear rules for their substitution in the event two or three psychologists are absent from work. During the NPM visit, however, the schedule was of no use as there was only one psychologist from a penitentiary ward in the whole establishment. The others were absent e.g. due to sick leave. Thus, during the visit of the National Mechanism one psychologist from a penitentiary ward had over 1,200 inmates to support (during the visit, there were 1,255 inmates in the establishment, of whom 33 were placed in the therapy ward)[267].

The Report of the Supreme Audit Office has emphasised that „The very large number of prisoners per psychologist results in a limited possibility of conducting examinations, even on urgent basis, of persons who have suicidal thoughts. It also causes problems relating to the provision of psychological support and drawing up recommendations for prisoners with registered suicidal attempts. Doubts are also raised with regard to the possibility to provide actual assistance to prisoners who require it, even within the system of crisis intervention"[268].

8. Situation of inmates with reduced physical abilities, chronic somatic diseases or old age

Within the Polish penitentiary system there is only one prison hospital ward for inmates with chronic somatic diseases, i.e. the Ward for Chronically Ill Prisoners in the prison in Czarne. As a result of a limited number of places in the facility, in some cases inmates have to wait for admission for more than a year.

During one of the visits, representatives of the NPM noted the presence of an inmate who, due to his health condition, required assistance from others in his daily activities. The inmate was held in a cell with other inmates who had agreed to help him but had not undergone any training in care provision to elderly or disabled persons. In addition, the cell in which the inmate lived did not have any support facilities for people with reduced mobility (handrails or a walker). The inmate had problems with consistency but did not get any disposable pads to protect the mattress from soiling. Also, information obtained by the NPM the inmate suffered from a fungal infection but had not been provided e.g. with separate washing bowl for his use so as to reduce the risk of transmitting the disease to his fellow inmates[269].

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[263] See: SPT report on the visit to Poland, CAT/OP/POL/ROSP/1, paras. 106 and 107.

[264] See: General intervention letters of the CHR to the Director General of the Prison Service of 17 May 2016, 19 February 2019 and 10 November 2020 (ref. no. KMP.571.8.2016).

[265] See: Reports of the Commissioner for Human Rights on the activities of the NPM in Poland in 2019, 2020, 2021 and 2022.

[266] See: Article 3(2) of Order No. 19/16 of the Director General of the Prison Service of 14 April 2016 on the detailed rules of conduct and organization of penitentiary work and on the scopes of activities of officers and employees of penitentiary and therapeutic units and penitentiary wards.

[267] See: NPM report on the visit to the prison in Włocławek (KMP.571.4.2023).

[268] Supreme Audit Office, Information on audit results: safety of prisoners, KPB.430.002.2020, ref. no. 52/2020/P/19/040/KPB, p. 58.

[269] See: NPM report on the visit to the prison in Sztum (KMP.571.6.2023).

One of the key problems in the area of support for dependent persons in penitentiary establishments is the lack of personnel specialised in care provision to chronically ill persons. This is particularly visible in cases of patients who require daily support in maintaining personal hygiene. In practice, the support is provided by cellmates who provide such assistance, to a greater or lesser extent, on their own initiative and without prior training. Another issue is the living conditions, e.g. architectural barriers that make it difficult for dependent inmates to move within the establishment (and thus have the same rights as others), and the lack or non-adjustment of facilities in the cell.

The situation of female prisoners in this regard is even more difficult. A significant systemic problem is the insufficient number of places in prison hospital wards for female prisoners who require medical care 24 hours a day[270].

The CPT recommends that prisoners who provide assistance to other dependent prisoners be provided with comprehensive training in the field of care of persons with disabilities[271].

The case law of the European Court of Human Rights states that detaining persons suffering from a serious physical disability in conditions inappropriate to their state of health, or leaving such persons in the hands of their cellmates for help with bathing and getting dressed or undressed is unacceptable as it amounts to degrading treatment[272].

9. Transgender persons in penitentiary establishments

During one of the visits in 2023, the NPM representatives met with a transgender prisoner[273]. Monitoring the situation of transgender inmates is of importance for the NPM in view of the urgent need to introduce systemic solutions and change the practice of dealing with transgender people in Polish penitentiary establishments. The issue has been discussed at length in the NPM's annual report for 2022[274] where, in line with the international standards, the Mechanism raised the need for reforms in areas such as: the inclusion of information on prisoner's gender identity in registers of prisoners, conditions and regime of imprisonment, body search, medical treatment and therapy, use of pronouns, image and staff training. The NPM calls for urgent changes in these areas as in 2023 no significant progress was made.

10. Activities for remand prisoners

The problem of a poor offer of cultural and educational activities for detainees in remand prisons was identified by the NPM already in 2014 and was referred to in the thematic report on the situation of detainees[275].

The visits conducted in 2023 and in the years before demonstrated that the situation had not improved. Remand prisoners spend most of their time (on average, 23 hours a day) in their cells. They may go for a one-hour walk a day and spend some time in the association room (on average, about one hour once or twice a week). They may also borrow books from the library. An example can be one of the visited remand prisons[276] where, on the day of the NPM's visit, there were 19 women in pre-trial detention. Apart from daily walks they could participate in activities in the common room (table football, table tennis and arts activities).

Physical activities for prisoners not only improve their well-being but are also an important factor in relieving tension and counteracting aggression. Of particular importance are outdoor activities that allow to intensify physical effort.

The CPT calls upon the Polish authorities to take decisive steps to develop programmes of activities for remand prisoners. The aim should be to ensure that prisoners are able to spend a reasonable

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[270] See: NPM report on the visit to Lubliniec branch unit of the prison in Herby (KMP.571.12.2023).

[271] See: CPT report on the visit to Italy in 2012, CPT/Inf (2013) 32, paras. 74–75.

[272] See: Judgment of the European Court of Human Rights of 12 February 2013 in the case of *D. G. v. Poland*, application no. 45705/07.

[273] Her situation is described in detail in point 5.4 of the report on the visit to the prison in Potulice https://bip.brpo.gov.pl/pl/kmpt/wizytacja-kmpt-w-zakladzie-karnym-w-potulicach.

[274] See: Report on the activities of the NPM in 2022 https://bip.brpo.gov.pl/pl/content/rpo-raport-dzialalnosc--kmpt-2022.

[275] See: Visits of the NPM to prisons' therapy wards for inmates with non-psychotic mental disorders or mental retardation, and wards for remand prisoners – a report available at: https://bip.brpo.gov.pl/pl/content/wizytacje-krajowego-mechanizmu-prewencji-oddzialow-terapeutycznych.

[276] Lubliniec branch unit of the prison in Herby.

part of the day (8 hours or more) outside their cells, engaged in purposeful activities of a varied nature (work, education, sport, etc.)[277].

11. Small living space

Measurements of the floor space of selected cells, taken during the visits, as well as analysis of documentation on the placement of inmates showed that they have at least 3 m² of living space per person, which is in line with the national law[278]. However, the standard is contrary to international standards and the practice followed by most European countries[279]. For years[280], the NPM has been calling for legislative changes to increase the living space per prisoner.

The minimum living space recommended to the Council of Europe member states is 6 m2 in a multiple-occupancy cell and 4 m2 in a single-occupancy cell, excluding the toilet area. Also, every cell should have at least 2 m between the walls and 2.5 m between the floor and the ceiling[281].

The SPT, in the report on the visit to Poland in 2018, recommended that the State party increase the minimum standard of living space per prisoner to the above-mentioned level. Poland should also recalculate the formally existing number of places in cells in penitentiary establishments[282].

The CPT points out that large-capacity dormitories inevitably imply a lack of privacy for prisoners in their everyday lives. Moreover, the risk of intimidation and violence is high. Such accommodation arrangements are prone to Foster the development of offender subcultures. They can also render proper staff control extremely difficult, if not impossible. Further, in such a situation the excessive burden on communal facilities such as washbasins or lavatories and the insufficient ventilation for so many persons will often lead to deplorable conditions[283].

In one of the establishments visited in 2023[284] there were 28 cells with the capacity of 11 beds. Although some of them were not fully occupied, the inmates pointed out that such a large capacity leads to various difficulties, e.g. in the case of morning washing. In other establishments visited in 2023 there were two 11-person cells[285], four 12-person cells and two 13-person cells[286]. The Ministry of Justice takes efforts to gradually eliminate cells for over 10 prisoners. As of 2 April 2024, of 379 cells existing in Polish penitentiary establishments, there were 24 multi-person cells for over 10 prisoners (2 cells for 11 persons, 1 cell for 15 persons and 21 cells for 16 persons). The cells, however, were no longer in use[287].

12. Washbasins located outside toilets

At the time of the visits to penitentiary establishments[288], some cells had washbasins at places other than toilets. According to Article 25(1) of the Regulation of the Minister of Justice of 23 December 2022 on the organisational rules on serving the penalty of deprivation of liberty[289] and Article 21 of the Regulation of the Minister of Justice of 23 December 2022 on the organisational rules on remand imprisonment[290], necessary sanitary facilities should be installed in places ensuring their unhindered use. Undoubtedly, a washbasin is a necessary sanitary item and should therefore be located at a place ensuring its unhindered use.

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277 See: CPT report on the visit to Poland in 2022, CPT/Inf (2022) 56, para. 55.
278 See: Article 110(2) of the Act of 6 June 1997 – Executive Penal Code (Journal of Laws of 2024, item 706).
279 See: European Union Agency for Fundamental Rights, Criminal detention conditions in the European Union: rules and reality; December 2019, point 1.2. National standards; pp. 17-19.
280 See: Reports of the Commissioner for Human Rights on the activities of the NPM in Poland in 2019, 2020, 2021 and 2022.
281 See: Living space per prisoner in prison establishments: CPT standards, 15 December 2015, CPT/Inf (2015) 44; Twenty-CPT Sixth General Report, CPT/Inf (2017) 5, para. 56; CPT report on the visit to Poland, CPT/Inf (2022) 56, para. 53.
282 See: SPT report on the visit to Poland, CAT/OP/POL/ROSP/1, paras. 80–81.
283 See: Extract from Eleventh General Report, CPT/Inf (2001) 16, para. 21.
284 Prison in Łowicz.
285 Branch unit of the remand prison in Kraków-Nowa Huta and Stawiszów branch unit of the remand prison in Grójec.
286 Prison in Rzeszów.
287 See: https://bip.brpo.gov.pl/pl/content/rpo-sw-zabudowa-kacikow-sanitarnych-ponowne-odp.
288 Prison in Chełm, prison in Tarnów, branch unit of the remand prison in Kraków-Nowa and Lubliniec branch unit of the prison in Herby.
289 Journal of Laws of 2022, item 2847.
290 Journal of Laws of 2022, item 2848.

The issue was reported to the Director General of the Prison Service in the Commissioner's general intervention letters of 17 July 2015[291] and 10 March 2016[292] and, most recently, in a letter of 2 May 2023[293]. The Deputy Director General of the Prison Service informed that related works were ongoing[294].

■ Areas for improvement

1. Treatment of prisoners

Representatives of the NPM received numerous reports of probable use of physical and psychological violence (including verbal violence) by officers, as well as inhumane and degrading treatment of inmates[295]. The places where violence was reported to take place included unmonitored spaces such as shower rooms, storage rooms, common rooms, duty officer's rooms or rooms for unmonitored visits. There were also reports regarding the use of violence in cells and on the way to isolation cells.

The reports of physical violence concerned e.g. arm twisting or beating inmates on the heels with a baton. One of the inmates said that the latter practice was so widespread that prisoners were often threatened with it and asked: "Do you want your heels done?"[296]. In another prison[297] one of the inmates said he had been punched on the stomach by an officer. This was not the only case of violence at that prison as disciplinary and court proceedings were already pending with regard to its officers (a CCTV recording showed an officer striking an inmate on the face with his open hand). Another inmate reported that he had been beaten and kicked by officers in the body search room, with his hands handcuffed behind his back. He also said that, as a result, had visible bruises on his face but none of the officers who saw them asked how they occurred. None of the interviewed inmates lodged an official complaint because they were afraid of the consequences they could suffer.

In another prison, a prisoner decided to officially report an offence to law enforcement authorities via the Commissioner for Human Rights[298]. In his report the prisoner stated that he had been choked by a prison service officer, hit on the face, kicked and knocked to the floor, his arms were twisted, and the officer used offensive and humiliating language. Similar acts by prison service officers were also described by other prisoners.

The analysed CCTV footage of the use of coercive measures at another prison[299] shows an inmate taken out of his cell. He is unable to stand on his right leg, is limping and looks as if he were in pain. The recording from the cell also shows the inmate complaining about pain in the leg and saying 'I think it's broken'. Every time he is touched, he reacts to the pain and shouts 'my foot, my foot, my foot!'. The inmate then says, 'You beat me up again, why? I didn't do anything. The leg, my leg is broken, why did you break it?', and then adds 'Ouch, don't press my right foot, it's broken!'. One of the officers says, 'But you're kicking your legs all the time!', which is not visible in the footage. The inmate then says, 'Why did you beat me with a wooden baton? Couldn't you use the... ouch! the rubber one? Why did you use a wooden baton, you broke my bone! Was it wood or metal? Something is broken there!'

During another visit[300], the National Mechanism employees were informed of many violent acts against prisoners: beating and kicking them on the face, head or testicles, hitting them with a baton and a hammer used for checking the bars, and threats of rape. Some of the inmates reported the acts to the Public Prosecutor's Office. According to one of the inmates, the violence on the part of officers intensified after they had been informed of that report. The purpose was to have the report withdrawn. According to the information from the Prosecutor's Office, in 2023, 17 reports on the use of violence at that prison were received and the total number of such reports since 2016 had reached 82. In almost 60% of the cases the Office refused to instigate proceedings and in almost 33% of the cases proceedings were discontinued. One case resulted in an indictment regarding an officer.

According to inmates, psychological violence in the visited penitentiary establishments included verbal abuse, threats of sexual violence, addressing male inmates using feminine forms or offensive terms

[291] Letter of the CHR of 17 July 2015 regarding case ref. no. II.517.6121.2014.
[292] Letter of the CHR of 10 March 2016 regarding case ref. no. IX.517.1494.2015.
[293] Letter of the CHR of 2 May 2023 regarding case ref. no. IX.517.1494.2015.
[294] More information is available on the Commissioner's website: https://bip.brpo.gov.pl/sites/default/files/2024-04/Odpowiedz_SW_kaciki_sanitarne_cele_wieloosobowe_4_04_2024_1.pdf.
[295] Prison in Sztum, prison in Barczewo, prison in Potulice, prison in Tarnów, prison in Włocławek, prison in Łowicz and prison in Grudziądz.
[296] Prison in Sztum.
[297] Prison in Włocławek.
[298] Prison in Barczewo.
[299] Prison in Sztum.
[300] Prison in Tarnów.

such as 'thug', "cripple" or 'loser'. The lack of respect on the part of officers was also reflected in addressing inmates by their first names[301] or using impersonal forms.

During the visits conducted in 2023, the NPM representatives encountered the problem of excessive means of supervision by officers over inmates in their private moments, i.e. when using the toilet. A prisoner placed in a security cell was supervised by several officers even in the toilet[302]. The analysis of CCTV materials showed that the practice was applied regardless of detainees' behaviour in the security cell. There was also a case in which a detainee handcuffed to his bed was not taken to the toilet and, as a result, urinated and defecated on the bed. Later, when the officers were changing the bedding, the inmate was taken to the toilet were officers stayed with him although this was not necessary for maintaining security.

The right of prisoners to go for a walk was also mentioned. Inmates reported that refusal of a walk to prisoners placed in solitary confinement was a form of additional informal penalty[303].

2. Healthcare

Most prisons face shortages of medical personnel, which translates into a long waiting time for an appointment with a general practitioner. Specialist doctors work for penitentiary establishments part-time so their consultations are also available only after a long waiting period. According to the National Mechanism, the number of doctors employed in prisons and remand prisons, as well as their working hours, are insufficient for the number of inmates.

The situation is similar with regard to nurses[304] as their working hours do not meet the CPT standards. Following its visit to Poland in 2017, the CPT recommended that the Polish authorities take steps to ensure that a person competent to provide first aid (which should include being trained in the application of CPR and the use of a defibrillator) is always present in every prison establishment, including at night and on weekends; preferably, this person should be a qualified nurse[305].

Another issue is the dispensing of medications to prisoners. Outside the nurses' working hours, medications are dispensed by ward officers[306] for whom they are left by nurses who prepare them in advance. They usually leave them in ready-prepared doses, in envelopes signed with the patient's name and surname. However, officers, as non-medical staff, are not authorised to supervise the taking of medication by the patient. As a result, medications are sometimes kept by inmates and used in the future as "currency" in the prison.

During a visit to a penitentiary establishment for women[307] the visiting team heard reports of humiliating treatment of inmates by a doctor. During medical consultations the doctor allegedly made offensive or sex-related comments, e.g. asked questions about the inmates' favourite sex positions. Also, according to the inmates, those patients who exposed as much of their naked body as possible during medical examinations had better access to medication.

The NPM representatives also heard reports of inmates having difficulties with access to health care services due to the fact that they were persons deprived of liberty[308]. During the visit, the prison's medical staff informed that health care entities and specialist doctors were unwilling (or reluctant) to see prisoners as patients. The problem concerned e.g. access to psychiatric care, dermatologists and haematologists.

3. Body search

The NPM received numerous reports about conducting body search of prisoners as a single-stage procedure[309]. One of the interviewed prisoners reported that he had been subjected to a body search in the presence of three other prisoners[310]. Such conduct of the procedure constitutes degrading treatment. The recommended method of conducting body search is described in the Regulation of the Minister of Justice[311].

One of the analysed CCTV recordings shows officers escorting a prisoner to a security cell and leaving him there on the tiled floor. Only after some time the commanding officer gives the order to place a mat under the man's body, to search him and change his clothes. Serious doubts are raised by the fact that the man's clothes (including underwear) were changed by the officers. This was not necessary

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301 Prison in Potulice and prison in Włocławek.

302 Prison in Chełm, Lubliniec branch unit of the prison in Herby and prison in Łowicz.

303 Prison in Potulice.

304 Prison in Sztum, Stawiszyn branch unit, remand prison in Mysłowice, Lubliniec branch unit of the prison in Herby, prison in Włocławek, prison in Łowicz, prison in Grudziądz, Płońsk branch unit of the prison in Płock and prison in Rzeszów.

305 See: CPT report on the visit to Poland in 2017, CPT/Inf (2018) 39, para. 76.

306 Prison in Sztum, Stawiszyn branch unit, remand prison in Mysłowice and prison in Chełm.

307 Prison in Grudziądz.

308 Prison in Rzeszów.

309 Branch unit of the remand prison in Kraków-Nowa Huta, Stawiszyn branch unit, remand prison in Mysłowice, prison in Chełm, prison in Łowicz and prison in Rzeszów.

310 Stawiszyn branch unit.

311 Regulation of the Minister of Justice of 9 December 2022 on the detailed procedure of conducting search of prisoners, remand prisoners, places and objects, as well as templates of the search reports (Journal of Laws, item 2701).

in the situation and could be distressing for the man. The prisoner was not aggressive, did not fight or try to break free - he was only saying something all the time. In the opinion of the National Mechanism, measures should have been taken to minimise the man's feeling of shame and allow him to change his underwear and prison clothes himself[312].

The NPM representatives received numerous reports of possible cases of abuse related to body search of inmates[313]. After meetings with their relatives, inmates were subjected to body search during which they were often told to squat. This took place in a room assigned to visits to prisoners. The procedure was then repeated in the ward where the prisoner's cell was located, just a few minutes after the previous search. It should be emphasised that all the time the inmates remained in the establishment, under the supervision of prison officers, and had walked only along monitored spaces. Body search conducted in the ward comprising the prisoner's cell often took place in a monitored room for so-called secure visits where direct contact between the prisoner and the visitor is not possible. The visiting team found that in one of the wards, the psychologist's office was also used for conducting body search.

4. Contact with the outside world

In 2022, significant amendments were introduced to the Executive Penal Code. They related e.g. to the rules of making telephone calls. According to the newly adopted provision of the Code (Article 105b(1)): "a prisoner may use a payphone at least once a week at their own expense or at the expense of the call receiver, in a manner and on dates and times indicated in the internal regulation of the prison." Undoubtedly, the standard constitutes a guarantee of a minimum number of telephone calls made by prisoners and remand prisoners.

The visited establishments use the narrowing interpretation of the provision, according to which a prisoner may use a payphone only once a week, at their own expense or at the expense of the call receiver; in some establishments, the duration of a call may not exceed 10 minutes[314]. In addition, outside the above-mentioned limit inmates may make one telephone call per week to a person referred to in Article 8(3) of the Executive Penal Code, i.e. their legal representative or defence counsel. However, representatives of the NPM received reports that, contrary to the rules set out in the establishment's internal regulations, there had been cases where, in individual weeks, inmates had to choose between a telephone call to their relative and a call to their defence counsel[315].

In one of the visited establishments[316], there was a problem with rewards for prisoners in the form of permission for an unsupervised visit or permission for an unsupervised visit in a separate room. The system of the rewards is described in the 'list of types and numbers of rewards granted to prisoners', provided by the establishment upon the visit. According to it, the prison director is not required to grant such a reward to an inmate but the grounds for refusal of the reward have to be presented to the prisoner, which is subject to review by the penitentiary court[317]. It is therefore unacceptable not to grant the rewards at all and to refuse them, as a rule, to all prisoners. The practice was followed also by other establishments: in one of them[318] no reward had been granted throughout the period 2022-2023, and in another one[319] none had been granted since the beginning of 2021.

Representatives of the NPM also heard reports of problems with sending correspondence from the prison. They concerned both private correspondence and correspondence with the authorities referred to in Article 8a(3) of the Executive Penal Code[320]. Inmates claimed that some of the letters in which they reported irregularities taking place in the facility did not reach the addressees. The most frequent problem was not receiving acknowledgment of receipt of the correspondence, referred to in Article 105(7) of the Executive Penal Code.

5. Right to information and a complaint mechanism

A recurring problem is access to information by foreigners who do not understand and use Polish at a communicative level (both in speech and in writing). Many of the visited establishments did not have

312 Prison in Rawicz.
313 Ibid.
314 Prison in Sztum, prison in Tarnów, remand prison in Mysłowice, prison in Chełm, Lubliniec branch unit of the prison in Herby, prison in Łowicz, Płońsk branch unit of the prison in Płock and prison in Rawicz.
315 Prison in Sztum, prison in Potulice, remand centre in Mysłowice, prison in Chełm, prison in Łowicz, prison in Grudziądz.
316 Prison in Rzeszów.
317 According to Article 2(1)(12) of the Regulation of the Minister of Justice of 26 August 2003 on the manner, scope and procedure of exercising penitentiary supervision (Journal of Laws No. 152, item 1496), such supervision consists in the control and assessment e.g. of granting rewards and temporary leave from prison and of imposing disciplinary penalties as a means of correctional influence on prisoners.
318 Lubliniec branch unit of the prison in Herby.
319 Prison in Grudziądz.
320 Prison in Sztum, prison in Barczewo and prison in Grudziądz.

the organisational rules on serving the penalty of imprisonment and on remand imprisonment, and the internal regulations of the prison available in any language other than Polish. Furthermore, records of initial interviews held by correctional officers with foreign nationals did not contain information about the language in which a given inmate communicated or the language in which the interview had been conducted[321]. There were cases in which the regulation sheets contained in personal files of prisoners who were foreign nationals had not been signed by them[322], or the signature was placed under the text in Polish, which raises doubts as to whether the prisoner understood the text[323]. There was also a practice of communicating with prisoners-foreign nationals using the assistance of other prisoners[324]. The solution raised concerns of the NPM because in the case of a language barrier, a foreign national may be afraid to convey information to prison staff through a person who is not an external professional interpreter and who, thus, does not guarantee confidentiality.

