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REPORT

TO THE GEORGIAN GOVERNMENT
ON THE VISIT TO GEORGIA CARRIED OUT BY
THE EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE
AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT
(CPT)

FROM 10 TO 21 SEPTEMBER 2018

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Adopted on 8 March 2019

CONTENTS

EXECUTIVE SUMMARY

Police establishments

The CPT's delegation spoke with many persons who were or had recently been in police custody, and received hardly any allegations of ill-treatment by police officers. As previously, no allegations were heard regarding the staff working in temporary detention isolators (TDIs). Furthermore, none of the very few allegations heard could be considered credible, backed by medical evidence and/or referring to recent past. Overall, the CPT received a very positive impression of the sustained efforts of the Ministry of Internal Affairs aimed at combating police ill-treatment.

As regards legal safeguards, notification of custody was performed systematically and, as a rule, soon after apprehension. Further, access to a lawyer was generally granted. As regards access to a doctor, medical examinations were performed systematically upon arrival at the TDIs and the examinations included the recording of injuries. As for information on rights, it appeared to be generally provided quickly but the CPT invited the Georgian authorities to make further efforts to improve the provision of oral information upon apprehension.

Material conditions of detention in the TDIs visited were on the whole acceptable for the intended purpose and maximum permitted period of police custody (i.e. 72 hours). However, several deficiencies remained: the national norm of 4 m² of living space per detainee was not yet fully and systematically implemented in practice and in-cell toilets were generally only partially screened. Furthermore, criminal suspects had still no access to a shower and outdoor exercise.

Immigration detention establishments

The delegation did not receive any allegations of ill-treatment by staff from the Temporary Accommodation Centre (TAC) of the Migration Department of the Ministry of Internal Affairs. Further, it appeared that conflicts between detained foreign nationals were rare and never of any serious nature. The overall atmosphere at the TAC was relaxed.

Material conditions at the TAC were generally very good and the offer of activities could be considered adequate. However, the CPT invited the Georgian authorities to make more efforts to offer some organised activities to foreign nationals accommodated at the TAC for extended periods.

Regarding health-care, the CPT expressed the view that it would be advisable to recruit nursing staff and organise 24/7 health-care coverage at the TAC. Further, the CPT recommended that the same screening, recording and reporting procedures be applied at the TAC as those already in place at the TDIs.

As for legal safeguards, foreign nationals were given information about their rights and *ex officio* legal assistance was available. Furthermore, interpretation services were provided if necessary. However, some of the detainees appeared ill-informed of the precise scope and content of their right of access to *ex officio* legal assistance. The CPT reiterated its recommendation that steps be taken to ensure that the right to have access to a lawyer (including an *ex officio* lawyer) is fully effective for all detained persons, as from the outset of deprivation of liberty.

The TAC employed specially trained custodial staff; however, the CPT invited the Georgian authorities to make further efforts to improve staff's language skills.

Prisons

The delegation heard hardly any allegations of ill-treatment of inmates by staff. Overall, there was a relaxed atmosphere and good staff-prisoner relations in the prisons visited. Only a few isolated allegations were heard of excessive force used while prisoners were transferred to so-called "de-escalation rooms", especially at Prison No. 6. The CPT stated that custodial staff in all Georgian prisons – and especially at Prison No. 6 – would benefit from more training in dealing with such high-risk situations and challenging inmates, including in verbal communication, de-escalation techniques and manual control.

As regards inter-prisoner violence, it was not a major issue in closed-type prisons, except for a few allegations and other indications – such as recorded injuries – at Prison No. 6. Likewise, inter-prisoner violence appeared rare at Prison No. 11. However, inter-prisoner violence was clearly a problem at Prison No. 15. This was hardly surprising given the very low staff/prisoner ratio and the limited presence of staff in inmate accommodation areas.

Another important factor at Prison No. 15 was the pernicious influence of the informal prisoner hierarchy. Faced with this situation, the management of Prison No. 15 acknowledged that it considered itself compelled to share a part of its responsibility for order and security with "strong prisoners" (so-called "watchers"), thus exposing weaker inmates to the risk of violence and intimidation. The CPT stressed that this was totally unacceptable; the (re)emergence of this phenomenon at Prison No. 15 was a troubling sign and major efforts were required to ensure that it did not spread throughout the prison system.

Overall, overcrowding was no longer a problem in the prisons visited. That said, the CPT was concerned that – unlike for sentenced prisoners (for whom the norm was 4 m² per person) – the norm of living space per remand prisoner had remained unchanged (3 m²). Other than this, material conditions varied but were generally acceptable (sometimes even good) although cells and communal areas were in clear need of refurbishment and cleaning at Prisons Nos. 6, 8, 15 and to a lesser extent No. 9.