During the visits, there were also reports that inmates were not aware of the possibility to read the Public Information Bulletin (PIB), as well as situations in which computer workstations with access to the Bulletin were out of use for various reasons or individual websites to which inmates should have access were not working[325].

During the monitoring visits it was also seen that notice boards for prisoners often lacked relevant information on contact details of authorities dealing with the protection of the rights of persons deprived of their liberty, or some of the information was out of date[326].

6. Coercive measures

The NPM points out that coercive measures have to be used in accordance with the rules set out in *Act on coercive measures and firearms*[327], including the principles of subsidiarity, proportionality and minimisation of damage. The principles require officers to assess the circumstances and dynamics of every incident on a case-by-case basis and to take individualised approach to every person with regard to whom coercive measures are to be applied.

The analysis of the footage of the application of coercive measures revealed a number of irregularities, e.g.:

- applying transport grappling in a manner causing pain; ignorance of such pain reported by prisoners; applying transport grappling in a way that makes it fully impossible for the prisoner to move; shouting instructions at prisoners[328];
- using pepper spray in a cell; making it impossible for an inmate to eat, drink and use the toilet, after leaving him in a protective helmet and a restraining for 16 hours[329];
- the practice of imposing a disciplinary penalty of 28 days in solitary confinement, contrary to the principle of penalty individualisation (the penalty was imposed 159 times between 2021 and 2023)[330];
- a broken arm with displacement, suffered by a prisoner during the application of physical restraint measures[331].

The NPM had also doubts regarding the forceful manner of conducting body search before the application of coercive measures. The analysed recordings show officers in a security cell using force during body search: handcuffed inmates are laid on the floor and pressed down by officers who then carry out body search that includes taking off prisoners' underwear[332].

In another prison[333], a recording was seen in which an inmate is taken to the security cell by two officers. On the way, the prisoner's shorts slip down. He enters the cell in his underwear, with his shorts around his ankles. He is placed on the floor on his stomach by the officers. His hands are handcuffed behind his back and there are three officers with him. Soon three more officers enter wearing personal protection equipment i.e. helmets and vests. The shift officer decides to carry out another body search despite the fact that the prisoner has remained under constant supervision of the officers after the

[321] Prison in Potulice, remand prison in Mysłowice, prison in Chełm, prison in Łowicz, prison in Włocławek, Płońsk branch unit of the prison in Płock, prison in Rzeszów and prison in Rawicz.
[322] Remand prison in Mysłowice.
[323] Prison in Chełm.
[324] Branch unit of the remand prison in Kraków-Nowa Huta.
[325] Prison in Rzeszów, prison in Rawicz, Płońsk branch unit of the prison in Płock, branch unit of the remand prison in Kraków-Nowa Huta and prison in Włocławek.
[326] Prison in Potulice, prison in Sztum, branch unit of the remand prison in Kraków-Nowa Huta, remand prison in Mysłowice, prison in Chełm, prison in Włocławek, prison in Łowicz, prison in Grudziądz, Płońsk branch unit of the prison in Płock, prison in Rawicz and prison in Rzeszów.
[327] Act of 24 May 2013 on coercive measures and firearms (Journal of Laws of 2024, item 383, as amended).
[328] Prison in Chełm, prison in Łowicz and prison in Grudziądz.
[329] Prison in Tarnów.
[330] Prison in Grudziądz.
[331] As above.
[332] Prison in Tarnów.
[333] Prison in Łowicz.

first search and was unable to get any dangerous items in that time. The second body search was thus unnecessary. It constituted excessive discomfort and the application of the coercive measure was pointless. Furthermore, conducting the body search in a security cell without the possibility of blurring the recording raises concerns as to the privacy and intimacy of the inmate.

The NPM notes that it is common practice to use handcuffs preventively, disregarding the principle of individualisation of applied measures (e.g. when transporting a prisoner with disabilities[334] or a prisoner accompanying her child during medical appointments outside the prison[335]). The practice was regularly applied with regard to convicts serving sentences in closed prisons during their use of payphones, going to the shower room and having individual meetings with prison staff members[336].

During two visits[337], representatives of the NPM encountered the practice of inmates being handcuffed during a medical appointment with a doctor/dentist. The use of handcuffs during medical examinations without sufficient reason should be considered unacceptable. The practice violates human dignity, hinders medical procedures, inhibits the building of an appropriate doctor-patient relationship and may be detrimental to the accuracy of medical findings.

The CPT points out that handcuffs should only be used on prisoners during transport if clearly justified by risk assessment in individual cases. When the use of such measures is deemed absolutely necessary, they should be used in such a way as to minimise the risk of injury to the person transported. Handcuffs should not be used when persons transported are confined in secure vehicle compartments[338].

The SPT points out that the use of any security measures (including handcuffs) should be based on an individual risk assessment, carried out according to clearly determined criteria and procedures. Handcuffs and other means of restraint should only be used when no less severe form of control of the existing risk is available, and should be removed as soon as possible. Handcuffs should not be used solely because of the status of the person deprived of liberty or as a disciplinary measure[339].

7. Staff

The problem of insufficient staffing levels, in particular in the security and penitentiary departments[340], highlighted in numerous NPM reports in previous years, continued to exist in some of the visited establishments[341]. The issue was raised by inmates and staff of the prisons and was publicly discussed by the Prison Service managers. In 2023, it was one of the subjects discussed by Deputy Commissioner for Human Rights Wojciech Brzozowski at his meeting with representatives of the trade union of Prison Service officers and prison employees[342].

The qualifications of staff of the establishments visited by the NPM have been assessed positively in most cases. At the same time, however, the NPM recommended expanding the staff training programmes to include issues related to: international standards of the protection of human rights and the prevention of torture, interpersonal communication, conflict de-escalation, dealing with inmates from vulnerable groups (e.g. persons with disabilities, senior persons and transgender persons), professional burnout and coping with stress. The NPM also recommended that staff be provided with regular supervision by an external expert.

The CPT emphasises that the cornerstone of a humane prison system will always be properly recruited and trained prison staff who know how to adopt the appropriate attitude in their relations with prisoners and see their work more as a vocation than as a mere job. Building positive relations with prisoners should be recognised as a key feature of that vocation. The development of constructive and

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334 As above.

335 Prison in Grudziądz.

336 Płońsk branch unit of the prison in Płock.

337 Prison in Tarnów and Stawiszyn branch unit of the remand prison in Grójec.

338 See: CPT standards regarding transport of people deprived of their liberty, set out in the document entitled 'Transport of detainees', Factsheet, June 2018, CPT/Inf (2018) 24, para. 3 Security measures; See also CPT reports on the visit to Switzerland CPT/Inf (2022) 9, para. 102 and the visit to Serbia, CPT/Inf (2016) 21, para. 53.

339 See: SPT reports on the visits to: Chile [CAT/OP/CHL/1, paras. 44-46], Romania [CAT/OP/ROU/1, paras. 104-105], Ukraine [CAT/OP/UKR/3, para. 84] and [CAT/OP/UKR/1, paras. 12 and 132], New Zealand [CAT/OP/NZL/1, paras. 110-112] and Brazil [CAT/OP/BRA/3, para. 16].

340 The issue of insufficient number of prison psychologists is discussed separately in the section on systemic problems.

341 Staff shortages of various degree were identified. See, in particular, the reports on the visits to: the prison in Potulice, the prison in Włocławek, Płońsk branch unit of the prison in Płock, Stawiszyn branch unit of the remand prison in Grójec and Lubliniec branch unit of the prison in Herby.

342 See: information available at https://bip.brpo.gov.pl/pl/content/zrpo-wojciech-brzozowski-spotkanie-nszzfipw.

positive relations between prison staff and prisoners will not only reduce the risk of ill-treatment but also enhance control and security. In turn, it will render the work of prison staff far more rewarding[343].

8. Psychological support

Apart from the issue of too small number of psychologists, the NPM representatives identified also other problems in the field of psychological support:

- Despite the broad offer of psychological support and therapy, the visiting team, during their interviews with inmates, came across many situations demonstrating that the prisoners were not aware of the type of therapy they underwent and of the content of their individual therapy programmes[344];
- the visiting team had doubts regarding the location of the psychologist's room in one of the establishments. It was located in the so-called connecting corridor between two wards. In the corridor, where shower rooms were also located, had lockable bars on both sides. The large flow of inmates (a dozen or more at a time, as well as convicts after transport from other establishments) did not positively influence the psychologist's work comfort and the required confidentiality of conversations with inmates[345];
- in the ward for so-called particularly dangerous inmates, meetings with a psychologist were conducted in such a way that the psychologist was standing in the corridor in front of the cell, accompanied by two officers, the cell door was open and the inmate stood inside the cell behind the bar[346];
- long waiting time for admission to the therapy ward, exceeding a year and a half[347];
- conversations between inmates and psychologists took place in the presence of correctional officers and sometimes even ward officers[348].

9. Access to legal aid

Some of the rooms for inmates' meetings with their defence counsels were monitored, which made it possible for prison officers to hear the conversations[349].

The SPT points out that monitoring of penitentiary establishments may not cover information that is legally protected and covered by legal professional privilege. The privilege should be understood as broadly as possible. It covers not only conversations but also materials exchanged between the client and the lawyer in the form of notes or documents. Holding inmates' meetings with their defence counsels in monitored rooms may undermine the relationship of special trust to the defence counsel and his or her mandate, and, consequently, may influence the effectiveness of the legal aid provided. Such meetings should take place in conditions ensuring full confidentiality[350].

10. Cultural and educational activities

An attractive and regularly available offer of sports, recreation, cultural and educational activities can contribute to relieving tensions and reducing problematic behaviours among inmates. Therefore, the NPM noted the problem of insufficient offer of such activities in some of the visited establishments[351]. For example, in one of the common rooms there was a schedule of sports, recreation, cultural and educational activities. The schedule was outdated by two months and during their five-day visit the members of the NPM delegation saw none of the activities being carried out. The CCTV footage showed that the common room had not been used for any recreational or educational activities. In another establishment, the common room in one of the wards contained only a television set, a few chairs, a table and a table tennis table. The cultural and educational activities were conducted in the establishment's main common room but access to them depended on the good will of individual correctional officers[352]. In another establishment, due to the

[343] See: Extract from Eleventh General Report, CPT/Inf (2001) 16, para. 26.
[344] Prison in Chełm.
[345] Prison in Łowicz.
[346] Prison in Tarnów.
[347] As above.
[348] Prison in Rawicz.
[349] Prison in Rzeszów.
[350] See: SPT recommendations included in the report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, paras. 116-117. See also: SPT views on the preventive role of lawyers and the need to comply with confidentiality requirements, as set out in the reports on the visits to: Sweden [CAT/OP/SWE/1, para. 61], Mexico [CAT/OP/MEX/1, paras. 126-127] and Ukraine [CAT/OP/UKR/3, paras. 49, 50 and 52].
[351] Stawiszyn branch unit, prison in Włocławek, prison in Łowicz and prison in Rzeszów.
[352] Prison in Rzeszów.

lack of correctional officers competent to conduct sports activities, the gym was not available to inmates at all. The prison had no correctional officer designated to conduct cultural and educational activities[353].

The European Prison Rules emphasise that properly organised activities to promote physical fitness and provide for adequate exercise and recreational opportunities shall form an integral part of prison regimes. Prison authorities shall facilitate such activities by providing appropriate installations and equipment[354].

The Nelson Mandela Rules also stipulate that young prisoners, and others of suitable age and physique, shall receive physical and recreational training during the period of exercise. To this end, space, installations and equipment should be provided[355].

11. Material conditions and adaptation to the needs of people with disabilities

Over the years, the NPM has noticed a number of positive changes in the living conditions in penitentiary establishments. However, some of the visited prisons still require changes in terms of material and sanitary conditions or even need major refurbishment[356].

The NPM representatives visited some establishments where they found: dampness or mould, damaged wall plastering and paint, st ains form dripping water, bedbugs, or too small roofs over walking yards[357]. In one of the wards, there was a hole in the floor, which posed a risk of falling through it for inmates and staff members. Washbasins were located outside the toilets, and some of the toilets were not fully separated from the cells, which made it impossible to maintain privacy there[358]. In many establishments windows had so-called window blinds. Such covering screens, especially of older types, significantly impede air circulation and limit access of natural light[359].

The adaptation of penitentiary establishments to the needs of persons with disabilities is progressing too slowly. The visiting team saw that some prisons take efforts[360] or even carry out thorough modernisation of the whole establishments[361] with the aim to ensure accessibility. However, there are still major deficiencies in this area, even in prisons designated for the placement of convicts with disabilities.

In this context, it should be pointed out that in one of the visited establishments designated for prisoners in wheelchairs the adopted architectural solutions made it impossible for such people to maintain basic independence and to exercise their rights outside their cells[362]. The deficiencies related in particular to: the width of the cell doors, which was 69 cm, making it impossible for a wheelchair to go through it; the size of the cells, which, in the opinion of the visiting team, made them inappropriate for people in wheelchairs; the toilets that were not adapted to the needs of people with disabilities (too small space, no handrails and damaged sliding doors), the location of the medical room on the second floor and the location of the common room on the fourth floor. In another visited establishment, the cell adjusted to the needs of prisoners with physical disabilities had a floor area of 12.38 m^2 and was designated for four inmates, including one with physical disability. The living space per inmate was slightly over the legally required limit of 3 m^2. However, it should be taken into account that a person in a wheelchair may need more space so the standard set in the national regulations may be insufficient for disabled prisoners and their inmates living in the same cell. In toilets, there were no handles for people in wheelchairs and the mirror was placed at a height making its use impossible for a person in a wheelchair[363].

The visits to other cells designated for wheelchair users revealed that, in reality, they did not meet the accessibility standards. There was not enough space for moving around freely. The prisoner in a wheelchair, in order to change the direction of movement, had to get into the bathroom. Another cell designated for wheelchair users was located in the ward for dangerous prisoners. However, the disabled inmate there had no "dangerous" status and lived there with an inmate assigned to assist him. The conditions in the cell, however, were not appropriate for a disabled person (the toilet was not separated and the cell was under video surveillance). Moreover, the disabled inmate was subject to the rules applicable to dangerous prisoners[364].

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353 Stawiszyn branch unit.
354 Rules 27.3 and 27.4.
355 Rule 23(2).
356 Remand prison in Mysłowice, prison in Chełm, Lubliniec branch unit of the prison in Herby, prison in Łowicz, prison in Rzeszów, Płońsk branch unit of the prison in Płock, prison in Rawicz and prison in Tarnów.
357 Płońsk branch unit of the prison in Płock, prison in Rawicz, prison in Rzeszów, Stawiszyn branch unit, prison in Łowicz, prison in Tarnów and remand prison in Mysłowice.
358 Prison in Tarnów, branch unit of the remand prison in Kraków-Nowa Huta, Lubliniec branch unit of the prison in Herby, and prison in Rawicz.
359 Prison in Potulice, remand prison in Mysłowice, prison in Włocławek and prison in Łowicz.
360 Prison in Włocławek.
361 Prison in Potulice.
362 Remand prison in Mysłowice.
363 Prison in Sztum.
364 See: Prison in Rzeszów.

The NPM recommends adjusting material conditions to the needs of persons with disabilities. Detailed technical standards for adapting spaces to the needs of inmates with disabilities, developed in cooperation with experts from the Integration Foundation, are laid down in the NPM thematic report[365].

DETENTION OF JUVENILES

In 2023, the NPM carried out visits to eleven facilities for juveniles: four youth care centres[366], three district youth care centres[367], three police establishments for children[368] and one juvenile detention centre with a juvenile shelter[369].

Good practices

1. Meal provision to minors immediately upon admission to a police establishment for children

At one of the visited police establishments for children[370] the NPM delegation was informed that every minor was provided with a meal immediately upon admission to the establishment, regardless of the time of day or night. The practice was applied despite the fact that, according to the regulations, a meal should be provided after five hours from admission, and only in particularly justified cases it may be provided earlier[371]. In the opinion of the NPM, the practice deserves appreciation. The establishment often admits minors who have run away from home or a juvenile facility and have not eaten for many hours. Therefore, the possibility to satisfy hunger and thirst immediately after admission is extremely important for them.

2. Electronic system for monitoring the progress of juveniles

The assessment of juveniles, carried out in one of the visited youth care centres[372], was based on a daily evaluation of their situation in the areas of education, health and social relations. The system made it possible to generate, at any time and for any period, a report on the trends in the development of a juvenile and the extent to which he or she meets the expectations regarding the social rehabilitation process. The juveniles had constant access to the system, which provided additional motivation for them. For the facility's personnel the monitoring system was a good tool for assessing the appropriateness and effectiveness of measures taken with regard to the juveniles and for required modification of such measures.

3. Diverse offer of recreational activities

At one of the centres, juveniles had access e.g. to a multifunction sports pitch, an outdoor gym, a paintball field, a meet smoker where they could smoke meats themselves, an apitherapy hut (where they could listen to the calming hum of the bees) and a gazebo where lessons were held on warm days[373].

At another centre, juveniles had access to a variety of sports and recreation activities, to a sports hall, gym, fitness centre, hippotherapy, relaxation activities using Tibetan bowls[374], a climbing wall, culinary workshops, Schultz relaxation activities and aggression replacement training. Also, thanks to financial support from the State Fund for Rehabilitation of Disabled Persons (PFRON), a scuba diving course entitled "Bounce Back from the Bottom" was held for the juveniles as an additional part of the social

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[365] See: NPM thematic report: https://bip.brpo.gov.pl/pl/content/monitoring-traktowania-wiezniow-z-niepelnosprawnoscia-fizyczna-i-sensoryczna-raport-z.

[366] Youth care centres in: Jaworek (KMP.573.1.2023), Babimost (KMP.573.2.2023), Łobżenica (KMP.573.3.2023) and Skarżysko-Kamienna (KMP.573.15.2023).

[367] District youth care centres in: Szczecin (KMP.573.4.2023), Szubin (KMP.573.9.2023) and Witkowo (KMP.573.20.2023).

[368] Police establishments for children in: Łódź (KMP.570.5.2023), Bydgoszcz (KMP.573.8.2023) and Poznań (KMP.570.12.2023).

[369] Juvenile detention centre with a juvenile shelter in Konstantynów Łódzki (KMP.573.17.2023).

[370] Police establishment for children in Bydgoszcz (KMP.573.8.2023).

[371] See: Article 8(1)(1)(d) and (h) of the *Regulations on police establishments for children*, attached as Annex 12 to the Regulation of the Minister of the Interior of 4 June 2012 Regulation of the Minister of the Interior of 4 June 2012 on rooms for detained persons or intoxicated persons brought to sober up, on transitional facilities and police establishments for children as well as rules and regulations on the stay in such facilities and procedures regarding image recording there.

[372] Youth care centre in Jaworek (KMP.573.1.2023).

[373] As above.

[374] District youth care centre in Szubin (KMP.573.9.2023).

rehabilitation and therapy programme. The aim of the programme was to strengthen the independence of people with disabilities and their sense of self-confidence[375].

The increase of the level of physical fitness was possible e.g. thanks to sailing trips on the great lakes of Mazury lake district[376]. The aim of the project was to develop the participants' responsibility, cooperation, willingness to help others, the sense of brotherhood and self-discipline and to improve their organisation skills and reliability at work.

4. Cooperation with other entities in support provision to juveniles

The NPM positively assessed the activities of the following non-governmental organisations providing support to young people from juvenile establishments:

- JAWOR Association for Assistance to People with Disabilities, founded by employees of the youth care centre in Jaworek. The cooperation makes it possible for juveniles to take part in numerous vocational training courses and extracurricular activities. They also help people with disabilities during Occupational Therapy Workshops. Thanks to grants received by the association the staff of the youth care centre also take part in numerous training courses focused on improving skills required in working with juveniles;
- Arka Noego Association for Support – among people working for the association there are addiction therapists, psychotherapists, a child and adolescent psychiatrist and a sexologist. The association's staff actively participate in the life of the youth care centre in Skarżysko-Kamienna, providing specialised care to the juveniles. Therapy activities are accompanied e.g. by sports activities[377];
- Po Drugie Foundation – the cooperation is focused on helping young people to become independent and on preventing homelessness among young adults. The foundation offers housing support for young people who reach the majority age as well as assistance of an educator and a psychologist[378];
- Alcoholics Anonymous groups from Konin and Września - the meetings focus on alcoholism prevention and social rehabilitation[379];
- Socioeconomic Institute in Łódź –activities aimed at professional activation of juveniles[380];
- Support activities for the local community – juveniles visit residents of local social care homes, read stories to children in kindergartens, in one case juveniles adopted two dogs from a dog shelter. Through these activities, juveniles learn how to be responsible, provide care to people and animals and protect those who are weaker and dependent on assistance from others[381].

5. Staff training

The NPM positively assessed the fact that staff members, apart from the required degree in pedagogy, oligophrenopedagogy, sociotherapy or psychology also attended postgraduate courses or other courses in the fields such as social rehabilitation, coaching or career counselling, in order to be able to better cope with current challenges. Many staff members also took part in additional training covering e.g. aggression replacement training (ART), prevention of addictions and online threats, or the application of coercive measures[382].

■ Systemic problems

1. No mandatory medical examinations of juveniles placed in police establishments for children

The NPM is of the opinion that every minor person, upon placement in a police establishment for children, should undergo a medical examination despite the fact that this is not required by national law.

The SPT recommends that that all persons who are detained be promptly examined free of charge by a medical specialist, without a police officer present. Such medical specialists should be trained in how to examine people who may have been subjected to torture or ill-treatment and on how to document such cases[383].

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375 District youth care centre in Witkowo (KMP.573.20.2023).
376 As above.
377 Youth care centre in Skarżysko-Kamienna (KMP.573.15.2023).
378 Juvenile detention centre with a juvenile shelter in Konstantynów Łódzki (KMP.573.17.2023).
379 District youth care centre in Witkowo (KMP.573.20.2023).
380 Juvenile detention centre with a juvenile shelter in Konstantynów Łódzki (KMP.573.17.2023).
381 Youth care centre in Skarżysko-Kamienna (KMP.573.15.2023).
382 District youth care centre in Witkowo (KMP.573.20.2023).
383 See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, paras. 53 and 55.

2. Access to a defence counsel from the outset of detention

In the visited police establishments for children[384] meetings with defence counsels were very rare. Some establishments had no list of lawyers to be made available to juveniles or their guardians seeking contact with a lawyer.

The legal regulations contained in the Act of 9 June 2022 on support and social rehabilitation of juveniles[385] make it possible for juveniles to exercise their right of defence, including the right to be assisted by a lawyer from the outset of detention and official activities involving a given juvenile, as well as the right to request the appointment of an ex officio public defender (Article 36(1)(1)). A detained juvenile has to be questioned immediately upon detention (Article 48(8)). A detained juvenile has the right to contact a lawyer without the participation of third parties (Article 48(7)). In Article 37(7) of the Act, the legislator provides for legal assistance to juveniles who are in need of immediate defence, including in the event of detention, questioning or application of a temporary preventive measure to a detained juvenile person. In such cases, the provisions of the Act of 6 June 1997 - Code of Criminal Procedure[386] relating to duties of attorneys in expedited proceedings are applicable. According to Article 48(6) and (7) of the *Act on support and social rehabilitation of juveniles*, a juvenile person, at his or her request, shall be immediately provided with a possibility to contact and meet in person with a lawyer.

In the opinion of the CHR, the above mentioned regulations meet only some of the requirements of Directive (EU) 2016/800 of the European Parliament and of the Council of 11 May 2016 on procedural safeguards for children who are suspects or accused persons in criminal proceedings[387]. It needs to be emphasised that the Polish regulations should clearly state that until legal advice provision to a juvenile concerned he or she should not be questioned or subjected to other evidence taking activities, which follows directly from Article 6(3) of Directive 2016/800[388].

Furthermore, the *Act on support and social rehabilitation of juveniles* sets out cases in which a juvenile is required to have a defence counsel (Article 38(1) and (2)). Furthermore, Article 38(3) of the Act stipulates that a juvenile, his or her parent or guardian may request the appointment of an ex officio defence counsel. The defence counsel will, however, be appointed by the family court only if considered necessary. The family court may annul the appointment of the counsel if it turns out that the circumstances based on which the appointment was made have ceased to exist (Article 38(8)).

In the opinion of the CHR, such provisions deprive non-affluent persons of effective access to professional (free of charge) legal assistance until the appointment of an ex officio defence counsel by the court. In the opinion of the Commissioner every citizen, in particular a juvenile one, should have access to a lawyer from the outset of detention and throughout the court proceedings. If it is impossible to have a lawyer of choice, an ex-officio lawyer should be appointed with whom communication in confidence is ensured from the outset of detention, already before the first questioning. A juvenile's access to a lawyer is a broader concept than legal assistance provision solely for the purpose of defence during court proceedings. Such access is a fundamental safeguard against torture, both with regard to officers apprehending and convoying the detainee and to staff member at the place of detention (e.g. officers on duty at the police establishment for children or staff of the youth care centre)[389].

In the report on the visit to Poland in 2017 pointed out that there is still no provision in Polish law allowing for the appointment of an ex-officio lawyer before the stage of court proceedings. Therefore, persons in police custody who are not in a position to pay for legal services are effectively deprived of the right of access to a lawyer.24 The Committee calls upon the Polish authorities to develop, without further delay and in co-operation with the Polish Bar Council – a fully-fledged and properly funded system of legal aid for persons in police custody who are not in a position to pay for a lawyer, to be applicable from the very outset of police custody[390].

[384] Police establishments for children in: Łódź (KMP.570.5.2023), Bydgoszcz (KMP.573.8.2023) and Poznań (KMP.570.12.2023).
[385] Journal of Laws of 2024, item 978.
[386] Journal of Laws of 2022, item 1375.
[387] Official Journal of the European Union L 2016.132.1.
[388] See: Opinion on the draft Act on support and social rehabilitation of juveniles, expressed in the letter of 25 August 2021, available at: https://bip.brpo.gov.pl/pl/content/rpo-resocjalizacja-nieletni-ustawa-opinia.
[389] See: Opinion on the draft Act on support and social rehabilitation of juveniles, expressed in the letter of 25 August 2021, available at: https://bip.brpo.gov.pl/pl/content/rpo-resocjalizacja-nieletni-ustawa-opinia.
[390] See: CPT report on the visit to Poland in 2017, CPT/Inf (2018) 39, para. 25.

3. Use of handcuffs on juveniles

The NPM has noticed for a long time a concerning practice of unnecessary preventive use of handcuffs on detainees by police officers. This applies to the escorting stage and to activities carried out at police stations[391].

It should be emphasized that in most cases juveniles who were handcuffed during transportation to a detention facility did not behave aggressively and followed the instructions of police officers. In the opinion of the CHR, the routine use of handcuffs on juveniles whose behaviour does not justify their preventive use constitutes abuse as well as degrading treatment of such persons within the meaning of Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms.

The CPT is also critical of preventive use of handcuffs during transportation[392].

In the opinion of the CPT, handcuffs should not be used, as a rule, during transportation (it is best for prisoners to be transported in secure escort vans, which eliminates the need to handcuff them during transportation)[393]. The application of handcuffs to detainees during transportation should only be resorted to when the risk assessment in an individual case clearly warrants it. When the use of such means is considered absolutely necessary, it should be done in such a way as to minimise any risk of injury to the detained person.

■ Areas that require improvement

1. Treatment of juveniles

In 2023, the NPM recorded the following cases of ill-treatment of juveniles:

- A juvenile was choked and pushed against a wall by a teacher and a belt was pressed to his neck. The incident took place in the presence of witnesses: security staff, other juveniles and staff members. None of the facility's staff reacted to the teacher's unacceptable behaviour during the incident[394];
- A teacher pushed a juvenile off a chair, pushed him and hit him on the face[395];
- A juvenile was hit by a security officer[396];
- Body search was carried out in a single stage[397];
- CCTV recording of the use of coercive measures was not sufficiently secured[398];
- Preventive handcuffing of juveniles during transportation, not warranted by their behaviour that was not aggressive, was applied by police officers. One of the juveniles reported that he had been transported in combination handcuffs on his hands and legs. Another juvenile reported that his hands were handcuffed in front of him and he had to use the toilet while handcuffed. One of the employees recalled a case where a juvenile had to go to the toilet in combination handcuffs[399].

2. Reports of mistreatment of juveniles by police officers

One of the juveniles reported that he had been beaten by officers during his apprehension at home. The report was confirmed by a photograph contained in the juvenile's file, in which he has numerous abrasions on his face, and an official record made upon his admission to the establishment, according to which he arrived with injuries. The juvenile said that he had been beaten with fists and that tear gas had been used against him. Another juvenile also reported that he had been beaten by police officers at the police station and had been threatened with a gun[400].

At another establishment, the NPM delegation heard a report of violent apprehension of juveniles by police officers. The juveniles stated that they had been thrown to the ground, handcuffed behind their backs and beaten by officers with fists all over their bodies (including their heads). One of the juveniles said he had been hit on his head against a wall. The juveniles reported that the officers had not given

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391 The issue was the subject of the CHR's general intervention letter to the Minister of the Interior and Administration of 20 January 2020.

392 See: Transport of detainees, Factsheet, June 2018, CPT/Inf (2018) 24, para. 3. Security measures; CPT report on the visit to Ireland, CPT/Inf (2007) 40, para. 101; CPT report on the visit to the United Kingdom, CPT/Inf (2006) 28, para. 23; CPT report on the visit to Hungary, CPT/Inf (2006) 20, para. 126 and CPT report on the visit to Serbia, CPT/Inf (2016) 21, para. 53.

393 See: Transport of detainees, Factsheet, June 2018, CPT/Inf (2018) 24, point 3. Security measures; CPT report on the visit to Serbia, CPT/Inf (2016) 21, point 53.

394 Juvenile detention centre with a juvenile shelter in Konstantynów Łódzki (KMP.573.17.2023).

395 Juvenile detention centre with a juvenile shelter in Konstantynów Łódzki (KMP.573.17.2023).

396 District youth care centre in Szczecin (KMP.573.4.2023).

397 District youth care centres in: Szczecin (KMP.573.4.2023 Szubin (KMP.573.9.2023 and Witkowo (KMP.573.20.2023).

398 District youth care centre in Szczecin (KMP.573.4.2023).

399 District youth care centres in Szczecin (KMP.573.4.2023) and Witkowo (KMP.573.20.2023).

400 District youth care centre in Szubin (KMP.573.9.2023).

them a possibility to follow their orders and had attacked them from the very beginning despite the fact that the boys had not been aggressive and behaved calmly[401].

Another report concerned detention of a juvenile, during which police officers arrived by a police car and 'nearly ran him over'. The officers then allegedly sprayed pepper spray in the boy's face, threw him to the ground and handcuffed him behind his back. He reported they had beaten him (including with their open hands), kicked him and pressed a stun gun for a while against his leg. The juvenile said that he had not resisted the officers and had not behaved aggressively during the apprehension. The subsequent examination by a doctor discovered sings of his leg having been hit by the police car[402].

In another establishment the juveniles reported that officers had usually handcuffed them preventively for transportation despite their non-aggressive behaviour. Usually, the handcuffs were locked behind their backs[403].

3. Discipline

During the visits it was found that at some of the establishments collective accountability was applied, for example in cases of theft. In such situations, the whole group was punished (e.g. lost access to their mobile phones) until the stolen or lost item was found[404]. The NPM emphasises that imposing penalties on juveniles who have not committed any offence causes the feelings of injustice, humiliation and hostility and can lead to retaliation against the actual perpetrator. It encourages the development of negative attitudes and leading a "double life". It also hinders the possibility to build a positive climate in the establishment, based on non-acceptance of violence. The application of collective accountability is also inconsistent with international standards.

The NPM also found that in one of the establishments juveniles had to clean the rooms and the floors as a penalty. They had to do it in their underwear. According to the delegation's findings, the reason for this was the concern that the boys would "get dirty and too hot while cleaning". This was surprising given that it was winter and the indoor temperature was 17°C. This situation was difficult to understand and humiliating, especially that a warmly dressed staff member supervised the juveniles working only in their underwear[405].

4. Second life

In two establishments, the NPM observed manifestations of the so-called second life[406] i.e. the presence of a hierarchical structure developed by the juveniles and governed by informal rules, most often based on violence.

For example, a group of "leaders" bullied weaker juveniles and collected "payments" from them in the form of cigarettes, sweets, food and sometimes clothes. The group also punished them for not observing those rules, e.g. by taking their belongings and sometimes using physical violence. The informal rules included e.g. the prohibition to wear slippers on carpet flooring or to eat meals together with others.

As found by the NPM delegation, many such situations were witnessed by the establishment's personnel who did not react to them. Furthermore, the visiting team also saw signs of departure from the formal relationship between the privileged group of "leaders" and the staff members. This was reflected by the fact that the juveniles, when speaking to the staff, used their first names.

The NPM emphasises that the presence of informal rules in the establishment, similar to those existing in the subcultures of prisoners or criminals, may pose a threat to the safety of the juveniles. The rules governing such subcultures lead to demoralisation, result in attitudes that are harmful from the point of view of ethics, and prevent the development of a positive climate and culture of non-acceptance of violence.

5. Medical care and documentation of injuries

In some of the establishments there were no preventive medical examinations of juveniles upon admission. Medical consultations were conducted only for juveniles who reported any ailments or if medical procedures were necessary[407]. The NPM came across many cases in which the first medical examination was conducted several weeks or even several months after the admission to the establishment[408]. The knowledge of the Istanbul Protocol among the staff was very limited[409]. In some establishments injuries

[401] Youth care centre in Jaworek (KMP.573.1.2023).
[402] As above (KMP.573.1.2023).
[403] District youth care centre in Witkowo (KMP.573.20.2023).
[404] Youth care centres in Jaworek (KMP.573.1.2023) and Babimost (KMP.573.2.2023).
[405] District youth care centre in Witkowo (KMP.573.20.2023).
[406] Youth care centres in Jaworek (KMP.573.1.2023) and Szczecin (KMP.573.4.2023).
[407] Youth care centre in Jaworek (KMP.573.1.2023).
[408] Youth care centres in Babimost (KMP.573.2.2023) and Łobżenica (KMP.573.3.2023).
[409] Youth care centres in: Jaworek (KMP.573.1.2023), Babimost (KMP.573.2.2023), Łobżenica (KMP.573.3.2023) and Skarżysko-Kamienna (KMP.573.15.2023) and district youth care centre in Szczecin (KMP.573.4.2023).

were not documented during medical examinations, body maps were not used[410] and descriptions of injuries were extremely brief[411].

The NPM emphasises that a medical examination upon admission, accompanied by appropriate documentation of injuries, is considered a fundamental safeguard against torture. It ensures identification of injuries sustained prior to placement in a youth care centre, documentation of signs of experienced violence for the needs of the criminal proceedings, and undertaking of effective measures in confirmed cases of torture. It also provides an opportunity to diagnose other medically significant conditions.

Another problem related to medical care was the fact that many of the visited establishments did not have any nurse employed[412].

In cases where juveniles were unable to swallow medicines prescribed by a doctor (including psychotropic drugs) the tablets were crushed into smaller pieces by teachers. This was done without the knowledge or consent of a doctor and there was no information about it entered in the juveniles' medical records[413]. In one establishment, the visiting team was informed that a doctor-specialist in psychiatry was aware of the practice and consented to it but there was no mention of it in the medical records[414]. Breaking tablets into smaller pieces to make it easier to swallow may not be a problem in itself but the NPM is against the practice of administering medications without the patient's awareness and consent and without the doctor's knowledge and is of the opinion that all medications have to be specified in the patient's records. If tablets are crushed into small pieces there is no certainty that the active substance enters the patient's body in a sufficient amount and that it works as intended. Some delayed-release medications ensure gradual release of the active substance over time. Crushing the tablet may remove the effect. The decision to crush tablets should be taken by a doctor.

At several establishments there was a practice of collecting advance consents, i.e. forms signed by a parent or legal guardian of a given juvenile and containing consent for future medical procedures, including surgery procedures for their child[415].

6. Psychological care

In one of the establishments[416], an NPM expert found that the number of hours in which psychologists were available was insufficient to ensure adequate psychological support for juveniles. The support and therapy activities were conducted by persons without the required qualifications, which could negatively influence their effectiveness.

Another risk area identified by an NPM expert was the lack of regular psychotherapy activities for juveniles who strongly needed them due to their emotional condition. Among them were young people who had reported traumatic experience prior to their placement in the establishment, e.g. violence in, abuse or depression, or juveniles with symptoms of post-traumatic stress disorder.

It was also found that all teachers had access to the records of conversations between psychologists and juveniles. This undermines the principle of security and confidentiality of personal information. Disclosing the content of the records of such conversations is against the ethics of therapy provision to patients, which is guaranteed by the Code of Ethics and Professional Conduct of the Polish Association of Psychologists. The Code refers to the requirement to maintain professional secrecy for the good of the patient.

7. Staff

For many years, the NPM has called for regular supervision over staff members of juvenile establishments. This would provide an opportunity for them to reduce tensions related to their professional duties. Such meetings could also contribute to improving relations between individual employees, which would translate into better quality of their work and level of care provided to juveniles[417].

In one of the visited youth care centres the visiting team was informed that support provided to staff members in the area of professional development was insufficient. The NPM representatives also heard reports of internal conflicts, the lack of appropriate flow of information, the feeling of injustice as well as mutual suspicions among the employees[418]. It was recommended to increase the availability of

[410] Youth care centre in Skarżysko-Kamienna (KMP.573.15.2023).
[411] District youth care centres in Szczecin (KMP.573.4.2023) and Witkowo (KMP.573.20.2023).
[412] Youth care centres in Jaworek (KMP.573.1.2023) and Babimost (KMP.573.2.2023).
[413] Youth care centre in Jaworek (KMP.573.1.2023).
[414] District youth care centre in Szczecin (KMP.573.4.2023).
[415] Youth care centre in Skarżysko-Kamienna (KMP.573.15.2023), district youth care centre in Szczecin (KMP.573.4.2023) and district youth care centre in Szubin (KMP.573.9.2023).
[416] Youth care centre in Jaworek (KMP.573.1.2023).
[417] Youth care centres in: Jaworek (KMP.573.1.2023), Babimost (KMP.573.2.2023), Łobżenica (KMP.573.3.2023) and Skarżysko-Kamienna (KMP.573.15.2023), and district youth care centres in Szczecin (KMP.573.4.2023), Szubin (KMP.573.9.2023) and Witkowo (KMP.573.20.2023).
[418] Youth care centre in Łobżenica (KMP.573.3.2023).

training courses for them, including regular workshops tailored to the needs of individual professionals and focused e.g. on interpersonal communication[419].

Another establishment reported the need to permanently employ a social worker[420]. Attention was also drawn to the shortage of others specialists, including in the areas of psychology, addiction therapy and Aggression Replacement Training[421].

8. Living and sanitary conditions

Several establishments had security solutions typical of penitentiary facilities, e.g. were surrounded by a concrete wall on top of which there was a razor wire (so-called concertina wire), or had windows protected by bars or metal protective screens that limit access of daylight[422]. In one establishment juveniles' bedrooms remained locked at night. As a result, toilet could be used only upon permission of a guard[423]. The use of such security measures is consistent with the applicable regulations[424]. However, in the opinion of the NPM, such infrastructure causes associations with penitentiary facilities, looks depressing and highlights the restrictive character of the establishment.

In one of the establishments the NPM found very poor conditions in the living part of the building. Furniture in the bedrooms was old and damaged, wardrobes had no doors, floors had holes and foam mattresses were damaged. The number of showers was far too small (2 showers for 24 juveniles). The showers and toilets were in need of refurbishment[425].

In another establishment, the visiting team assessed the living conditions as consistent with the formal requirements but very modest and meeting only the minimum criteria. Most of the furniture was old and damaged (e.g. scribbled with permanent markers) and required replacement or repair. Only few bedrooms had desks, and most bedrooms did not even have chairs or additional lamps for reading and writing. The doors to the rooms had holes in them (covered with plywood patches); the same was found in wardrobes in the boys' rooms. In bathrooms there were no mirrors that facilitate maintenance of daily hygiene, and shower curtains were in a condition which did not ensure privacy during washing. The visiting team also heard reports from juveniles, confirmed by the staff members, that frequently there was no hot water (it was heated by an electric heater the capacity of which was insufficient)[426].

One of the visited police establishment for children[427] failed to meet many requirements set out in law[428] despite the fact that the overall assessment of the facility by the NPM delegation was relatively good (on the day of the visit, the place was tidy and clean). The living space standard was met and the floor area per person in the juveniles' bedrooms was no less than 3 m^2. Yet, the beds were so close to each other that there was not enough personal space.

9. Adaptation of the establishment to the needs of people with disabilities

The failure to adapt the establishments to the needs of people with various types of disabilities results in exposing such people to degrading or humiliating treatment[429]. In the opinion of the NPM, people with disabilities

[419] Youth care centre in Skarżysko-Kamienna (KMP.573.15.2023), police establishment for children in Poznań (KMP.570.12.2023), juvenile detention centre with a juvenile shelter in Konstantynów Łódzki (KMP.573.17.2023), district youth care centre in Szubin (KMP.573.9.2023) and district youth care centre in Witkowo (KMP.573.20.2023).

[420] Youth care centre in Skarżysko-Kamienna (KMP.573.15.2023).

[421] Youth care centre in Skarżysko-Kamienna (KMP.573.15.2023).

[422] District youth care centres in: Szczecin (KMP.573.4.2023), Szubin (KMP.573.9.2023) and Witkowo (KMP.573.20.2023).

[423] District youth care centre in Szczecin (KMP.573.4.2023).

[424] See: Articles 51, 52 and 67(1) of the Regulation of the Minister of Justice of 31 August 2022 on the operation of district youth care centres, juvenile detention centres and juvenile shelters (Journal of Laws, item 1897).

[425] Youth care centre in Łobżenica (KMP.573.3.2023).

[426] Youth care centre in Skarżysko-Kamienna (KMP.573.15.2023).

[427] Police establishment for children in Łódź (KMP.570.5.2023).

[428] See: Regulation of the Minister of the Interior of 4 June 2012 on rooms for detained persons or intoxicated persons brought to sober up, on transitional facilities and police establishments for children as well as rules and regulations on the stay in such facilities and procedures regarding image recording there (Journal of Laws, item 638).

[429] Youth care centre in Skarżysko-Kamienna (KMP.573.15.2023), district youth care centre in Szczecin (KMP.573.4.2023) and district youth care centre in Witkowo (KMP.573.20.2023).

should be provided with conditions enabling their full participation in a safe environment free of architectural barriers[430]. The rights of such persons are protected both at the national and international levels[431].

10. Contact with the outside world

In one of the police establishments for children[432], due to technical conditions, telephone conversations had to be conducted in the presence of an officer. The impossibility of having a telephone conversation in conditions that ensure confidentiality creates, in the opinion of the NPM, a risk that a juvenile who wants to convey important information, e.g. about experienced violence or embarrassing ailments, will not report the problems.

The NPM encountered a similar problem in one of the district youth care centres where meetings with relatives took place on sofas in the hall at the entrance to the building. The delegation understands the statutory obligation to supervise visits to juveniles and the need to ensure safety in the facility, but encourages its managers to assign a separate room for the visits so that they do not have to take place in common space[433].

11. Right to information and access to a complaint mechanism

Some facilities were advised to display, in common areas, their internal regulations and other important information including contact details of institutions that can be contacted by the juveniles or their relatives[434].

In one of the establishments, the NPM found that no register of complaints and requests was kept[435].

The NPM always emphasises the importance of the provision to juvenile foreign nationals, in a manner understandable to them, of information about their rights, obligations and legal situation. In two district youth care centres it was noticed that all documents and statements of key importance from the point of view of the rights and obligations of the juveniles were drawn up in Polish. Therefore, it was not certain whether the juveniles understood the content of the documents they had read and/or signed[436].

The NPM delegation has also doubts as to the practice of police establishments for children, which consists in entering the statement 'The juvenile has understood the information. The juvenile does not intend to exercise the rights" in documents regarding juvenile foreign nationals who do not know the Polish language, law and procedures. As shown by an analysis of detention reports in one of the police establishments for children, over two years there had been a large number of juveniles from Ukraine who had come to Poland as a result of the war. Among them were also children from orphanages who were waiting in the establishment for transport to educational institutions. They signed the detention reports although no interpreter was present during the procedural activities and the documents contained mentions of difficulties in communication due to the language barrier. In such circumstances, it is difficult to believe that the juveniles understood the documents[437].

In another establishment, representatives of the NPM analysed the documentation of a Romanian citizen. They found that the juvenile had been provided with a Romanian translation of the internal regulations of the establishment and the annex to the report on the juvenile's hearing. The other documents, drawn up in Polish (including the detention report and the deposit receipt) did not contain any information about the presence of an interpreter or any other means of communicating the information to the foreign juvenile in a language he could understand[438].

12. Distinguishing between a body search and a preventive check

In one of the police establishments for children[439] officers had difficulty distinguishing between a body search and a preventive check. According to the *Act on the Police*, upon admission to a juvenile

[430] Guidelines on accessibility for persons with disabilities, developed by an expert from Fundacja Integracja, can be found in the NPM thematic report entitled 'Monitoring the treatment of prisoners with physical and sensory disabilities' of 2019, pp. 52-78. The report is available at: https://bip.brpo.gov.pl/pl/content/monitoring-traktowania-wiezniow-z-niepelnosprawnoscia-fizyczna-isensoryczna-raport-z.

[431] See: Convention on the Rights of Persons with Disabilities, adopted by the United Nations General Assembly on 13 December 2006 (Journal of Laws of 2012, item 1169); Charter of Rights of Persons with Disabilities adopted by the Sejm of the Republic of Poland on 1 August 1997 (M.P. No. 50, item 475).

[432] Police establishment for children in Bydgoszcz (KMP.573.8.2023).

[433] District youth care centre in Szubin (KMP.573.9.2023).

[434] Youth care centres in Łobżenica (KMP.573.3.2023) and Skarżysko-Kamienna (KMP.573.15.2023) and district youth care centre in Szczecin (KMP.573.4.2023).

[435] District youth care centre in Szubin (KMP.573.9.2023).

[436] District youth care centres in Szczecin (KMP.573.4.2023) and Szubin (KMP.573.9.2023).

[437] Police establishment for children in Łódź (KMP.570.5.2023).

[438] Police establishment for children in Bydgoszcz (KMP.573.8.2023).

[439] Police establishment for children in Poznań (KMP.570.12.2023).

establishment, juveniles undergo a preventive check. However, at the visited establishment the mouth, nose, ears, hair and intimate areas were also checked. This goes beyond the scope of preventive check as defined in the regulations. It constitutes, instead, body search which should only be conducted upon admission only in exceptional circumstances.

NURSING FACILITIES AND RESIDENTIAL CARE AND TREATMENT FACILITIES

In 2023, the NPM carried out visits to 8 private long-term care facilities[440] and 5 social care homes[441], as well as 1 follow-up visit to a social care home[442] and 2 follow-up visits to residential care and treatment facilities[443].

■ Best practices

- Provision of psychological care to residents and patients[444].
- Diverse offer of therapeutic and physical rehabilitation activities for patients of residential care and treatment facilities[445].
- Use of automatic bed lifts, which facilitates care provision to bedridden patients while ensuring their safety and minimising discomfort[446].
- Employment of a psychotherapist who also works as a social skills coach and a sex educator[447].
- Running a small shop in the facility where residents can buy food and hygiene products and can work as volunteers, as part of their social skills training[448].
- Cooperation with external volunteers and institutions working for children and young people[449].
- Maintenance of direct contacts with residents temporarily placed in a hospital[450].
- Openness to accepting new residents with their pets or furniture[451].
- Provision of medical care to residents with somatic diseases – access to specialist doctors at the facility and development of detailed procedures for medical care provision to people with somatic diseases[452].

■ Systemic problems

1. Legality of stay of residents who are not legally incapacitated but whose health condition makes it impossible for them to conclude a care provision contract

Residential care and treatment facilities admit persons who are not legally incapacitated but whose health condition makes it impossible for them to conclude a contract. Such persons are usually unable to place a signature under their service contract or statement of will to be admitted to the facility. In such situations, the documents are signed by their relatives. According to the regulations, actual carers

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[440] Private long-term care facilities: "Barbara" in Wielka Wieś (KMP.573.7.2023), "Pogodna Jesień" in Odrowąż (KMP.573.6.2023), "Słoneczny Las" in Wierzbica (KMP.573.10.2023), "DARDOM" in Marki near Warsaw (KMP.573.13.2023), "Alter Domus" Care and Rehabilitation Centre in Otwock (KMP.573.14.2023), "Dom Ufnej Starości" (Trusted Home for Seniors) of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023), "Family Care Home" in Stare Babice (KMP.573.16.2023) and "Willa Chopina" long-term care facility in Toruń (KMP.573.8.2021).

[441] Social care homes: home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023), home in Babica (KMP.575.1.2023), Wiktoria Michelisowa social care home in Lublin (KMP.575.2.2023), 'Słoneczne Wzgórze' in Ryjewo (KMP.575.3.2023), Stanisław Broniewski "Orsza" home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023).

[442] "Etola" social care home in Ruda Pilczycka (KMP.575.3.2022). The findings of the follow-up visit are described in a separate chapter of this report.

[443] Nursing care facility in Sejny (KMP.573.5.2023) and A. I A. Karos 'Dar-Med' residential care and treatment facility in Łódź (KMP.573.11.2023).

[444] Wiktoria Michelisowa social care home in Lublin (KMP.575.2.2023) and nursing care facility in Sejny (KMP.573.5.2023).

[445] Nursing care facility in Sejny (KMP.573.5.2023).

[446] Wiktoria Michelisowa social care home in Lublin (KMP.575.2.2023).

[447] Social care home in Babica (KMP.575.1.2023).

[448] Social care home in Babica (KMP.575.1.2023).

[449] Home of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023).

[450] As above.

[451] As above.

[452] As above.

are not authorised to make decisions regarding the placement of such persons in a facility. The existing legislative gap and lack of safeguards encourage arbitrary approach of persons who sign the contracts. In view of the above, the issue should be regulated at the statutory level[453].

2. CCTV monitoring

At present, the issue of CCTV monitoring in residential care and treatment facilities is not regulated in any way. Video surveillance is used in order to ensure the safety of residents and patients, but at the same time it constitutes an invasion of their privacy. For the use of such surveillance to be lawful, it should meet the requirements set out in Article 31(3) of the Polish Constitution, including the requirement regarding statutory restrictions.

3. Use of non-standard forms of protecting residents

In the care provision, there are situations in which non-standard forms of protection are used to protect the residents' health and ensure their safety. Such forms include non-attested stabilization belts, thera-bands or other items that are intended to protect a resident from falling off a bed or wheelchair is not, formally, a coercive measure but there is a risk that it may interfere with the individual's freedom. Their use should therefore be accompanied by a number of procedural and material safeguards regulated at the statutory level[454].

4. Differentiation of salary levels between nurses employed in medical entities and those employed in social care homes

Social care homes operate within the social welfare system and the remuneration of nurses employed there is paid from the budget of the relevant local government. Nurses employed in the medical sector receive higher salaries from the National Health Fund a as well as additional benefits, allowances etc. This causes problems with finding nurses for social care homes, and their frequent resignation from employment there and transfer to health care entities This, in turn, translates into lower standards of nursing care for social care home residents[455].

5. The staff of social care homes acting as legal guardians of residents

A legal guardian should monitor whether the person under his/her guardianship receives appropriate care and whether their dignity is not violated. When a social care home employee is at the same time the legal guardian of an incapacitated resident, there is a risk of a conflict of interests. Personnel of care homes may have difficulties in maintaining objective approach when performing the role of legal guardians of the home's residents, especially in view of their work for the employer. The additional responsibilities may also lead to a lack of motivation and reliability in the performance of professional duties.

The problem has been highlighted also by the CPT which emphasises that solutions should be found which better guarantee the independence and impartiality of guardians[456].

6. Insufficient supervision by courts of the stay in social care homes of persons who are legally incapacitated or have been placed there based on a court decision

Insufficient judicial control over the placement of incapacitated persons and persons placed pursuant to a court decision in social care homes with a profile other than for patients with mental illness or intellectual disability remains a problem.

According to Article 43(1) of the *Act on mental health protection*, the obligation of judicial control of the legality of the admission to and stay in a social care home of persons with mental disorders, of the observance of their rights and the conditions in the facility applies only to social care homes for persons with mental illness or intellectual disabilities.

However, such persons may also be placed in other types of homes that are not subject to such control[457]. The solution is disadvantageous for such residents of social care homes a, particularly in terms of the possibility to verify the grounds and duration of their deprivation of liberty at the facility.

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[453] See: General intervention letter of the CHR to the Minister of Family and Social Policy of 25 January 2022 (KMP.573.1.2022) and the Report of the Commissioner for Human Rights on the activities of the NPM in Poland in 2022, p. 112.

[454] See: Report of the Commissioner for Human Rights on the activities of the NPM in Poland in 2022, p. 113.

[455] As above.

[456] See: CPT standards set out in the document entitled "Persons deprived of their liberty in social care establishments", a Factsheet, 21 December 2020, CPT/Inf (2020) 41, para. 32.

[457] See: Report of the Commissioner for Human Rights on the activities of the NPM in 2018.

7. Online court hearings in cases concerning legal incapacitation

During the state of epidemic threat and the state of epidemic, declared due to COVID-19, and within one year afterwards, it was permissible to conduct court hearings in civil cases in the form of videoconferences[458].

The NPM is of the opinion that hearings concerning such important matters as legal incapacitation should be held in person, with the adjudicating panel having personal contact with the parties to the proceedings. A decision on legal incapacitation has far-reaching legal consequences that influence the person's right to freedom and right to make independent decisions about oneself and one's property. Therefore, particular attention should be paid to ensuring procedural safeguards for the person concerned. Account has to be taken of all circumstances, including the person's physical and mental health and ability to function in everyday life so that the legal solution applied is best adjusted to the situation of the person.

Remote hearings are characterised by obstacles and risks related e.g. to poor quality and/or interruptions of online connections. This may affect the understanding of the proceedings and information (in particular by older and/or hard-of-hearing persons) and make it difficult for the judge to identify and record any allegations of torture and ill-treatment. For example, poor quality of video connection may make it impossible to see injuries or their extent[459].

8. Cooperation of social care homes with psychologists

The regulations in force do not require social care homes to employ a psychologist but only to provide access to a psychologist to their residents. In the opinion of the NPM, a condition of appropriate care provision to social care homes' residents is regular and unrestricted access to a psychologist [460].

■ Areas that require improvement

Private long-term care facilities

1. Legality of stay

In all the visited facilities, contracts on admission to the facility were concluded between the owner of the facility and the actual guardian of the resident[461]. The situation shows that there is no actual legal basis for the resident's admission to the facility[462]. It is difficult to identify an optimal solution to the problem, as pointed out in the section on systemic problems.

The NPM recommends that in such cases a tripartite agreement be concluded and signed by the resident, the resident's guardian and a representative of the facility. A person who can express verbal consent but is unable to sign a written consent to the placement in a private long-term care facility and the contract regarding the placement (due to a health condition that makes writing impossible for the person) should be allowed to place an ink fingerprint[463]. In other cases, court approval should be required.

The issue was highlighted by the CPT in its report on the visit to Poland in 2009. As pointed out by the CPT, steps should be taken to ensure that to ensure that all residents who are not or no longer able to give a valid consent to their placement, do not have a guardian and are prevented from leaving the establishment, are notified to the competent court[464].

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458 Based on the repealed provisions of Article 15zzs1 of the Act of 2 March 2020 on special measures for preventing, counteracting and combating COVID-19 and other infectious diseases and crisis situations caused by them (Journal of Laws of 2024, item 340, as amended). The practice was observed at the social care home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023).

459 The CPT emphasises the importance of personal access to a judge as an important element of the prevention of torture. See: CPT Twelfth General Report, CPT/Inf (2002) 12, para. 45.

460 The issue is discussed in more detail in the Report of the Commissioner for Human Rights on the activities of the NPM in 2018.

461 Some of the contracts had attached consents of individual residents to their placement in the private long-term care facility and, therefore, the residents could legally be parties to the contracts.

462 Private long-term care facilities: "Alter Domus" Care and Rehabilitation Centre in Otwock (KMP.573.14.2023), "Willa Chopina" long-term care facility in Toruń (KMP.573.8.2021), "Słoneczny Las" Family Home for Seniors in Wierzbica (KMP.573.10.2023), "Family Care Home" in Stare Babice (KMP.573.16.2023), "Pogodna Jesień" care home in Odrowąż (KMP.573.6.2023), "Barbara" care home in Wielka Wieś (KMP.573.7.2023) and "Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023).

463 See: Article 79 of the Act of 23 April 1964 – Civil Code.

464 See: CPT report on the visit to Poland, CPT/Inf (2011) 20, para. 166.

In 2023, at one of the facilities[465] the visiting team had doubts as to the authenticity of the signatures on the contracts. In another facility, the NPM representatives were refused access to the contracts regarding resident placement, which raised doubts as to whether such contracts had been concluded at all[466]. At yet another[467] facility, the visiting team were refused access to a full list of residents, both on the day of the visit and in the subsequent period, after the NPM had sent a letter to the facility managers. The documentation on residents of another facility[468] did not include court decisions on placement in the facility and decisions on legal incapacitation.

The NPM reminds that the requirement to have the said documents arises directly from the Act on Social Welfare[469].

The NPM also observed the practice of admitting additional residents for so-called day care provided only at daytime, without overnight accommodation[470]. The situation may cause problems from the point of view of the standard offered to the long-term residents. Not every care home has conditions to accommodate additional persons. The carers who, as a rule, should look after the long-term residents have to devote their time and attention also to those who stay there only during the day. The practice may result in lowering the standard of services and reducing the control over the situation of residents.

In one of the cases, the maximum number of residents set in the permit issued by the head of the voivodeship government was nearly doubled[471]. As a result, the service standard and living conditions of the residents drastically worsened.

The NPM recommends the observance of limits set in permits issued by heads of voivodeship governments.

2. Treatment of residents

The NPM employees heard reports of ill-treatment of residents in some facilities. Apart from the issue of mistreatment of persons who are vulnerable due to their age and health condition[472], which is discussed in other parts of this chapter, there were also reports of the use of offensive language and shouting at residents at one of the facilities2[473]. In another facility, residents were threatened, e.g. one of them heard that she would be taken out of her room and not let back if she does not 'behave calmly'3[474].

The NPM emphasises the need to treat people in care facilities with respect and to communicate with them in a controlled manner, regardless of the circumstances and behaviour of the residents. The use of offensive language should be strictly prohibited. Measures should be taken to build an organisational culture that promotes appropriate behaviour of staff and motivates them to counteract inappropriate and humiliating treatment.

At the same time, the NPM recommends that staff of the facilities be trained in the area of human rights protection and humane treatment. Residents of such facilities, due to their age, health condition or disability are a particularly vulnerable group at risk of ill-treatment, which is why it is so important to ensure their safety.

In one of the visited facilities there was a practice of locking bedrooms of bedridden residents1[475]. This constituted deprivation of their liberty, posed a risk to their health, including mental health, and made it difficult or even impossible to provide immediate assistance to them in the event of emergency. Employees of private long-term care facilities have no powers to lock residents in their rooms. The practice restricts the freedom of people who, upon admission to a private long-term care facility, trust in the provision of best possible assistance to them.

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[465] Private long-term care facility "DARDOM" in Marki near Warsaw (KMP.573.13.2023).
[466] Private long-term care facility "Willa Chopina" in Toruń (KMP.573.8.2021).
[467] Private long-term care facility "Słoneczny Las" Family Home for Seniors in Wierzbica (KMP.573.10.2023).
[468] Private long-term care facility "Barbara in Wielka Wieś (KMP.573.7.2023).
[469] Act on Social Welfare of 12 March 2004 (Journal of Laws of 2024, item 1283).
[470] Private long-term care facility "Pogodna Jesień" in Odrowąż (KMP.573.6.2023).
[471] Private long-term care facility "DARDOM" in Marki near Warsaw (KMP.573.13.2023).
[472] The NPM found the situation particularly alarming in the following private long-term care facilities: "Słoneczny Las" in Wierzbica (KMP.573.10.2023), "DARDOM" in Marki near Warsaw (KMP.573.13.2023) and "Pogodna Jesień" in Odrowąż (KMP.573.6.2023).
[473] Private long-term care facility "DARDOM" in Marki near Warsaw (KMP.573.13.2023).
[474] Private long-term care facility "Pogodna Jesień" in Odrowąż (KMP.573.6.2023).
[475] Private long-term care facility "Słoneczny Las" Family Home for Seniors in Wierzbica (KMP.573.10.2023).

The NPM recommends that the practice of locking residents in their rooms be discontinued.

The NPM representatives pointed out that the visited facilities, as a rule, do not have procedures in place to regulate the response of staff members to difficult situations (e.g. aggressive behaviour of a resident, undesirable incidents, self-harm or a suspicion of offence)[476]. This leads to situations in which, among others, staff of private long-term care facilities decide not to report a suspected offence against a resident.

In one of the facilities, the visiting team heard a report of a resident who, in autumn 2022, was brought back from a hospital with numerous bruises. He died three days later. The situation was not documented in any official report. The facility owner only took photographs which she had on her telephone; they were not included in any documentation. The facility did not take any action in connection with the situation and did not report a suspected crime to a prosecutor[477].

The visiting team also encountered the case of a resident who, according to her statement, had experienced sexual violence before her placement in the private long-term care facility[478]. Despite the staff's awareness of the situation she did not receive any professional assistance, including psychological support.

The NPM takes the view that if staff have been informed of any form of violence used with regard to a person under their care, the victim should have access to psychological support, even if the incident took place before the person's placement in the private long-term care facility. Law enforcement authorities should also be notified. This is of particular importance in the case of persons with intellectual disabilities, as they are particularly vulnerable to violence and require increased protection. The NPM reminds that "Anyone who has learnt of the commission of an offense prosecuted ex officio has a public obligation to notify the prosecutor's office or the police thereof"[479].

3. Right to health care

In some of the visited private long-term care facilities patients were seen by a doctor once a week[480]. In others[481], doctors were not employed on permanent basis but were available only under a contract with the National Health Fund. Several homes had a nurse employed on permanent basis and available daily for two or three hours. Some residents had to wait a few days for a medical consultation. Two facilities[482] did not even have a nurse. In one of them, medications for patients were prepared by a volunteer. In the other one[483], no list of nursing care activities was kept, which made it impossible to verify whether the residents received sufficient care.

Signs of injuries in persons admitted to the visited facilities or returning to them from other places were not recorded in the form of body maps[484]. Taking photographs of injuries, bedsores or bruises was not a standard practice of nurses although, according to the NPM, such documentation is helpful in pursuing the rights of residents, including in criminal proceedings. In some of the facilities, when a resident had bedsores after returning to the facility, they were documented with a photograph taken by a staff member and forwarded to the facility owner. The photographs were not attached to the resident's medical records and no external institution was notified of the negligence with regard to the resident[485]. The size of the bedsores was not documented either as, according to the staff "what matters is not the size but the severity of the bedsore". In other facilities, injuries and bedsores were documented with photographs[486] forwarded to the resident's relatives. However, this was not confirmed in the medical records.

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476 Private long-term care facilities: "Barbara" in Wielka Wieś (KMP.573.7.2023), "Family Care Home" in Stare Babice (KMP.573.16.2023), "DARDOM" in Marki near Warsaw (KMP.573.13.2023), "Pogodna Jesień" in Odrowąż (KMP.573.6.2023) and "Willa Chopina" in Toruń (KMP.573.8.2023).

477 Private long-term care facility "Pogodna Jesień" in Odrowąż (KMP.573.6.2023).

478 Private long-term care facility "Barbara" in Wielka Wieś (KMP.573.7.2023).

479 Article 304(1) of the Act of 6 June 1997 – Code of Criminal Procedure (Journal of Laws of 2024, item 37).

480 Private long-term care facilities: "Alter Domus" Care and Rehabilitation Centre in Otwock (KMP.573.14.2023) and "DARDOM" in Marki near Warsaw (KMP.573.13.2023).

481 Private long-term care facilities: "Willa Chopina" in Toruń (KMP.573.8.2021), "Family Care Home" in Stare Babice (KMP.573.16.2023) and "Pogodna Jesień" in Odrowąż (KM P.573.6.2023).

482 Private long-term care facilities: "Pogodna Jesień" in Odrowąż (KMP.573.6.2023) and "DARDOM" in Marki near Warsaw (KMP.573.13.2023).

483 Private long-term care facility "DARDOM" in Marki near Warsaw (KMP.573.13.2023).

484 Private long-term care facilities: "Alter Domus" Care and Rehabilitation Centre in Otwock (KMP.573.14.2023), "Willa Chopina" in Toruń (KMP.573.8.2021), "Family Care Home" in Stare Babice (KMP.573.16.2023), "Barbara" in Wielka Wieś (KMP.573.7.2023) and "Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023).

485 Private long-term care facilities: "Willa Chopina" in Toruń (KMP.573.8.2021), "Słoneczny Las" Family Home for Seniors in Wierzbica (KMP.573.8.2021) and "Pogodna Jesień" in Odrowąż (KM P.573.6.2023).

486 Private long-term care facility "Pogodna Jesień" in Odrowąż (KM P.573.6.2023).

In one of the facilities[487], the staff did not cooperate with any doctor and medical treatment of the residents was left to their relatives. According to Article 68 of the *Act on Social Welfare*, private long-term care facilities are required to provide care and nursing services, including care during illness. They are also under the obligation to provide the necessary assistance in personal matters, which is understood by the NPM as including health matters. The NPM is of the opinion that arranging for residents' medical treatment should not be left to their relatives, which is against the law, and that it constitutes a responsibility of the carers at the facility.

In all the visited facilities, there were cases of administering crushed medications to patients, sometimes by deception, without their knowledge and consent and without the consent of a doctor, recorded in the patient's documentation[488]. Detailed argumentation against the practice, highlighting the need for a doctor's consent to the administration of crushed medications is presented in this report in the chapter on detention of juveniles.

In one of the facilities[489], in residents' medical files the visiting team found advance consents to medical procedures, bearing no date and issued by legal guardians of legally incapacitated residents. Another facility followed instructions of the families with regard to the provision of medical services to the residents, which created a risk of death (without the consent of the family it was not possible to call an ambulance). There were cases in which distant family members had to consent to vaccinating a resident against an infectious disease dangerous to seniors[490].

According to Article 32(2) of the *Act on the professions of physician and dentist*[491], if a person is unable to give informed consent to medical treatment but is not legally incapacitated, the physician should apply to the guardianship court for consent to the treatment. The facilities' staff may not make a resident's treatment dependent on the decision of a relative who is not a legal guardian of the resident. The NPM also recommends calling the emergency services whenever necessary, without consulting third parties.

In one private long-term care facility results of medical tests were kept in residents' general files accessible not only to medical staff. Doctors providing care to the residents did not keep any medical records other than handwritten notes on loose sheets of paper[492]. Such form of medical documentation violates the right to protection of medical data, which falls within the scope of the right to privacy (Articles 47 and 51 of the Polish Constitution).

The NPM recommends that in private long-term care facilities medications and medical services be provided to residents without publicly disclosing information on them, and without providing access to information on medical condition of the residents to unauthorised persons (other than medical personnel cooperating with a given facility). The only exception to the rule should be the risk to the life of a resident.

4. Activation of residents and contact with a psychologist

Residents of most of the visited facilities by the NPM do not have access to a psychologist[493]. It should be noted that psychological support is essential, especially in the initial period of stay after the change of the place of residence and separation from relatives. At that time, residents are likely to experience the feelings of confusion, depression, anxiety, withdrawal and reluctance to contact other people. A person newly admitted to the facility may also feel strong resistance to the drastic change in their living situation.

The NPM recommends that every private long-term care facility establish cooperation with a psychologist to provide support to residents, their families and the facility's staff.

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487 Private long-term care facility "Family Care Home" in Stare Babice (KMP.573.16.2023).

488 Private long-term care facilities: "Alter Domus" Care and Rehabilitation Centre in Otwock (KMP.573.14.2023), "Słoneczny Las" Family Home for Seniors in Wierzbica (KMP.573.8.2021), "Family Care Home" in Stare Babice (KMP.573.16.2023), "Pogodna Jesień" in Odrowąż (KM P.573.6.2023) and "DARDOM" in Marki near Warsaw (KMP.573.13.2023).

489 Private long-term care facility "Barbara" in Wielka Wieś (KMP.573.7.2023).

490 Private long-term care facility "Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023).

491 Act on the professions of physician and dentist of 5 December 1996 (Journal of Laws of 2023, item 1516).

492 Private long-term care facility "DARDOM" in Marki near Warsaw (KMP.573.13.2023).

493 Private long-term care facilities: "Barbara" in Wielka Wieś (KMP.573.7.2023), "Family Care Home" in Stare Babice (KMP.573.16.2023), "DARDOM" in Marki near Warsaw (KMP.573.13.2023), "Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023), "Pogodna Jesień" in Ordowąż and "Willa Chopina" in Toruń (KMP.573.8.2021).

Most of the visited facilities had no occupational therapy for their residents[494]. Despite attempts by staff members to engage residents in different activities, they spent most of their time in their bedrooms watching television, reading newspapers, singing or praying together. In rare cases some facilities established cooperation with volunteers or local kindergartens and schools to organise visits to the residents. Physical rehabilitation services were also provided to an insufficient extent.

In the opinion of the NPM, residents of private long-term care facilities should have access to professional occupational therapy aimed at their physical, psychological and intellectual activation. The therapy should be documented in order to enable assessment of its effectiveness. The National Mechanism recommends employing an occupational therapist. Cooperation with a physiotherapist should also be considered.

5. Contact with the outside world

In most of the visited facilities residents were not allowed to leave the premises. The facilities justified this by residents' poor health condition, including problems with consciousness[495]. Only sporadically staff members took residents for a walk.

The NPM reminds that any restrictions on leaving private long-term care facilities may be imposed only on the basis and within the limits of applicable law. In every case, a medical certificate issued by a doctor is required to confirm the grounds for the restriction; the certificate may be issued for no more than 6 months[496]. The certificate has to be attached to the resident's file. The guardianship court for the area in which the facility is located also has to be informed of the restriction. The document should be delivered to the resident and, if he or she is legally incapacitated in full, also to their legal representative.

In one of the facilities residents, at the request of their family members, had limited contact with people from outside the facility, and their private mobile phones were taken in the evenings[497]. This should be considered humiliating and unlawful treatment that restricts the freedom of the residents.

The NPM points out that placement in a private long-term care facility does not deprive people of the right to make decisions regarding themselves and does not provide grounds for their belongings being taken from them by the personnel.

6. Right to information and a complaint mechanism

According to the NPM findings, the director of one of the facilities[498] informed newly placed residents upon admission that they were placed in the home for a specific period of time or for a health resort stay. Placement in a facility entails a radical change in the residents' lives as they leave their homes and start living with people not known before, in the conditions of dependence on the staff and care provided by them and in separation from their previous environment. Thus, the NPM is of the opinion that misinforming residents about the nature of the facility and the purpose of their stay there violates their fundamental right to information, raises doubts as to the legality of the placement and, in certain situations, may even be considered cruel treatment.

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[494] Private long-term care facilities: "Barbara" in Wielka Wieś (KMP.573.7.2023), "Family Care Home" in Stare Babice (KMP.573.16.2023), "DARDOM" in Marki near Warsaw (KMP.573.13.2023) and "Pogodna Jesień" in Odrowąż (KM P.573.6.2023).

[495] Private long-term care facilities: "Barbara" in Wielka Wieś (KMP.573.7.2023), "Family Care Home" in Stare Babice (KMP.573.16.2023), "DARDOM" in Marki near Warsaw (KMP.573.13.2023), "Słoneczny Las" Family Home for Seniors in Wierzbica (KMP.573.8.2021), "Pogodna Jesień" in Odrowąż (KM P.573.6.2023), "Willa Chopina" in Toruń (KMP.573.8.2021), and "Alter Domus" Care and Rehabilitation Centre in Otwock (KMP.573.14.2023).

[496] See: Article 68(2a)-(2h) of the Act on Social Welfare.

[497] Private long-term care facility "DARDOM" in Marki near Warsaw (KMP.573.13.2023)

[498] Private long-term care facility "Słoneczny Las" Family Home for Seniors in Wierzbica (KMP.573.8.2021).

Some private long-term care facilities[499] did not have any internal regulations governing their operation and no notice boards in visible places with important information for residents[500], including about entities that can be contacted in the event of violation of their rights.

The NPM recommends that every newly admitted resident be informed about the nature of the facility and their stay there. Clear and understandable information about the facility should be placed inside it on publicly accessible notice boards.

The visited private long-term care facilities usually had no complaint mechanism in the form of a book of complaints[501], and if it existed, it contained no entries[502]. All complaints and requests were received verbally by the staff and, according to their statements, were dealt with on an ongoing basis. The residents' awareness of the possibility to file a complaint resulted from their familiarity with the rules commonly followed in the relations between citizens and institutions, gained during their earlier life experience, and not from information provided by the facility staff[503]. Not all residents were aware of the possibility to file a complaint.

It should be pointed out that the CPT has developed standards regarding complaint mechanisms, which are worth taking into account in the management of a facility[504].

The NPM recommends the use of a book of complaints in which residents could report them and the private long-term care facility would enter its responses. The Mechanism also suggests the installation of a complaints box located in a place that ensures privacy of the reports. Given the generational changes in the forms of communication, electronic reporting of complaints and requests should also be available.

7. Registers, procedures and documentation

Some of the private long-term care facilities had no register of applied coercive measures[505], which is required under the *Act on Social Welfare*[506].

In the opinion of the SPT, appropriately kept records are an important safeguard against torture and other forms of ill-treatment of persons deprived of their liberty[507].

Not all private long-term care facilities kept a register of incidents (such as falling down by a resident, self-harm, bodily injuries, etc.)[508]. The regulations that require such registers to be kept entered into force in 2024. Yet, the recording of such incidents was recommended by the NPM already in 2023 in order to strengthen the protection of residents against violence.

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499 Private long-term care facilities: "Alter Domus" Care and Rehabilitation Centre in Otwock (KMP.573.14.2023), "Willa Chopina" in Toruń (KMP.573.8.2021), "Pogodna Jesień" in Odrowąż (KM P.573.6.2023), Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023), "Family Care Home" in Stare Babice (KMP.573.16.2023) and "Słoneczny Las" Family Home for Seniors in Wierzbica (KMP.573.8.2021).

500 Since 1 November 2023, there has been a requirement for the notice board in every facility to contain contact details of competent authorities, institutions and organisations working in the area of human rights as well as relevant supervisory bodies, in particular: the Commissioner for Human Rights; the Patient Ombudsman; the state district sanitary inspector; the social welfare department of the voivodeship office ; the social welfare centre responsible for the area where the facility is located; the district prosecutor's office and the guardianship court (Article 68a(3) of the Act on Social Welfare).

501 Private long-term care facilities: "Alter Domus" Care and Rehabilitation Centre in Otwock (KMP.573.14.2023), "Willa Chopina" in Toruń (KMP.573.8.2021), "Family Care Home" in Stare Babice (KMP.573.16.2023), "Pogodna Jesień" in Odrowąż (KM P.573.6.2023) and "Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023).

502 Private long-term care facility "Barbara" in Wielka Wieś (KMP.573.7.2023).

503 Private long-term care facility "Słoneczny Las" Family Home for Seniors in Wierzbica (KMP.573.8.2021).

504 See: CPT Twentieth General Report, CPT/Inf (2018) 4, paras. 68–91.

505 Private long-term care facilities: "Family Care Home" in Stare Babice (KMP.573.16.2023), "DARDOM" in Marki near Warsaw (KMP.573.13.2023), Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023), "Pogodna Jesień" in Odrowąż (KM P.573.6.2023), "Willa Chopina" in Toruń (KMP.573.8.2021).

506 Article 68a of the Act on Social Welfare.

507 See: Subcommitee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT); See also: SPT report on its visit to Ukraine, CAT/OP/UKR/1, paras. 49–52.

508 Private long-term care facilities: "Barbara" in Wielka Wieś (KMP.573.7.2023), "Family Care Home" in Stare Babice (KMP.573.16.2023), "DARDOM" in Marki near Warsaw (KMP.573.13.2023), "Pogodna Jesień" in Odrowąż (KMP.573.6.2023) and "Willa Chopina" long-term care facility in Toruń (KMP.573.8.2021).

The individual files of residents of one of the private long-term care facilities contained their identity cards but did not contain consents of the owners for their cards to be kept in deposit by the facility[509].

According to Article 79(2) of the Act of 6 August 2010 on identity cards[510], anyone who retains another person's identity card without legal grounds is subject to restriction of liberty or a fine. According to the interpretation made by the Court of Appeal in Katowice in its judgment of 9 December 2010 II Aka 397/10, 'there is no offence (...) if another person's identity card is retained with the acceptance and consent of the card owner'.

The NPM recommends that the resident or the legal guardian of an incapacitated resident give consent to retaining the resident's identity card in deposit.

8. Living conditions

Apart from the issue of overcrowding at some of the visited private long-term care facilities, which has been raised in the section on the legality of stay, not all of the facilities met the standards relating to the condition, size and equipment of the rooms, even in light of the minimum requirements set out in the *Act on Social Welfare*.

At one of the facilities, residents were accommodated in a part of the building that had not been approved for use as a care home by the head of the voivodeship government, and the overcrowding on the upper floor was only one of the problems identified in the facility[511]. In two other facilities, the standard of equipment caused concern of the visiting team:

a) Despite the objections raised in the past by the voivodeship government office[512], the living conditions observed during the visit by the National Preventive Mechanism drastically failed to meet the standards set out in the *Act on Social Welfare*.
   - The NPM team found that the rooms for residents were too small. In some of them, the additional residents had low-height rollaway beds from which it was difficult for them to stand up; some of them could not stand up at all without the help of others. This caused progressive decline in the fitness of those residents and their increased dependence on others. All the bedrooms of the residents were worn out and gloomy. Damage was visible on the walls, skirting boards and beds. The furniture in the rooms was incomplete and varied in size, and its degree of wear and tear was very high. During the visit, there was an unpleasant smell suggesting insufficient cleanliness of the facility. In some bedrooms the windows had no handles and could not be opened, which limited access of fresh air. At the time of the visit, there were 69 residents with disabilities at the facility. The number was almost twice as high as that approved in the permit by the head of the voivodeship government. For example, in double and triple rooms there were four beds, some of which were low-height rollaway beds [513]. The standard of floor space per person was not met[514]: according to the regulations, the minimum floor area should be 6 m^2 per person[515].

b) The residents' bedrooms were sparsely furnished and some residents did not even have basic furniture items. There was mould on the walls and ceilings in most of the rooms on the lower floor, which was considered by the NPM to pose a health hazard. Representatives of the State Sanitary Inspector of the poviat of Końskie, who were notified of the conditions in the facility, were not allowed by the personnel to enter and inspect it. After the NPM notified the relevant authorities, the facility moved to another location[516].

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509 Private long-term care facility "Pogodna Jesień" in Odrowąż (KM P.573.6.2023).

510 Journal of Laws of 2022, item 671.

511 Private long-term care facility "Słoneczny Las" Family Home for Seniors in Wierzbica (KMP.573.8.2021).

512 There were 25 seniors with physical disabilities in the private long-term care facility. Most of them had limited or no verbal communication abilities and were physically frail. The people in the attic were living there in conditions that threatened their health and lives. The rooms were foul-smelling and stuffy and had no access to fresh air. Only one room had a full-size window; two had no windows at all, and the others had small skylight-type windows. The rooms were poorly lit and had no access to a permanent source of electricity and light such as lamps on the ceiling or wall lamps. The windows were locked and covered with dirty damaged sheets and other fabrics. Light came from light bulbs fixed to the ends of unprotected wires. The bedrooms of the residents had camping beds with thin mattresses and some mattresses without a bed. The bedding on was very dirty, stained, damaged and incomplete. Apart from the beds and mattresses, the rooms had one damaged table, several chairs and a television set. In the attic, there was one bathroom without a door, one toilet, a shower, a washbasin, and a washing machine. In one of the bedrooms there was also a portable toilet. There were two carers with the residents in the attic".

513 In three-person rooms, fours residents were living. The legislator makes it possible for care facilities to have four-person rooms on condition that they are occupied only by bedridden persons (see Article 68(4a) of the Act on Social Welfare).

514 Private long-term care facility "DARDOM" in Marki near Warsaw (KMP.573.13.2023).

515 See: Article 68(4)(2)(b-c) of the Act on Social Welfare.

516 Private long-term care facility "Pogodna Jesień" in Odrowąż (KM P.573.6.2023).

Apart from the above-mentioned examples, in one of the private long-term care facilities the NPM representatives saw that the number of bathrooms was too small for the number of residents placed there (in some of the showers adjacent to the bedrooms, shower drains were sealed with a tape). It was possible to have a bath only with the assistance of another person, even if the health of the resident did not require the provision of additional support. Residents could take a bath only once a week[517].

Adaptations to the needs of persons with disabilities in the visited private long-term care facilities were sometimes insufficient and/or defective (e.g. handles that should sustain a person's whole body mass were attached with suction cups that easily came off[518]). A common problem was the lack of call systems in bedrooms and bathrooms[519].

Even in the facilities' buildings which were, in general, adapted to the needs of persons with disabilities and in which residents were placed on the ground floor or floors accessible by lift, there were other inadequacies, mainly relating to bathrooms (e.g. small space for moving, mirrors placed too high, non-functional handles, etc.)[520].

In another facility[521] single rooms did not meet the requirements applicable to them, although the building had also much larger rooms which, however, were not in use.

In many cases, no lockable furniture items were available for residents' personal belongings[522].

The CPT[523] recommends that nursing home residents have access to lockable storage for their belongings. In the opinion of the CPT, the lack of a place where residents can store and lock their belongings may undermine their sense of security and autonomy[524].

The situations such as those described above may violate the residents' right to dignified treatment. The National Mechanism points out that all residents should have enough space in the rooms they use, mainly in bedrooms. All rooms should be sufficiently lit (with natural and artificial light) and should have the possibility to let fresh air in (windows in rooms should be openable). Residents should have home-like furniture in their rooms, including a bed appropriate to their health condition and needs, a lockable cupboard and space in a wardrobe, as well as a table and chairs/armchairs that are safe in the event of falling.

It is illegal to place an excessive number of people in one room and to accommodate residents in places that are difficult to access, e.g. an attic without a lift.

Ideally, every resident should have his or her bathroom with a shower, or at least a bathroom shared by a limited number of people and located close to the bedroom.

All rooms should be well-lit, properly equipped, ventilated, cleaned on daily basis and adapted to the needs of senior people with disabilities or with reduced mobility.

The entrance to the building and the outdoor premises should also be adapted for wheelchair users or people using walking sticks or crutches.

A call system has to be installed in bedrooms and bathrooms, regardless of the presence of staff nearby.

In private long-term care facilities, living rooms should have comfortable seats and tables, access to a TV set, as well as sufficient space for various activities for the whole community of residents.

All rooms, but in particular bedrooms should have a temperature level appropriate for the season of the year and should be equipped with heating devices as well as cooling devices in case of heat waves that are increasingly frequent and can threaten the life and health of a senior person.

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517 Private long-term care facility "Family Care Home" in Stare Babice (KMP.573.16.2023).

518 Private long-term care facility "Family Care Home" in Stare Babice (KMP.573.16.2023).

519 Private long-term care facilities: "Family Care Home" in Stare Babice (KMP.573.16.2023), "Pogodna Jesień" in Odrowąż (KM P.573.6.2023), "Barbara" in Wielka Wieś (KMP.573.7.2023), "DARDOM" in Marki near Warsaw (KMP.573.13.2023) and "Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023).

520 Private long-term care facilities "Family Care Home" in Stare Babice (KMP.573.16.2023) and "Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023).

521 Private long-term care facility "Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023).

522 Private long-term care facilities: "Pogodna Jesień" in Odrowąż (KM P.573.6.2023), "DARDOM" in Marki near Warsaw (KMP.573.13.2023) and "Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna (KMP.573.18.2023).

523 See: Persons deprived of their liberty in social care establishments, Factsheet, 21 December 2020, CPT/Inf (2020) 41, para. 10.

524 See: CPT Eighth General Report, CPT/Inf (98) 12, paragraph 34.

9. CCTV monitoring

CCTV monitoring systems were present in several private long-term care facilities[525]. The cameras were located, in most cases, in common areas or only outdoors. In one facility, a monitor with CCTV image streaming was located in the building's part in which the facility owners lived. This meant that the images could be seen also by persons not working at the facility and, therefore, not authorised to watch the residents (e.g. the owners' guests or family members). According to the findings of the NPM team the residents were not aware of the existence of the monitoring system[526].

The concerns regarding the need to ensure the rights to privacy and security are laid down in the section on systemic problems.

10. Staff

In two private long-term care facilities, the visiting team found that the number of staff was insufficient[527]. In one of them, there was organisational chaos, no clear division of responsibilities and work was performed by persons without the required qualifications[528].

For appropriate operation of a private long-term facility in accordance with the minimum requirements set out in the *Act on Public Healthcare* it is necessary to ensure:

- A sufficient number of staff with the required qualifications and acceptable results of medical tests required to perform the work;
- A precise schedule of individual employees' shifts, including the number of persons on every day shift and night shift;
- The practice of making monthly work schedules of individual persons who work at the facility;
- Precise definition of the scope of duties of every employee. If an employee has duties characteristic of different positions, there should be a time schedule indicating the hours in which the individual duties are performed by the person at daytime and at night-time.

Given the specific nature of work in a care home, difficult situations may occur in employees' relations with residents, also due to mental strain associated with the profession.

In this view, the NPM recommends that, in addition to work organisation according to the above-mentioned rules, a range of training courses and workshops be made available for the staff. They should cover subjects such as methods of coping with stress, aggression and burnout, contact with difficult residents; motivational dialogue, crisis intervention as well as international human rights standards aimed at preventing torture and other forms of ill-treatment.

The NPM also recommends that supervision for staff be ensured. Such supervision should be provided by an external expert.

The CPT emphasises that, given the difficult nature of their work, staff of care facilities (nurses, ward cleaners, caregivers) should receive the necessary support and counselling to avoid burnout and maintain high standard of care[529].

Furthermore, in accordance with the recommendation of the Committee of Ministers of the Council of Europe, carers of older persons should be adequately trained and should receive support to be able to provide the necessary assistance in an appropriate manner[530].

Social care homes

1. Legality of stay

One of the issues analysed during every preventive visit by the NPM, and discussed in more detail in the section on systemic problems, is the performance by staff of social care homes of the role of legal guardians of legally incapacitated persons. During the visits conducted in 2023, a case was encountered

[525] Private long-term care facilities: "Family Care Home" in Stare Babice (KMP.573.16.2023), "Pogodna Jesień" in Odrowąż (KM P.573.6.2023), "Willa Chopina" in Toruń (KMP.573.8.2021) and "Alter Domus" Care and Rehabilitation Centre in Otwock (KMP.573.14.2023).

[526] Private long-term care facility "Family Care Home" in Stare Babice (KMP.573.16.2023).

[527] Private long-term care facilities "Family Care Home" in Stare Babice (KMP.573.16.2023) and "DARDOM" in Marki near Warsaw (KMP.573.13.2023).

[528] Private long-term care facility "DARDOM" in Marki near Warsaw (KMP.573.13.2023).

[529] See: Persons deprived of their liberty in social care establishments, CPT Factsheet, 21 December 2020, CPT/Inf (2020) 41, para. 17; see also: the CPT report on the visit to Bulgaria in 2017, CPT/Inf (2018) 15, para. 149.

[530] See: Article 34 of Recommendation CM/Rec (2014) 2 on the promotion of human rights of older persons, adopted by the Committee of Ministers of the Council of Europe on 19 February 2014.

in which a court had ordered a social care home to appoint a legal guardian for a resident if none of his relatives agrees to take the role[531].

Another problem found by the NPM was that the number of residents actually living in a given facility was higher than the limit set by the head of the voivodeship government[532].

In one of the homes, the documentation of some patients lacked court decisions on their placement in the home or, in the case of legally incapacitated persons, an official statement of who the legal guardian of the resident was[533].

2. Treatment and discipline

In one of the facilities, the staff did not always address residents politely[534]. In another facility, there were a few reports from residents that some carers laughed at them and were rude or sarcastic[535].

During a visit to another home[536], a member of the NPM team witnessed a situation in which a resident reported the need to use the toilet and asked for help in getting there but was refused. The reason given by a staff member was that she was wearing a diaper so she did not have to use the toilet. In the same home, some residents also expressed dissatisfaction with the care and service quality. They reported, as an example , that meals for bedridden residents were brought in the morning but the dirty plates were taken away only in the evening. Another example was that a bedridden person needed to be covered but due to the negligence of the staff another resident had to do it.

During one of the NPM visits, there were isolated reports of psychological abuse by one of the carers. She was said to shout at some residents and build an atmosphere of fear of disturbing her, especially at night (one resident with urological problems did not report wetting her bed for fear of the carer's reaction). The carer was also said to make unpleasant and critical comments about residents' body mass and refuse larger food portions to people whom she considered obese. The residents were also under pressure to eat a lot at the supper time not to ask for any food after 8 p.m.[537]

In one of the facilities residents reported that the staff performed all activities themselves, without giving the residents any independence[538].

The NPM recommends that staff be regularly reminded of the need to treat residents with respect and dignity. More attention should be paid to polite verbal contact with residents as well as to giving them an opportunity to carry out everyday activities by themselves (if they are able to perform them).

3. Medical care

In most of the visited social care homes[539] residents had access to a general practitioner once a week. Psychiatric treatment was provided on an ad hoc basis, within private medical visits, and appointments with other specialist doctors were made by the nurses[540].

In some of the visited homes there were no written procedures to be followed in case of finding signs of violence against a resident[541]. There was no practice either of conducting a medical examination upon admission to the home, although it provides an opportunity to detect signs of any earlier violence against a given resident.

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[531] Social care homes: home in Babica (KMP.575.1.2023), home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023) and "Słoneczne Wzgórze" in Ryjewo (KMP.575.3.2023).

[532] Stanisław Broniewski "Orsza" social care home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023).

[533] Social care home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023).

[534] Social care home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023).

[535] Social care home in Babica (KMP.575.1.2023).

[536] Stanisław Broniewski "Orsza" social care home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023).

[537] Social care home "Słoneczne Wzgórze" in Ryjewo (KMP.575.3.2023).

[538] Social care home in Babica (KMP.575.1.2023).

[539] Social care homes: in Babica (KMP.575.1.2023), Stanisław Broniewski "Orsza" home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023), Wiktoria Michelisowa home in Lublin (KMP.575.2.2023) and home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023) and "Słoneczne Wzgórze" in Ryjewo (KMP.575.3.2023).

[540] Stanisław Broniewski "Orsza" social care home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023).

[541] Social care homes: Stanisław Broniewski "Orsza" home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023), Wiktoria Michelisowa social care home in Lublin (KMP.575.2.2023) and home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023).

The CPT recommends that initial medical examinations be carried out without undue delay, preferably within 24 hours of admission. A record of such examination should include: an objective and precise description of the condition of the resident, including any injuries; the results of any additional medical tests, reports on any specialist medical consultations, proposed treatment of any injuries, if found; and indications for further work with the person[542]. The NPM also recommends that a medical examination be carried out after every long-term absence from the care home.

Another problematic area is the availability of nurses, including at night, which is lacking in many facilities[543].

In the opinion of the NPM, nurses should be available 24 hours a day to ensure the safety of residents of social care homes.

The CPT also pointed to the need to ensure the presence of at least one nurse at night, by emphasizing that medical and psychiatric treatment forms an important part of overall care. To this end, a general practitioner and a psychiatrist should be present on a regular basis according to the residents' needs and the size of the establishment, and at least one nurse should always be present, including at night[544].

The staff of the visited social care homes[545] had not undergone any training on the Istanbul Protocol. The document contains useful information for doctors and psychologists, e.g. on how to determine whether a person has been a victim of ill-treatment and how to document and report such cases to courts or investigative bodies.

The NPM recommends documenting residents' injuries using a special form, a so-called body map, on which injuries should be marked. The form, together with photographic documentation, should be included in the resident's medical records. The NPM also recommends that training be carried out on the Istanbul Protocol and the application of the guidelines contained therein.

The lack of training on the Istanbul Protocol translates into inability to apply injury documentation procedures. In one of the social care homes[546] a resident had fallen out of bed and suffered extensive injuries. The incident was described in a report of a nurse but without attaching any photographs and without a body map marking the injuries.

The use of the Istanbul Protocol is recommended by CAT[547], SPT[548], CPT[549] and the UN Special Rapporteur on Torture[550].

Another problem is that for years the NPM has observed the practice of crushing medications before administering them to residents. According to information from the staff, this is done with the consent of a doctor but is not recorded in residents' medical records[551]. Arguments for crushed medication to be administered to people only with a consent of a doctor are set out in this report's section on detention of juveniles.

The National Preventive Mechanism recommends that the administration of crushed medication be recorded in residents' medical records.

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542 See: CPT Twentieth General Report, CPT/Inf (2013) 29, paras. 71–84.

543 Social care homes: Wiktoria Michelisowa social care home in Lublin (KMP.575.2.2023), home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023) and "Słoneczne Wzgórze" in Ryjewo (KMP.575.3.2023).

544 See: Persons deprived of their liberty in social care establishments. Factsheet, CPT/Inf (2020) 41, para. 19.

545 Social care homes: Stanisław Broniewski "Orsza" home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023) and home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023).

546 Stanisław Broniewski "Orsza" social care home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023).

547 See: CAT Conclusions and Recommendations for Poland, 29 August 2019, CAT/C/POL/CO/7, paras. 27–28.

548 See: Report on the visit to Portugal on 1–10 May 2018, CAT/OP/PRT/1, para. 63 and report on the visit to Poland on 9–18 July 2018, CAT/OP/PRT/1, para. 55.

549 See: CPT report on the visit to Denmark, CPT/Inf (2019) 35, para. 20 and footnote 11; CPT report on the visit to Georgia, CPT/Inf (2019) 16, para. 80.

550 See: Interim report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 20 July 2018, A/73/207, para. 77(e).

551 Social care homes: in Babica (KMP.575.1.2023), Stanisław Broniewski "Orsza" home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023), Wiktoria Michelisowa social care home in Lublin (KMP.575.2.2023), home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023) and "Słoneczne Wzgórze" in Ryjewo (KMP.575.3.2023).

In one of the homes[552] for legally incapacitated patients there were blank consent forms i.e. statements of legal guardians of residents with consent to their medical examinations, hospital treatment or other healthcare services; the statements had no date. The situation is against the *Act on the professions of physician and dentist*[553], according to which a physician may perform an examination or provide other health care service only after obtaining the patient's consent. If the patient is legally incapacitated in full, consent has to be given by his or her legal representative. If the patient is capable of expressing an informed opinion, his or her consent is also necessary. Consent may be given verbally or by a clear expression of the person's will to undergo the medical procedures suggested by the doctor. The NPM recommends that consent for medical procedures be obtained from the patient or their representative on every occasion.

4. Right to contact with the outside world

In three social care homes, residents with signs of dementia or with mobility problems were not allowed to leave the premises on their own but had no possibility either to get another person's support in going outside the home[554].

The NPM representatives are aware that in some cases, for the safety of the residents, their possibility to leave the home on their own has to be restricted, in particular in the case of people with diagnosed dementia. However, it should be remembered that such restrictions should be introduced on the basis of applicable law rather than informally.

Article 55(2b)-(2i) of the *Act on Social Welfare* sets out the rules of restricting residents' possibility to leave a social care home on their own. The provisions stipulate that in the event of a risk to the life or health of a resident with mental disorders, the director or manager of a care home may restrict the resident's possibility to leave the home on their own on the basis of a medical certificate. The certificate has to be issued for a specified period of time not exceeding 6 months, and should indicate the reason for the restriction. The regulations also specify that such a restriction should be made in writing and should include: the name of the person to whom the restriction applies; the period for which it has been issued; the reason for the restriction; and information about the right to apply to the guardianship court to have the restriction lifted.

The restriction certificate has to be delivered to the resident of the home and, if the person is legally incapacitated in full, also to his or her legal representative. The director or manager of the home has to inform the resident of their right to apply for the restriction to be lifted. The director or manager, within 3 days of the restriction certificate's delivery to the resident, has to send information on the restriction to the guardianship court with jurisdiction over the area in which the home is located. The resident, including a legally incapacitated resident, their legal representative, spouse, direct relative, sister, brother or person providing actual care to the resident may apply to the guardianship court for the restriction to be lifted. None of the visited social care homes had such certificates in their files.

The NPM recommends that files of residents with restricted possibility to leave the care home on their own be supplemented with medical certificates referred to in Article 55(2b)-(2i) of the *Act on Social Welfare* and that such restrictions be based only on those provisions and be reported to the guardianship court.

5. Activating therapy for residents

In one of the visited care homes no attempts were taken to activate some bedridden residents[555]. They were not visited by any relatives but only by a priest and carers. There was no physical rehabilitation, exercise or occupational therapy for them. The situation undoubtedly contributed to the deterioration of their mental health. In the opinion of the NPM, the activation of bedridden residents should not be limited to reading newspapers and watching television.

Importantly, social care homes should provide daily life support, care and educational services, in the scope and forms resulting from the individual needs of their residents[556]. The services provided should

[552] Social care home "Słoneczne Wzgórze" in Ryjewo (KMP.575.3.2023).

[553] See: Article 32 of the Act of 5 December 1996 on the professions of physician and dentist (Journal of Laws of 2024, item 1287, as amended).

[554] Social care homes: "Słoneczne Wzgórze" in Ryjewo (KMP.575.3.2023), Stanisław Broniewski "Orsza" home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023) and Wiktoria Michelisowa social care home in Lublin (KMP.575.2.2023).

[555] Stanisław Broniewski "Orsza" social care home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023) and Wiktoria Michelisowa social care home in Lublin (KMP.575.2.2023).

[556] See: Article 55(1) of the Act on Social Welfare.

take into account, in particular, the freedom, privacy, dignity and sense of security of the residents, as well as their physical and mental condition[557].

The NPM recommends implementing programmes to activate bedridden residents and providing them with appropriate occupational therapy and rehabilitation activities.

6. Staff

In one of the visited facilities[558], the NPM team found that the number of carers was insufficient. During the day, there were three-four carers and nurses, and at night there was one carer and one nurse. As the staff members pointed out, there should be a minimum of three employees on night shifts (two carers and one nurse).

The National Preventive Mechanism recommends that the number of care personnel in social care homes be adjusted to the number of residents.

It should be noted that staff training is an important mechanism of preventing torture and building an appropriate organisational culture. In the opinion of the NPM, the training offered in all the visited social care homes is insufficient. Its scope should be broadened and the participation in such training should be possible for all employees of social care homes.

In accordance with the recommendation of the Committee of Ministers of the Council of Europe, carers for older people should be properly trained and receive support enabling them to provide the necessary assistance appropriately[559].

The National Mechanism recommends that the scope of staff training be broadened to include the issues of: first aid provision, care provision to people with disabilities, respect for the rights of such people, interpersonal communication in employee-resident relations, humane treatment of residents, protection of human rights, conflict de-escalation, ways of coping with stress and aggression, the issue of burnout and methods of overcoming it, coping with difficult and conflict situations and the practical application of the Istanbul Protocol.

The CPT emphasised that Given the challenging nature of their job, it is essential that ward-based staff (i.e. nurses and orderlies) be provided with the necessary support and counselling to avoid burn-out and to maintain high standards of care[560].

The NPM also recommends that supervision for staff be ensured. Such supervision should be provided by an external expert.

7. Registers, procedures and documentation

In one of the social care homes[561], medical records and psychologists' records were accessible to unauthorised persons, which resulted from improper document flow managed by the social work team instead of authorised persons.

In view of the above, the National Mechanism recommends introducing document flow rules for social care homes. Medical personnel (including medical assistants) should make copies of all medical records. Medical staff and psychologists (after preparing documentation for sending to the court) should place it a non-transparent sealed envelope with the resident's name and surname and the words 'medical/psychological documentation' and leave it in this form for the social work team.

The same home had an incorrect system of collecting residents' medical documents from healthcare facilities and the National Health Fund. The documents were collected by drivers and included e.g. medical test results the confidentiality of which was not protected in any way (e.g. by document placement in an envelope); the content of the documents could thus be read by the drivers.

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[557] See: Article 55(2) of the Act on Social Welfare.
[558] Social care home in Babica (KMP.575.1.2023).
[559] See: Article 34 of Recommendation CM/Rec (2014) 2 on the promotion of the rights of older persons, adopted by the Committee of Ministers of the Council of Europe on 19 February 2014.
[560] See: Persons deprived of their liberty in social care establishments, Factsheet, CPT/Inf (2020) 41, para. 17; See also the CPT report on the visit to Bulgaria in 2017, CPT/Inf (2018) 15, para. 149.
[561] Social care home "Słoneczne Wzgórze" in Ryjewo (KMP.575.3.2023).

During the analysis of documentation at the care home, the NPM delegation saw chaotically kept documents (e.g. records kept by nurses, or a register of coercive measures applied). The pages were not numbered and the chronology of the documents was unclear, which could result in overlooking important information on a specific resident.

The NPM recommends that documentation pages be numbered. It helps avoid information chaos and facilitates the correct order of documents in the files, e.g. when they are removed for copying and placed back in the file. It would also facilitate the analysis of documents and minimise the risk of omitting important information.

At another care home[562] the visiting team found that a resident's personal file contained a sealed envelope with keys to her apartment. In the opinion of the NPM, a personal file is not a suitable place for keeping such items.

The National Mechanism recommends that keys and similar items be stored in the establishment's deposit, with the consent of the resident or his or her legal guardian if the resident is legally incapacitated.

8. Living conditions

Residents of one of the visited social care homes[563] complained about dirty walls and too high temperature in the bedrooms in the summer months.

In another home, there were no locks in wardrobes and sometimes things were stolen from them. Staff members reported a problem with some residents neglecting their personal hygiene. The NPM suggested taking activities to improve the situation, e.g. carried out by psychotherapists or medical personnel. The visiting team noticed that the home was not adapted to the needs of people with disabilities. The residents complained about too high beds and too high shower trays that created a risk of falling over. Bedridden persons were washed on their beds because the home did not have special washing beds[564].

Social care homes gradually introduce call systems. Yet, sometimes they are out of order or are switched off[565]. Call buttons are often located in inappropriate places, too high or too far from the bed[566], and thus are of no use.

The NPM recommends that social care homes be fully adapted to the needs of persons with disabilities and have call systems that can be used by all residents, including those who are bedridden.

It is also necessary to ensure appropriate temperature in social care homes, e.g. by installing and using air conditioning installations in the summer.

9. Right to information and complaint mechanism

Notice boards placed in common areas of the social care homes contained information about the Commissioner for Human Rights, the Patient Ombudsman, the Helsinki Foundation for Human Rights and the Family Assistance Centre. In some cases the information was out of date[567].

The NPM recommends updating the information on the notice boards so that residents have access to current contact data and other information important for them (e.g. menu, day schedule, religious practices, therapy activities, etc.).

All the visited homes had procedures for filing complaints.

In one of the establishments[568], if a resident's health condition made it impossible for him or her to file a complaint, it could be filed by a member of the medical staff. However, the NPM is of the opinion that a verbal complaint may be accepted instead of a written complaint. Furthermore, the book of complaints was not confidential (all staff members had access to it), which could discourage people from making complaints for fear of retaliation from the staff.

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[562] Wiktoria Michelisowa social care home in Lublin (KMP.575.2.2023).
[563] Social care home in Babica (KMP.575.1.2023).
[564] Social care home in Babica (KMP.575.1.2023) and Stanisław Broniewski "Orsza" home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023).
[565] Stanisław Broniewski "Orsza" social care home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023).
[566] Social care home of the Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary in Kraków (BPK.575.1.2023).
[567] Stanisław Broniewski "Orsza" social care home run by 'Gniazdo Rodzinne' Foundation in Warsaw (KMP.575.4.2023).
[568] Social care home in Babica (KMP.575.1.2023).

The NPM recommends that complaints be accepted in writing or verbally and be entered in a confidential register.

Residential care and treatment facilities

As a result of the visits held in 2023, the NPM representatives revealed the following shortcomings:

- **There is no legal regulation on the admission of adults who are not legally incapacitated but who, due to their health condition, are unable to sign the admission application themselves and have no legal representative** to do it for them[569].
- Furthermore, the analysis of medical records showed that **persons capable of placing a signature on the admission application often provided a fingerprint instead**. In other cases, the patient's signature was replaced by that of a doctor. The problem concerned general profile facilities. In psychiatric facilities, a person who is mentally ill, is not legally incapacitated but is unable to express his or her will due to mental illness is placed in a residential care and treatment facility under Article 21 in conjunction with Article 3(1) and (2) of the *Act on mental health protection*. The problem was highlighted in the CHR's general intervention letters to the Minister of Health[570].
- One of the visits revealed a **problem related to leaving the facility after completing the treatment**[571]. One of the patients informed the visiting team that she did not want to stay in the facility any longer and wanted to return to her home. The patient was not legally incapacitated. Interviews with the staff showed that in her health condition, she could function at home provided that she had constant care and assistance with housekeeping and shopping. The only factor that, in the opinion of the staff, constituted grounds for the patient's stay in the facility was the fact that none of her family members would take her from there. The NPM reminds that the stay of a non-incapacitated person in a residential care facility is voluntary. Detaining people solely because of the fact that their relatives do not take them home is groundless and constitutes deprivation of liberty and action against the patient's will.
- **Despite the overall good assessment, the living conditions in the residential care and treatment facilities had some shortcomings**. In some rooms there were no doors, which caused a risk of violating the right to privacy, or there were no window blinds to protect the patients from direct sunlight[572]. In the other facility[573], the rooms were too small[574].
- **The residential care and treatment facilities were not fully adapted to the needs of persons with disabilities**; for example, one of the visited facilities had a lift and a ramp only to the entrance door[575].
- **No call systems in bedrooms and bathrooms**. Even if a call system was installed, the staff did not inform the patients how it worked[576].
- **The NPM did not hear any reports of ill-treatment of patients in the residential care and treatment facilities**. There was only a single complaint in one facility that after changing bed pads, the old ones were left on the floor before being put in a rubbish bag[577]. The risk of insufficient care of patients at the facility was increased because **one nurse position was vacant due to lack of candidates for the job** and it was impossible to have two nurses on a shift.

PSYCHIATRIC HOSPITALS

In 2023, the NPM carried out visits to four psychiatric hospitals[578]. The problems found and the good practices identified are presented below.

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569 The problem concerned Dar-Med residential care and treatment facility in Łódź (KMP.573.11.2023).

570 General intervention letters of the CHR to the Minister of Health of 9 December 2018 and 3 October 2023 (KMP.573.18.2018).

571 Dar-Med residential care and treatment facility in Łódź (KMP.573.11.2023).

572 As above

573 Nursing care facility in Sejny (KMP.573.5.2023).

574 In too small rooms, there is no possibility to access a patient's bed from three sides. This is against the requirement of Article 18(1) of the Regulation of the Minister of Health of 26 March 2019 on specific requirements applicable to rooms and equipment at entities that provide health care services (Journal of Laws of 2022, item 402).

575 Nursing care facility in Sejny (KMP.573.5.2023).

576 Dar-Med residential care and treatment facility in Łódź (KMP.573.11.2023) and nursing care facility in Sejny (KMP.573.5.2023).

577 Dar-Med residential care and treatment facility in Łódź (KMP.573.11.2023).

578 National Centre of Forensic Psychiatry for Juveniles in Garwolin (KMP.574.3.2023), Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023), Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital for Mentally Ill Patients in Cibórz (KMP.574.4.2023) and Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023).

■ Good practices

- Patients had access to a theatre room, music room, bowling alley and other leisure facilities located in a separate building of the psychiatric rehabilitation centre[579]. There were also a volleyball pitch, outdoor gym, benches, etc. The facility area was not separated from the neighbourhood by any architectural constructions (such as a wall) that could reinforce the sense of isolation or stigmatisation of the patients.
- There was a procedure of communicating with patients who did not speak Polish[580]. The doctors were required to contact a designated person from the hospital who knew a given language. If a patient communicated in a language not known by any staff member, the hospital was required to contact the relevant embassy or consulate.

■ Systemic problems

1. Lack of call systems

Many rooms in the hospitals visited by the NPM had no call systems or their technical condition was very poor. The systems are of key importance for people's safety.

According to the NPM, call buttons should be available in all rooms used by patients (e.g. bathrooms, patient rooms and isolation rooms where coercive measures may be applied). The need for such systems was reported to the Minister of Health already in 2017[581] but they are still not available. The CPT has repeatedly recommended the installation and maintenance of call systems in its reports on visits to psychiatric hospitals[582].

2. Hospital employees acting as patients' legal guardians

An employee of one of the hospitals was a legal guardian of an incapacitated patient[583]. The practice raised serious concerns of the NPM, similar to those described in the section on residential care and treatment facilities.

The problem has been raised also by the CPT. It emphasised that one of the guardians' duties is to safeguard the rights of persons with disabilities in their relations with the institutions in which they are placed. The exercise of the function of guardian by an employee of the institution may lead to a conflict of interests and jeopardise the impartiality of the guardian. The CPT recommends that the authorities seek alternative solutions to ensure sufficient independence of guardians[584].

3. Hearing of persons admitted to a psychiatric hospital without consent

In two hospitals[585] there was still the practice of remote hearings, by supervising judges, of patients placed in the hospital without consent. The practice introduced during the COVID-19 pandemic was still in use[586]. The hearings were conducted via an online communicator (in the event of restrained patients the hearing had the form of a telephone conversation).

Placement in a psychiatric hospital strongly interferes with the person's right to liberty. Therefore, proceedings in such cases should be conducted with particular attention paid to procedural safeguards for the patient.

In the opinion of the NPM, in-person contact between the patient and the judge increases the possibility of objective and reliable assessment of the patient's health. For this reason, it is recommended that the practice of remote hearings be abandoned and that court hearings are held in hospitals again.

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579 Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital in Cibórz (KMP.574.4.2023).

580 Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023).

581 See: General intervention letter of the CHR of 22 May 2017, KMP.574.4.2017.

582 See: CPT reports on the visits to: Spain [CPT/Inf (2007) 28, para. 132], Turkey [CPT/Inf (99) 2, para. 198], Hungary [CPT/Inf (2006) 20, para. 134] and CPT/Inf (2010) 16, para. 95.

583 Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

584 See: CPT standards set out in the document entitled "Persons deprived of their liberty in social care establishments", Factsheet, 21 December 2020, CPT/Inf (2020) 41, para. 32; See also CPT reports on the visits to: Poland in 2009, CPT/Inf (2011) 20, para. 167; Bulgaria in 2020, CPT/Inf (2020) 39, para. 81; Ukraine in 2019, CPT/Inf (2020) 1, para. 44 and Latvia in 2016, CPT/Inf (2017) 16, para. 157.

585 Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital for Mentally Ill Patients in Cibórz (KMP.574.4.2023), Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023).

586 Article 45(2) of the Act on mental health protection.

4. Use of handcuffs during transportation

There are still cases[587] of handcuffed patients brought to psychiatric hospitals by the police[588]. The NPM emphasises that preventive use of handcuffs on every patient is an abuse. Article 6 of the *Act on Coercive Measures* provides that the measure should be applied in a manner that is necessary for achieving the objective of its application, is proportionate to the degree of threat and causes the least possible discomfort to the person.

The problem of the use of handcuffs by the police with regard to this group of patients was raised by the CHR in 2022 in his general intervention letter[589] to the Minister of the Interior and Administration.

5. Shortage of places in strict-regime psychiatric wards for juveniles and in general psychiatric wards for children and adolescents

The NPM delegation analysed the documentation of a patient who had been referred to a hospital's basic-regime psychiatric ward but was placed in a strict-regime ward due to a lack of places in the basic wards[590]. Placement of a patient in a strict-regime ward without a reason extends the time of the therapy, makes it impossible for the person to be granted a leave, and interrupts the therapy. Such patients should be placed in a unit appropriate for their health condition as soon as possible.

6. Discharging adult patients who still require psychiatric treatment in a hospital

According to the *Act on support and social rehabilitation of juveniles*, treatment in a psychiatric hospital's ward for adolescents ceases when a minor-age patient reaches the age of 18. The problem arises when, in the opinion of doctors, the patient still requires hospitalisation.

The CHR, in his general intervention letter to the Minister of Health, reported the problem of the lack of systemic solutions for young people in mental health crisis who, after reaching the age of majority and leaving a medical facility, still require comprehensive and specialist support but the required care and therapy cannot be ensured by their families[591].

7. No list of hospitals where the treatment can be conducted

The amendment, in March 2017, of the Regulation of the Minister of Health of 20 April 2005 on detailed rules of referral, admission, transfer, discharge and stay of minor-age patients in non-private medical facilities[592] repealed the annexes to the act. They contained data of hospitals with strict-regime and enhanced-regime wards for juveniles, including their capacity and area covered by their operations. The removal of the annexes causes difficulties and delays in arranging for therapy as a place for the patient at an appropriate facility has to be sought.

In the opinion of the NPM it is necessary to draw up a list of hospitals providing therapy in basic, enhanced and strict regime wards. This will greatly facilitate the work of the courts and the Committee on psychiatric treatment of juveniles.

8. Temporary placement of juveniles

The staff of the visited hospitals pointed out many times to the problem of placement of juveniles in medical facilities on a temporary basis, i.e. under Article 42 and Article 44(7) of the Act on support and social rehabilitation of juveniles, in order to prevent further demoralisation and commission of a subsequent offence by the juvenile in the course of the proceedings and to ensure their appropriate conduct.

According to the regulations, in one hospital ward there may be juvenile offenders from the age of 13 who have committed a crime (e.g. theft, robbery or murder), juveniles from the age of 10 who show signs of demoralisation (e.g. skipping school, running away from home, smoking) and juveniles with regard to whom proceedings are conducted to determine whether they have committed an offence or show

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587 Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital for Mentally Ill Patients in Cibórz (KMP.574.4.2023).

588 According to the Act of 24 May 2013 on coercive measures and firearms (Journal of Laws of 2024, item 383, as amended).

589 See: General intervention letter of the CHR to the Minister of the Interior and Administration of 11 April 2022 (II.574.1.2022).

590 National Centre of Forensic Psychiatry for Juveniles in Garwolin (KMP.574.3.2023).

591 See: General intervention letter of the CHR of 31 January 2019 to the Minister of Health (III.502.4.2018) https://bip.brpo.gov.pl/pl/content/panstwo-nie-wspiera-rodzicowdziecka-z-niepelnosprawnoscia-w-kryzysie-psychicznym-gdy-skonczy-18-lat.

592 Journal of Laws of 2018, item 1928. The act was repealed by the Act of 9 June 2022 on support and social rehabilitation of juveniles, Journal of Laws, item 1700.

signs of demoralisation. At this stage, it is not yet certain whether a given juvenile requires psychiatric hospitalisation as no expert opinion on that is required prior to temporary placement.

In the opinion of the NPM, it is necessary to develop systemic solutions for juveniles placed in psychiatric wards for the duration of the proceedings, so as to meet their needs and ensure their safety.

■ Areas that require improvement

1. Documenting injuries

In all the visited hospitals, injuries of admitted patients were registered by staff in medical records. Yet, only one hospital additionally used the marking of injuries in a special graphic form[593] with an outline of a human body. None of the visited hospitals took photographs of the injuries, which is advisable (upon patient's consent).

The NPM recommends that hospital staff be familiarised with the Istanbul Protocol.

In the opinion of NPM representatives, the form of documenting injuries, set out in the Istanbul Protocol is needed in all places of detention. The issue was also highlighted by the CPT during its visit to Poland[594]. The fundamental importance of the Istanbul Protocol in the prevention and detection of torture is emphasised by the SPT[595], CAT[596], CPT[597] and the Special Rapporteur on Torture[598].

2. Use of coercive measures

In two of the hospitals there was a practice of describing the reasons for applying coercive measures in an imprecise and too general way, and in some cases even of indicating false reasons[599]. In one of the hospitals, the visiting team found that the indicated reason contradicted the CCTV footage. According to the medical records, the patient was struggling and shouting. Yet, the CCTV recording shows that he is behaving calmly and after he is restrained he is not moving at all. The patient remained restrained for 15 hours although there were no indications for it[600].

The NPM emphasises the need to precisely and accurately describe the reasons for applying coercive measures, which is necessary for verifying whether they are justified and are used in accordance with the law.

According to the CPT standards, coercive measures should be used as last resort and their duration should be as short as possible; as soon as the reason for their use ceases the measures should be discontinued. Excessively long use of coercive measures is unjustified and can, in the CPT's view, constitute ill-treatment. Once the means of restraint have been removed, it is essential that a debriefing of the patient take place to explain the reasons for the restraint, reduce the psychological trauma of the experience and restore the doctor-patient relationship[601].

During the monitoring visits, the representatives of the NPM noticed that in the use of coercive measures in the form of restraint, the standards set in the *Act on mental health protection* with regard to medical examinations were not always observed[602]. The condition of the patients was not monitored by a nurse in

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593 Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023).

594 See: CPT report on the visit to Poland in 2017, CPT/Inf (2018) 39, para. 80.

595 See: SPT observations and recommendations contained in the reports on the visits to: Poland [CAT/OP/POL/ROSP/1, para. 55], the United Kingdom [CAT/OP/GBR/ROSP/1, paras. 69 and 71], Portugal [CAT/OP/PRT/1, paras. 34, 89, 93] and Spain [CAT/OP/ESP/1, paras. 46, 63-64, 70].

596 See: CAT Conclusions and Recommendations for Poland, 29 August 2019, CAT/C/POL/CO/7, paras. 27 and 28.

597 See: CPT reports on the visits to: Moldova [CPT/Inf (2020) 27, para. 29], North Macedonia [CPT/Inf (2021) 8, para. 29], Portugal [CPT/Inf (2020) 33, paras. 71 and 72], Denmark [CPT/Inf (2019) 35, para. 20] and Georgia [CPT/Inf (2019) 16, para. 80].

598 See: Reports of the Special Rapporteur on Torture of: 16 July 2021 [A/76/168, paras. 22, 25, 34, 66(g)], 20 March 2020 [A/HRC/43/49, paras. 13, 21] and 20 July 2018 [A/73/207, para. 77(e)].

599 Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023), Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

600 Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

601 See: CPT report on the visit to Romania in 2022, CPT/Inf (2023) 28, para. 59; CPT report on the visit to Austria in 2021, CPT/Inf (2023) 03, para. 156.

602 See: Article 18a(3) of the Act of 19 August 1994 on mental health protection: 'The physical condition of a person with mental disorders who is restrained or isolated shall be checked by a nurse at least every 15 minutes, including during the person's sleep.' Paragraph 8 of that article provides that after the first 4 hours of use of coercive measures the patient has to be examined in person by a doctor (Journal of Laws of 2024, item 917).

15-minute intervals and no physical examination of the restrained patient was carried out in case of extended use of restraint[603]. The NPM reminds of the need to comply with the relevant provisions of the Act.

In three of the visited hospitals[604] coercive measures in the form of restraint were not used in isolation rooms but in the presence of other patients. This violates the patient's right to privacy, is humiliating, and may be dangerous for patients if no monitoring is ensured. Thus, the NPM recommends that restraint be applied solely in isolation rooms.

The CPT also pointed out that 'Patients should not be subjected to mechanical restraint in view of other patients (unless the patient explicitly expresses a wish to remain in the company of a certain fellow patient); visits by other patients should only take place with the express consent of the restrained patient[605].'

Furthermore, according to the findings of the NPM, patients, prior to their restraining (regardless of their condition) have diapers put on. It means that the staff do not expect releasing the patient from restraint even for the time of using the toilet[606]. Some partially restrained patients could use a urine bottle in the presence of other patients or paramedics[607].

A juvenile patient had a diaper put on and a urine bottle next to the bed. The CCTV recording shows the partially naked and restrained juvenile patient using the bottle in the presence of other juveniles. He is then lying down in the bed in the presence of other patients. He is not released for a meal and is fed by a staff member.

A similar situation was found in the case of a juvenile female patient who, before being restrained, was told to put on a diaper in the presence of medical staff and male security officers[608].

The NPM recommends that the practice of undressed patients having to put on a diaper before being restrained be discontinued. The patients should be allowed to use the toilet and should be adequately clothed during restraint.

The SPT and CPT emphasise that patients subjected to coercive measures should be adequately clothed and, as far as possible, be able to eat and drink and use the toilet[609].

In general, the means and techniques of restraining patients and fastening the restraint belts, used in one of the hospitals[610] and visible in the CCTV footage raised serious concern of the NPM as potentially leading to degrading or inhuman treatment. The issue has also been raised by the SPT in its report on the visit to Poland in 2018 containing a recommendation that the state party review the mechanical and chemical means of restraint used at the facility[611].

3. Body search

In one of the visited hospitals, patients from the child and adolescent psychiatric ward reported that they had been subjected to body search upon admission to the ward[612]. The search, according to the reports, was out by nurses in a doctor's office. Several patients reported that they had to undress (in one stage). The NPM points out that body search is an invasive and potentially humiliating measure.

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603 Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023), Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023).

604 Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital for Mentally Ill Patients in Cibórz (KMP.574.4.2023), Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023) and Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

605 See: Coercive measures in psychiatric establishments for adults (revised CPT standards), 21 March 2017, CPT/Inf (2017) 6, para. 3.5.

606 Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023) and Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

607 Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023) and National Centre of Forensic Psychiatry for Juveniles in Garwolin (KMP.574.3.2023).

608 Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

609 See: SPT report on the visit to Mongolia in 2017, CAT/OP/MNG/1, para. 123; CPT report on the visit to Croatia in 2022, CPT/Inf (2023) 30, para. 198; Measures of restraint in psychiatric institutions for adults (revised CPT standards), CPT/Inf (2017) 6, para. 3.3.

610 National Centre of Forensic Psychiatry for Juveniles in Garwolin (KMP.574.3.2023).

611 See: SPT report on the visit to Poland in 2018, CAT/OP/POL/ROSP/1, paras. 130 and 131.

612 Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

The applicable regulations do not authorize hospital staff to carry out body search and thus the practice should be discontinued[613].

Body search of patients was legally permitted in another visited hospital ward, under Article 119 of the *Act on support and social rehabilitation of juveniles*, as the ward had the status of a strict security regime unit. The NPM findings show that instances of body search conducted in the ward were not mentioned in any report that could later be used as a basis for filing a complaint to the family court regarding the legitimacy, legality and correctness of the search. The right to file such a complaint arises from Article 19 of the *Act on support and social rehabilitation of juveniles*[614]. The NPM recommends that the procedure be extended by all the elements set out in the law.

4. Use of violence

Representatives of the NPM did not receive any reports of beating or other brutal treatment of patients by staff in any of the visited hospitals. One serious incident of violence against a minor-age patient was reported[615]. A paramedic on a night shift hit a patient on the head so hard that the boy fell to the floor (the incident was visible in the CCTV recording). In the opinion of the NPM, the hospital managers reacted correctly: the patient was referred to a medical examination, the perpetrator and another officer on duty at that time (who did not help the boy and did not report the incident) were dismissed from work, and the prosecutor's office was notified of a suspected offence.

In another hospital, staff allegedly used verbal aggression against patients, intimidated and provoked them and, in one case, imposed a humiliating punishment on a patient (beating on the bare buttocks with a shoe)[616]. The visiting team also heard reports of sexual and gender-based violence between the patients, which were reported to the staff but were left without any reaction from them[617].

The NPM recommends that hospital staff be provided with training in the field of sexual and gender-based violence (SGBV) so as to ensure that they react appropriately to any signs thereof. The NPM also recommends that staff members be reminded of the principle of treating patients with respect.

5. Use of punishments and collective accountability

The NPM delegation heard reports of informal punishments and collective accountability used in one of the visited psychiatric hospitals. The practice may generate the feelings of injustice, humiliation and hostility in the patients and create an obstacle to the treatment process. The NPM strongly recommends that the use of collective accountability be discontinued[618].

6. Contact with the outside world

In two of the visited hospitals[619] patients' contact with the outside world is restricted. There is a minimum age limit set for visitors. Patients are allowed to go outdoors only after several days or more of their admission to the ward (even if they are in good physical and mental condition). In one of the hospitals, patients' mobile phones are taken away (patients can use a payphone in the hall).

The NPM emphasizes that regular contact with the patient's close persons can positively contribute to the therapy process. As regards visits available only for persons over a certain age, the NPM points out that long separation of a parent-patient from his or her child may deteriorate the patient's psychological condition and negatively affect the ties with the child.

The CPT also emphasizes that patients should have access to telephones (including mobile phones) on daily basis unless there are serious security concerns or there is a lawful and reasoned medical recommendation or a court order against their use, based on an individual risk assessment. All patients should also be able to communicate by telephone in conditions that ensure privacy. Such confidentiality is particularly important during conversations with a lawyer, unless there is a reasoned medical recommendation against it, caused by security considerations[620].

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613 As above.

614 National Centre of Forensic Psychiatry for Juveniles in Garwolin (KMP.574.3.2023).

615 As above.

616 Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

617 As above.

618 As above.

619 Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023) and Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

620 See: CPT report on the visit to Croatia in 2022, CPT/Inf (2023) 30, para. 214.

7. Contacts with ex-officio lawyers

During a monitoring visit to one of the hospitals[621] the NPM delegation was informed that patients had no real contact with their ex-officio lawyers referred to in Article 48 of the *Act on Public Procurement*. Moreover, patients usually were not even aware of the name of their lawyer as this information together with the lawyer's contact details was sent, as a rule, to the patient's home address while the patient was at the hospital.

The CPT emphasizes that, regardless of the place of deprivation of liberty, effective and confidential access to legal aid (including free of charge aid) is one of the fundamental safeguards against torture[622]. In view of this, the NPM requested the Head of the relevant District Bar Council and the District Association of Attorneys to remind ex-officio lawyers of their role in the prevention of torture and the need to follow professional ethics.

8. Right to information and complaint mechanisms

The notice boards in two of the visited hospitals did not mention the Commissioner for Human Rights, the District Sanitary Inspector, the court supervising the entity, the prosecutor's office or non-governmental organisations working in the area of the protection of human rights as entities with which complaints can be filed in the event of violation of a patient's rights[623].

The NPM recommends that the contact details of these entities be displayed on the notice boards in a manner visible for patients, visitors and staff.

In one of the hospitals, the visiting team found a number of irregularities in the area of staff communication with patients who did not speak Polish[624]. For example, the internal regulations were not translated into foreign languages and some of the documents of foreign patients did not include information on whether the person understood spoken or written Polish.

Therefore, the NPM recommends that all statements signed by foreign nationals be translated into a language they understand, and that any communication difficulties, information on the language spoken by the detainee and whether translation was provided and how be entered in the documentation. The NPM also recommends considering the purchase of electronic translators for the staff and drawing up an information booklet in foreign languages (in particular Ukrainian, Russian and English)[625].

9. Cultural, educational, and therapeutic activities

In one of the visited hospitals, occupational therapy was conducted on weekdays but consideration should be given to its availability also on weekends and in the afternoons[626].

In another hospital, the information about the variety of activities available to patients, provided to the NPM representatives by the managers, differed significantly from the information provided by the patients. The managers informed that there was a diverse offer of such activities. The patients reported that the only available activities were monotonous walks around the hospital building. The psychiatric ward for children and adolescents at the same hospital conduced activities such as therapeutic community meetings, psycho-drawing, group therapy, social skills training, relaxation and psychoeducation; they were available from Monday to Friday in the mornings[627].

The NPM recommends diversifying the range of activities offered to patients and organising therapeutic activities also in the afternoons and on weekends.

The CPT also draws attention to the need to provide psychiatric hospital patients with broad access to rehabilitation and therapeutic activities, including occupational therapy, group therapy, art therapy, music therapy and other activities[628].

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621 Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital for Mentally Ill Patients in Cibórz (KMP.574.4.2023).

622 See: Involuntary placement in psychiatric establishments. Extract from Eighth General Report, CPT/Inf (98) 12-part, para. 54.

623 Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023) and Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital for Mentally Ill Patients in Cibórz (KMP.574.4.2023).

624 Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital for Mentally Ill Patients in Cibórz (KMP.574.4.2023).

625 As above.

626 Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023).

627 Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

628 See: CPT Eighth General Report, CPT/Inf (98) 12, para. 37.

10. Living conditions

In one of the hospitals[629], representatives of the NPM noticed that the floor area per patient was very small and that the number of lockers for patients' clothes and personal belongings was insufficient.

In the opinion of the CPT, patients should be allowed to keep certain personal belongings (photographs, books, etc). The importance of providing patients with lockable space in which they can keep their belongings should also be underlined; the failure to provide such a facility can impinge upon a patient's sense of security and autonomy[630].

In the same hospital, the NPM delegation saw bars in the windows in patient rooms and corridors. According to the regulations in force, the windows in patient rooms should be glazed with safety glass and secured against being opened by patients[631]. Bars should not be used as a security measure. The NPM emphasizes that bars can cause the feeling of threat and isolation in patients. People placed in a psychiatric hospital are not prisoners and any analogies to penitentiary establishments should be eliminated.

The use of window bars in psychiatric establishments is criticised also by the CPT which points out that they make a setting typical of penitentiary establishments[632]. The Committee also emphasizes that efforts should be made to ensure material conditions that are conducive to treatment and well-being of patients[633].

In another visited hospital the NPM delegation noted problems with female patients' access to toilets: the only toilet for patients, located in the corridor, was used by men[634]. In the opinion of the NPM hospital wards should have a sufficient number of toilets separate for male and female patients. The CPT emphasizes that creating a positive therapeutic environment involves, first of all, providing sufficient living space per patient as well as adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting hospital hygiene requirements[635].

11. Staff

In two of the hospitals visited in 2023 the number of employees in psychiatric wards was sufficient[636] but in the other two there were staff shortages. One hospital had a shortage of nurses: there were situations where only one nurse and one assistant per floor were on duty. This resulted in a decreased degree of supervision over patients, in particular restrained ones [637].

In another hospital, the NPM delegation heard reports from patients that the attending physician did not devote enough time to them. According to the patients, the doctor often spoke to the patients in the hall and only for a few minutes. The insufficient availability of doctors could be caused by their too small number and part-time employment only. In those conditions it was difficult to build a diagnostic and treatment team, to monitor diagnostic processes and treatment results. Finally, it translated into reduced coordination in the area of diagnosis and therapy as well as poorer cooperation between the staff and the patients[638].

The NPM recommends continued efforts to increase the number of medical staff to meet the needs of individual units, with particular emphasis on employees authorised to apply coercive measures[639].

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[629] Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital for Mentally Ill Patients in Cibórz (KMP.574.4.2023).

[630] See: Extract from Eighth General Report, CPT/Inf (98) 12, para. 34.

[631] See: Article 5, Chapter VIII of Annex 1 to the Regulation of the Minister of Health of 26 March 2019 on specific requirements applicable to rooms and equipment at entities that provide health care services (Journal of Laws of 2022, item 402).

[632] See: CPT report on the visit to Serbia in 2015, CPT/Inf (2016) 21, para. 156; CPT report on the visit to the United Kingdom in 1994, CPT/Inf (96) 11, para. 268 and CPT report on the visit to Finland in 2014, CPT/Inf (2015) 25, para. 97.

[633] See: Extract from Eighth General Report, CPT/Inf (98) 12, para. 32.

[634] Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

[635] See: Involuntary placement in psychiatric establishments, CPT/Inf (98) 12-part, para. 34.

[636] Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023) and National Centre of Forensic Psychiatry for Juveniles in Garwolin (KMP.574.3.2023).

[637] Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital for Mentally Ill Patients in Cibórz (KMP.574.4.2023).

[638] Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023).

[639] As above.

In all the visited hospitals the need to broaden the range of training courses available to the staff was emphasized. In particular, training was required in the areas of conflict resolution, methods of coping with aggression, prevention of burnout[640] as well as prevention of gender-based violence and sexual violence[641].

In the context of psychiatric hospitals, the CPT also points out that human resources should be adequate in terms of the number of employees, their professional preparation, experience and training. Deficiencies in this area can lead to high-risk situations for patients, regardless of the good intentions and best efforts of the staff in service[642].

SOBERING-UP CENTRES

In 2023, the NPM conducted visits to two sobering-up centres (hereinafter referred to as the centre or facility) operating within the Diagnostic and Observation Unit of the Municipal Centre for Therapy and Health Prevention in Łódź[643] and within the Facility for Intoxicated Persons of MONAR Wielkopolska Region Support Centre in Rożnowice, based in Poznań[644].

■ Areas that require improvement

1. Treatment of persons placed at the centres

In one of the visited centres, CCTV recording made when nine people were present there showed irregularities on the part of the staff in the treatment of people placed in the centre[645].

Physical violence was used against a patient who was restrained. He was hit on the head and pressed to the floor with a knee on the head, neck and chest. While restrained, patients were not allowed to use the toilet. The staff did not react to a bleeding wound of the restrained person. The doctor present on site did not disinfect or dress the bleeding place. The centre staff and the officers who apprehended the man made unprofessional, unpleasant and potentially provocative comments about him.

Hitting on the head, pressing with a knee on the head, neck or chest, choking, pushing, twisting arms and legs and addressing intoxicated people in an unacceptable manner constitutes, in the opinion of the NPM, inhuman and degrading treatment and in extreme cases, when such actions are combined, may amount to torture.

In the opinion of the NPM, it is necessary to introduce a mechanism for supervising the application of coercive measures (e.g. by analysing CCTV recordings to assess the behaviour of the centre's staff and uniformed officers who bring intoxicated persons there). Such a solution will not only ensure the recording of possible irregularities but will also play an important role in the professional development of the staff.

In one of the centres, the NPM delegation heard of an instruction to place patients with mental disorders in single rooms and, for security reasons, to leave them in their underwear only[646]. Notably, the latter requirement may constitute a violation of Article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms, which provides e.g. for the protection of physical and mental integrity of the human being and respect for his or her private life. Interference with this right is permissible only in cases provided for by law and necessary for the reasons of national security, public safety, protection of public order, prevention of crime or protection of people's health. However, no provisions of national law, including those governing the operation of psychiatric establishments, require patients to be left in their underwear. According to Article 5(1) of the Regulation of the Minister of Health of 8 December 2014 on

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640 Residential Psychiatric Wards A, B and C of the Voivodeship Specialist Hospital for Mentally Ill Patients in Cibórz (KMP.574.4.2023), Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023), Psychiatric Ward of the Voivodeship Specialist Hospital in Ciechanów (KMP.574.6.2023) and National Centre of Forensic Psychiatry for Juveniles in Garwolin (KMP.574.3.2023).

641 Forensic Psychiatry Ward with basic security regime and Psychiatric Ward for Children and Adolescents of the Voivodeship Hospital for Mentally Ill Patients in Bolesławiec (KMP.574.2.2023) and National Centre of Forensic Psychiatry for Juveniles in Garwolin (KMP.574.3.2023).

642 See: Involuntary placement in psychiatric establishments. Extract from Eighth General Report, CPT/Inf (98) 12-part, para. 42.

643 See: Report on the visit to the Diagnostics and Observation Unit of the Municipal Centre for Therapy and Health Prevention in Łódź (KMP.574.1.2023).

644 See: Report on the visit to the sobering-up centre at the Facility for Intoxicated Persons of MONAR Wielkopolska Region Support Centre in Rożnowice, based in Poznań (KMP.574.5.2023).

645 As above.

646 See: Report on the visit to the Diagnostics and Observation Unit of the Municipal Centre for Therapy and Health Prevention in Łódź (KMP.574.1.2023).

sobering-up centres and facilities established by local government units[647] (hereinafter: the regulation on sobering-up centres), a person placed in a sobering-up centre shall be provided with replacement clothing for the duration of their placement there, if their clothing is unsuitable for use or if it use is unacceptable for hygienic reasons. If elements of the patient's clothing may pose a risk to his life or health, the patient should be provided with replacement clothing without dangerous elements such as shoe laces, belts, etc. The same should be done if the patient's clothing is unsuitable for use or unacceptable for hygienic reasons, as stated in the regulation.

In the opinion of the NPM, the requirement for patients to remain in their underwear should be considered contrary to the law. Security measures that interfere so strongly with human freedoms and privacy (through the connection with one's body and nudity) should be provided for in the law.

2. Documenting cases of the use of coercive measures

In one of the visited centres, the NPM found that no separate register of applied coercive measures was kept and their use was not analysed. They were, however, recorded in patient files and in the register of patients[648].

In the opinion of the NPM, the keeping of such a register is of importance from the point of view of protecting detainees against torture, inhuman and degrading treatment or punishment.

The NPM recommends the separate registers applied coercive measures are kept with information on the date and time of application of the coercive measure; the name and surname of the patient; the names and surnames of the persons who applied or witnessed the coercive measure; the reason for its application and the name and surname of the staff member who supervised the patient.

In the same centre, the analysis of documents revealed irregularities in reporting the use of coercive measures. The report form based on the template included in Annex 2 to the Regulation on sobering-up centres was not in use. The form should be used to register: the use of coercive measures, placement in isolation, forced administration of medications, the reasons for applying the measure, the detainee's state during and after its application and the start and end times of their use.

Analysis of CCTV recordings also showed that in one of the centres the documentation failed to indicate the actual hours at which the condition of a detainee restrained with belts was monitored[649]. The monitoring method did not ensure the detainees' safety. The results of the health condition monitoring that should take place every 15 minutes according to the Act of 26 October 1982 on upbringing in sobriety and counteracting alcoholism were not recorded.

The NPM always pays particular attention to coercive measures due to their invasive nature and the related risk of abuse and mistreatment. The use of such measures should always be in line with the law, and in particular with the requirements for: reliable in-person monitoring (every 15 minutes) of the physical condition of detainees subjected to measures such as restraint or placement in isolation; CCTV recording of applied coercive measures, and keeping a register of the applied measures.

In one of the visited centres[650] the register of applied coercive measures mentioned the following reasons for their application: a risk of self-harm, a risk of suicidal attempt, failure to follow instructions, obscene behaviour, aggression towards the staff, aggression towards other people detoxified in the centre, and damaging equipment in the centre.

According to Article 42(1) of the *Act on upbringing in sobriety*, coercive measures may be applied only if a person poses a threat the life or health of their own or of another person, or destroys objects within their reach. In the opinion of the NPM, it is therefore unacceptable to apply coercive measures to people who are simply offensive or do not follow instructions.

3. Living conditions and ensuring accessibility for people with special needs

In the visited centres, the NPM found that toilets were not separate from the rooms (in one case, the toilet was not separated at all and in another case the toilet walls did not reach the ceiling). In one of the centres there was a squat toilet and no washbasin. The toilets were located in the front parts of the rooms and patients could be seen when using them[651]. In both centres, the CCTV monitoring covered the toilet and did not blur people's intimate areas. According to Article 42(13) of the *Act on upbringing in sobriety*, video monitoring of sanitary facilities should ensure the covering of intimate parts of the body of people who use them.

At one of the centres, the visiting team noticed that the call system was damaged. Regardless of this, it was placed at a height that made its use difficult for people with physical disabilities.

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[647] Journal of Laws of 2022, item 2075.

[648] See: Report on the visit to the Diagnostics and Observation Unit of the Municipal Centre for Therapy and Health Prevention in Łódź (KMP.574.1.2023).

[649] As above.

[650] As above.

[651] As above.

In the centre, only separated bathrooms had some adaptations for people with disabilities, in particular wheelchair users. In one of the bathrooms, there was a swing handle but it was mounted far from the toilet, close to the washbasin. In the space between the handle and the toilet there was a washing machine, which made the handle useless for wheelchair users. The patient rooms had hardly any items and their size was too small for wheelchairs.

Another visited centre had no single-use underwear, footwear or bras for women[652]. Disposable cups were not available to everyone. CCTV footage showed some men drinking water directly from the tap. One of the recording showed that in the room there was only one disposable cup shared by several people.

According to Article 5(2) of the regulation on sobering-up centres, people admitted to them should use disposable cups.

4. Medical examinations and documentation of injuries

In one of the centres, the NPM saw that medical interviews and examinations were conducted in the hall, in the presence of the shift supervisor or the officers who had brought the patient to the centre. The admitted patients were not asked about or checked for injuries, with the exception of those on the visible parts of their body[653].

In the opinion of the NPM, such a medical examination does not fulfil its preventive function, which is to detect and document any signs of torture or other forms of degrading treatment. Documenting injuries is a fundamental safeguard against torture and has been described in detail in the previous sections of this report.

5. Right to information and a complaint mechanism

The NPM delegation encountered irregularities in the implementation of the right to information. The centres' basic documents related to the placement in them were not translated into any foreign language. The documentation concerning the placement of foreign nationals did not include information about the language in which the centre staff communicated with them and whether they knew Polish at a communicative level. On the day of the visit to one of the centres[654], the NPM delegation noted that none of the persons brought in for sobering up was informed of their rights and obligations. The notice boards in the facility contained information only in Polish. The visiting team recommended that the information be displayed also in Ukrainian, Russian and English.

In one of the centres[655] the contact details of human rights institutions placed on the notice boards were incomplete.

The NPM emphasises the need for placing notice boards with brief information on the centre's internal regulations as well as patients' rights (in different languages). The boards should be visible also to people in wheelchairs. Every person admitted to the centre should be informed about their rights and obligations in a language they understand.

6. Notifying another person of the placement in a sobering-up centre

In one of the centres[656] none of the patients placed there on the day of the visit was informed about the possibility of notifying another person of the placement in the sobering-up centre. One of the men who was brought in made such requests several times but the visiting team did not see him being permitted to make a telephone call. Another person admitted on that day, who spoke English, requested the possibility to speak to his mother but in response he was only told that he would soon be released.

In view of the above, the NPM points to the need for the possibility to exercise the right to notify another person of the placement in a sobering-up centre, in accordance with Article 40(11) of the Act on upbringing in sobriety and counteracting alcoholism.

7. Staff

In both visited facilities, the NPM noted the problem of the lack training for the staff in the area of human rights protection and humane treatment of patients, methods of coping with stress and

[652] See: Report on the visit to the sobering-up centre at the Facility for Intoxicated Persons of MONAR Wielkopolska Region Support Centre in Rożnowice, based in Poznań (KMP.574.5.2023).
[653] As above.
[654] As above.
[655] See: Report on the visit to the Diagnostics and Observation Unit of the Municipal Centre for Therapy and Health Prevention in Łódź (KMP.574.1.2023).
[656] See: Report on the visit to the sobering-up centre at the Facility for Intoxicated Persons of MONAR Wielkopolska Region Support Centre in Rożnowice, based in Poznań (KMP.574.5.2023).

aggression, professional burnout and its counteracting methods[657]. The visited centres did not provide regular supervision by an external expert to their employees.

The NPM recommends regular training of staff in these areas and the provision of regular supervision by an external expert.

FOLLOW-UP VISITS

In 2023, the NPM representatives conducted two follow-up visits: to the National Centre for the Prevention of Dissocial Behaviours (Polish: Krajowy Ośrodek Zapobiegania Zachwaniom Dyssocjalnym, hereinafter: KOZZD) – branch facility in Czersk and to "Etola" social care home in Ruda Pilczycka. The purpose of such visits is to verify the status of implementation of the recommendations issued by the NPM during the previous visits.

National Centre for the Prevention of Dissocial Behaviours in Gostynin –branch facility in Czersk

Following the visits to the Gostynin centre in 2019[658] and 2021[659] and to its branch unit in Czersk in 2022[660], the National Mechanism recommended to the Minister of Health a revision of the rules of functioning of KOZZD and the development of comprehensive regulations governing its operation, taking into account the constitutional rights of individuals and the relevant international standards. On 29 April 2022, the Commissioner for Human Rights sent to the Minister of Health an opinion on the draft act amending the *Act on the procedures for dealing with persons with mental disorders, who pose a threat to the lives, health or sexual freedom of other individuals*, the *Act on health care services financed from public funds* and the *Act on health care provision*[661]. In the post-visit report of 2023, the recommendation was reiterated because, despite the passage of four years, the regulations governing the work of KOZZD had not been amended.

The systemic problems that continue to exist in the visited centre relate to: the issue of so-called special passes for detainees; the rules of conducting body search; mandatory video and audio recording by the CCTV system of the application of coercive measures in the form of isolation and restraint; the need to eliminate overcrowding; the need to analyse the legality of patients' placement pursuant to so-called temporary security measure ordered by a court pursuant to the provisions of the Code of Civil Procedure and the need to adopt clear provisions making it possible for a court that rules on a person's release from KOZZD to place the person in a psychiatric hospital or a social welfare home, similar to the currently binding provisions of the Act on mental health protection. The legislator should also consider amending regulations on patients' access to health care services so that such patients get immediate access to healthcare facilities not designated for people deprived of their liberty.

The administrators of KOZZD have failed to implement a number of the recommendations aimed at increasing the safety of persons placed in the centre. The staff has not received training on the Istanbul Protocol, no special forms with an outline of human body (body maps) have been introduced for documenting injuries, and newly admitted patients do not undergo medical examinations[662]. The NPM's recommendation that required precise determination of the starting date of every restriction imposed on a KOZZD patient has not been fully complied with; the same applies to the possibility for KOZZD patients to receive parcels. Despite the NPM's recommendation, the security staff members continue to wear visible equipment used for coercive measures, which may increase patients' sense of threat and negatively impact the relations between the staff and the patients. At the end of 2022, Prison Service officers ceased to work at the branch unit of the centre. However, the recommendation to change the type of uniforms worn by the security staff has been implemented only in part and thus remains valid. On the day of the visit the security staff were not wearing black uniforms but the analysed CCTV footage showed that staff members applying coercive measures wore T-shirts with the word 'security' on them.

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[657] See: Report of the NPM on the visit to the Diagnostics and Observation Unit of the Municipal Centre for Therapy and Health Prevention in Łódź (KMP.574.1.2023).

[658] See: Report of the NPM on the visit to KOZZD in Gostynin carried out on 18–20 February 2019, KMP.574.1.2019, points 4 and 6; See also: Report of the Commissioner for Human Rights on the activities of the NPM in Poland in 2019, pp. 105-109.

[659] See: Report of the NPM on the visit to KOZZD in Gostynin carried out on 8–10 March 2021, KMP.574.1.2019, point 4; See also: Report of the Commissioner for Human Rights on the activities of the NPM in 2021, p. 123.

[660] See: Report of the NPM (KMP.574.2.2022), point 5.1.

[661] See: Opinion of the Commissioner for Human Rights of 29 April 2022 (IX.022.3.2022), available at: https://bip.brpo.gov.pl/pl/content/rpo-kozzd-projekt-nowelizacji-opinia.

[662] See: Report on the visit to KOZZD branch unit in Czersk (KMP.574.2.2022).

The National Mechanism reiterated its recommendation to standardise the clothing worn by the security staff. Furthermore, the method of supervising patients has not been changed to a less invasive one and based on an individual assessment of the risk posed by the patient.

KOZZD patients still do not have medical beds. Bedding and hygiene products are not changed with the recommended frequency. The showers have no curtains that would give the patients the sense of privacy when washing. The branch unit of KOZZD does not keep a separate register of coercive measures applied and does not have a book of complaints. KOZZD staff does not undergo regular supervision and training on the Istanbul Protocol, the international human rights standards, prevention of torture, working with people with trauma and victims of violence, the use of pepper spray, communication skills, conflict de-escalation and resolution techniques, or methods of coping with stress and preventing burnout. The recommendation to appoint an employee authorised to make key decisions and replace the centre's Director in managing the unit and supervising the staff has not been implemented either.

"Etola" social care home in Ruda Pilczycka

Following the visit in 2022, the NPM recommended to the home director that special security measures be applied to residents only if ordered by a doctor and that they be registered in the patient's medical records. During the visit in 2023, the NPM representatives found that the recommendation had been implemented in part. The doctor is informed about the application of the measures but only after their use by the nurses. The NPM points out that the doctor should be informed of the need to apply such measures in advance to assess whether their use is justified by the resident's state of health and the circumstances. Only in exceptional situations of risk to the health or safety of the resident or other people the decision to apply such measures should be taken e.g. by a nurse who should then inform the doctor. The register of applied coercive measures had no box for the signature of the doctor who approved their use.

Another recommendation that has been implemented in part is to ensure access to a nurse at night and on weekends. Due to staff shortages and ongoing education by a nurse who is still waiting for her professional certificate, access to a qualified nurse on all weekends and at night is not possible. At night, medical carers look after the residents.

During the follow-up visit the NPM delegation found that residents were still engaged in the existing conflicts between the home's employees. Some residents, incited by certain staff members, continue to make recordings of work of other employees and to collect information about them (what they do, how they perform their duties and who they contact) and pass the information to the staff members who asked them to gather the data.

During the visit carried out in 2022, the visiting team found that there were no notice boards in common spaces (e.g. in corridors or at the entrance to the facility) with information on human rights institutions. In 2023, a list of such institutions was placed on a notice board but was incomplete.

Two other recommendations have not been implemented. During the follow-up visit the NPM delegation found that the book of complaints does not contain entries on how a given case/complaint/request was resolved. The home, according to Instruction no. 3/2023 of 26 January 2023 of the director of Etola social care home in Ruda Pilczycka on days and hours in which complaints and requests from residents are received, keeps a book of complaints according to the template attached to the instruction. The book does not contain a place for indicating how a given request/complaint was resolved.

The other recommendation that remains unimplemented is to use special forms with an outline of the human body (body maps) for registering any injuries of residents. The body maps together with photographs taken with the resident's consent, should be included in the resident's medical records. The medical staff reported that body map forms were available but were not used in practice. According to the information obtained by the visiting team injuries were described by nurses in nurse shift logs.

Visits of the National Preventive Mechanism in 2023 – tables by type of establishment

PRISONS

	Date of visit
Barczewo	23–26.01.2023
Łowicz	6–9.03.2023
Włocławek	20–24.03.2023
Potulice	8–12.05.2023
Potulice	1–2.06.2023
Sztum	26–30.06.2023
Chełm	7–10.08.2023
Grudziądz (ZK Nr 1)	18–22.09.2023
Tarnów	9–13.10.2023
Grudziądz (ZK Nr 1)	18–19.10.2023
Rawicz	21–24.11.2023
Rzeszów	20–24.11.2023
Total: 12	

REMAND PRISON

	Date of visit
Mysłowice	17–19.04.2023
Total: 1	

BRANCH UNITS OF PENITENTIARY ESTABLISHMENTS

	Date of visit
Stawiszyn branch unit of the remand prison in Grójec	16–18.08.2023
Lubliniec branch unit of the prison in Herby	29.08–1.09.2023
Płońsk branch unit of the prison in Płock	4–7.12.2023
Kraków-Nowa Huta branch unit	24–27.07.2023
Total: 4	

ROOMS FOR DETAINED PERSONS WITHIN POLICE ORGANIZATIONAL UNITS

	Date of visit
Police station in Piastów (subordinate to Poviat Police Headquarters in Pruszków)	6.02.2023
Poviat Police Headquarters (PPH) in Strzyżów	27.03.2023
Poviat Police Headquarters in Aleksandrów Kujawski	3.04.2023
Poviat Police Headquarters in Kętrzyn	5.06.2023
Poviat Police Headquarters in Lubliniec	28.08.2023
Poviat Police Headquarters in Opoczno	25.09.2023
Poviat Police Headquarters in Otwock	23.10.2023
Poviat Police Headquarters in Starachowice	23.10.2023
Poviat Police Headquarters in Pułtusk	24.10.2023
Poviat Police Headquarters in Rawicz	20.11.2023
Poviat Police Headquarters in Pabianice	27.11.2023
Poviat Police Headquarters in Turek	4.12.2023
Total: 12	

YOUTH CARE CENTRES

	Date of visit
Jaworek	7–9.02.2023
Babimost	13–16.03.2023
Łobżenica	11–14.04.2023
Skarżysko-Kamienna	24–26.10.2023
Total: 4	

PSYCHIATRIC HOSPITALS/PSYCHIATRIC WARDS

	Date of visit
Garwolin – National Centre of Forensic Psychiatry for Juveniles	17–20.07.2023
Bolesławiec – Voivodehip Hospital for Mentally Ill Patients in Bolesławiec	31.07–4.08.2023
Cibórz – Voivodeship Specialist Hospital for Mentally Ill Patients	6–9.11.2023
Ciechanów – Psychiatric Ward of the Voivodeship Specialist Hospital	18–20.12.2023
Total: 4	

SOCIAL CARE HOMES

	Date of visit
Krakow (ul. Podgórki Tynieckie 96) – Congregation of Sisters Servants of Immaculately Conceived Blessed Virgin Mary	13–16.02.2023
Babica	28–30.03.2023
Lublin (Wiktoria Michelisowa home)	29–31.05.2023
Ryjewo	10–14.07.2023
Warsaw – 'Gniazdo Rodzinne' Foundation (ul. Kilińskiego 10/12)	22–25.08.2023
„Etola" in Ruda Pilczycka	26–29.09.2023
Total: 6	

DISTRICT YOUTH CARE CENTRES

	Date of visit
Szczecin (ul. Modra 11)	16–19.05.2023
Szubin	4–6.07.2023
Witkowo	5–7.12.2023
Total: 3	

SOBERING-UP CENTRES

	Date of visit
Łódź	27.04.2023
Poznań	14.11.2023
Total: 2	

POLICE ESTABLISHMENTS FOR CHILDREN

	Date of visit
Łódź	26.04.2023
Bydgoszcz	3.07.2023
Poznań	13.11.2023
Total: 3	

PRIVATE LONG-TERM CARE FACILITIES FOR PEOPLE WITH DISABILITIES, CHRONIC ILLNESSES OR OLDER AGE

	Date of visit
Toruń – „Willa Chopina"	4–6.04.2023
Wielka Wieś – „Barbara" care home	19–21.06.2023
Odrowąż – „Pogodna jesień"	21–22.06.2023
Wierzbica – „Słoneczny Las"	21.08.2023
Marki – „DARDOM" (ul. Ząbkowska 55)	9–10.10.2023
Otwock – „Alter Domus"	11–12.10.2023
Konstancin-Jeziorna – „Dom Ufnej Starości" of the Congregation of St. Vincent de Paul Charity Sisters in Konstancin-Jeziorna	6–7.11.2023
Stare Babice – „Family Care Home"	8–9.11.2023
Total: 8	

RESIDENTIAL CARE AND TREATMENT FACILITIES

	Date of visit
Sejny	23–25.05.2023
Łódź Dar-Med	11–14.09.2023
Total: 2	

BORDER GUARD POSTS

	Date of visit
Warszawa-Okęcie	17.02.2023
Lipsk	18.09.2023
Nowy Dwór	19.09.2023
Kuźnica Białostocka	19.09.2023
Bobrowniki	20.09.2023
Narewka	20.09.2023
Białowieża	21.09.2023
Dubicze Cerkiewne	21.09.2023
Mielnik	22.09.2023
Total: 9	

GUARDED CENTRES FOR FOREIGNERS

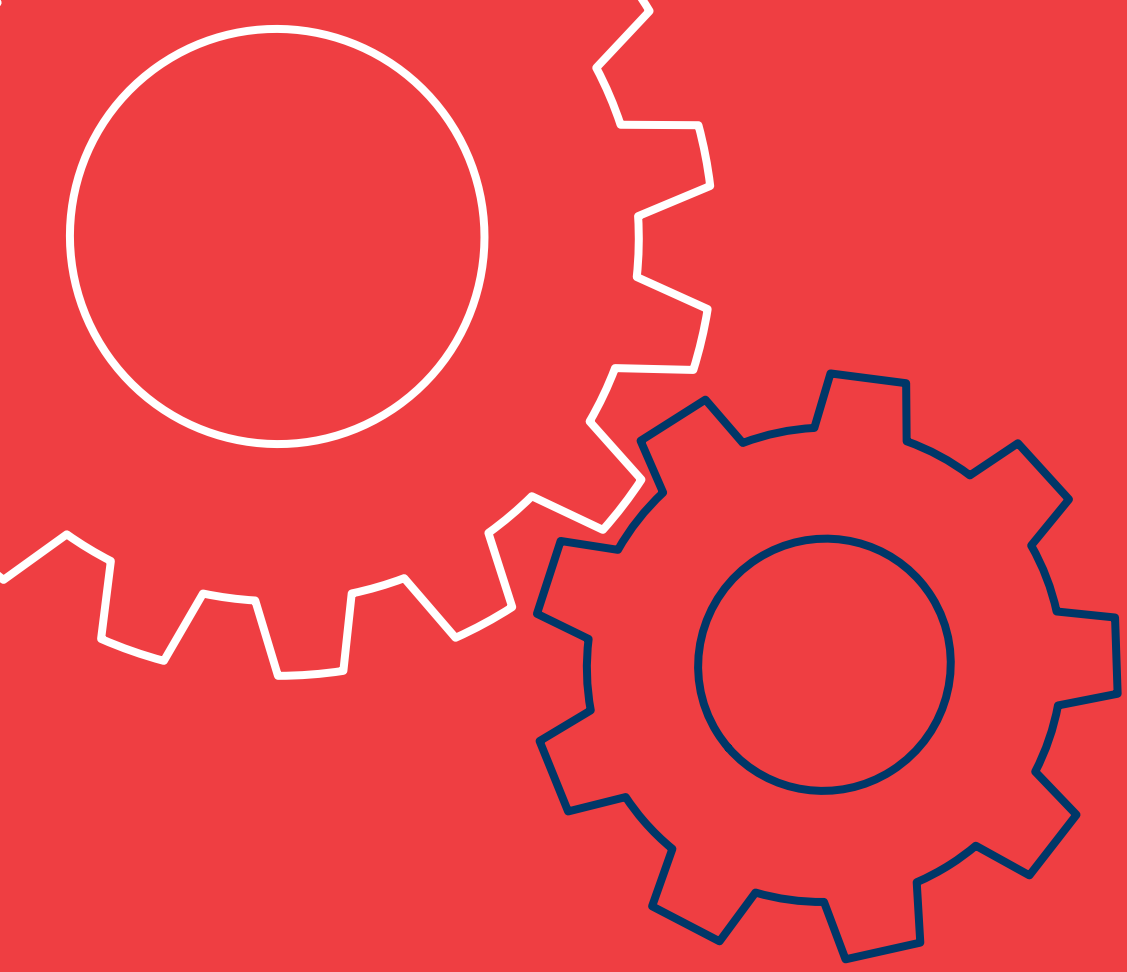
	Date of visit
Lesznowola	20.02.2023
Kętrzyn	6–7.06.2023
Przemyśl	4–8.09.2023
Biała Podlaska	3–6.10.2023
Total: 4	

JUVENILE DETENTION CENTRE WITH A JUVENILE SHELTER

	Date of visit
Konstantynów Łódzki	28–30.11.2023
Total: 1	

POST-PENAL DETENTION FACILITY

	Date of visit
	Date of visit
KOZZD – branch office in Czersk	16–19.10.2023
Total: 1	



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