As had been the case during previous visits, progress had been much less impressive in drawing up programmes of purposeful, out-of-cell, activities for prisoners. The delegation again observed that prisoners in closed-type establishments visited (Prisons Nos. 3, 6, 7, 8 and 9) were locked up in their cells for most of the day, in a state of enforced idleness. For some of them (those in so-called "high-risk" category), the regime could amount to *de facto* solitary confinement for years on end. The situation was not much better in the semi-open Prison No. 15 – although not locked up during the day and free to move around the prison's territory, inmates were basically left with nothing to do. The only positive exception to the aforementioned situation was observed at the juvenile Prison No. 11 in Avchala.

The CPT once again called upon the Georgian authorities to take decisive steps to develop the programmes of activities for both sentenced and remand prisoners. The aim should be to ensure that prisoners are able to spend a reasonable part of the day (8 hours or more) outside their cells, engaged in purposeful activities of a varied nature (work, education, sport, etc.) tailored to the needs of each category of prisoner (adult remand or sentenced prisoners, inmates serving life sentences, female prisoners, etc.).

The CPT also recommended that the recently-introduced individual risk assessment (for all prisoners) and individual sentence plans (for sentenced inmates) be fully implemented in practice. As regards prisoners classified as "high-risk", there is an urgent need to completely rethink the philosophy and the approach to them, so as to ensure that any restrictions on organised activities, association, privacy and contact with the outside world are only imposed based on a genuine and frequently reviewed (at least every 6 months) individual risk and needs assessment. The current blanket approach is grossly excessive.

The CPT noted further improvement in prisoners' access to both primary and secondary health care in all prisons visited. The medical facilities and equipment were of a satisfactory level in all the establishments except for Prisons Nos. 6 and 15, and there were no major concerns regarding the supply of medication (except for psychiatric medication). In all the prisons visited, medical screening (including screening for injuries) was performed shortly after the arrival of a new prisoner. However, the CPT recommended that the existing procedure be amended so as to require using "body charts" and taking photographs (and reporting this information) whenever prison doctors believe there are grounds to suspect ill-treatment/inter-prisoner violence, irrespective of whether the prisoner concerned alleged any ill-treatment and agreed to such recording and reporting. There were individual medical files for prisoners in all the establishments visited, and they seemed to be generally well kept. However, as in the past, medical confidentiality was not always respected; this was of particular concern as regards the medical screening on arrival and the recording of injuries.

The CPT noted a further significant improvement in the prevention and treatment of infectious diseases (such as tuberculosis, HIV and hepatitis) in prisons. By contrast, the CPT was very concerned by the persistent serious shortcomings in the provision of mental health care. More generally, the CPT expressed the view that there was a lack of a national strategy of dealing with challenging mentally disordered prisoners.

The Georgian authorities acknowledged from the outset that addiction to illicit drugs and other intoxicating substances (such as alcohol) continued to be a problem affecting a significant proportion of the prisoner population, and the delegation's findings in the prisons visited only confirmed this. The CPT called upon the Georgian authorities to develop and implement a comprehensive strategy for the provision of assistance to prisoners with drug-related problems (as part of a wider national drugs strategy) including harm reduction measures.

There had been no noteworthy changes in the living conditions at the Prison Hospital since the 2014 visit; as previously, they could be considered adequate. Overall, the hospital was well staffed, the medical equipment and supply of materials were adequate, and there was no shortage of medication. To sum up, the level of healthcare appeared to be generally satisfactory. However, treatment options remained very limited on the psychiatric ward. The CPT reiterated its recommendation that steps be taken to develop a broader range of psycho-social therapeutic activities for patients, in particular for those who remain on the ward for extended periods.

More generally, the CPT stressed that a transfer of responsibility for prison health-care services to the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs was needed to improve the quality of health care through its better integration with the public health system, and also to strengthen the professional independence of health-care staff working in prisons. The time has come to start concrete preparations for such a transfer, including setting precise deadlines.

The staffing situation in the prisons visited varied. While it was satisfactory or even good at Prisons Nos. 3, 6, 7, 9 and 11, it was much less favourable at Prison No. 8 and quite poor at Prison No. 15. In the latter establishment, the shortage of staff put at risk the security of both staff and prisoners and resulted in the management and staff considering themselves compelled to rely to a certain extent on prisoners to assist them in performing custodial tasks. Overall, the conclusion reached on previous visits that the staffing levels in prisons were too low (especially if the Committee's recommendations concerning the development of regime and activities were to be implemented), remained valid.

With the exception of Prison No. 3, formal disciplinary sanctions were resorted to very rarely. As for material conditions in disciplinary cells, these were found to be acceptable in all prisons that had them. That said, the CPT was told that there had been no change to the rules concerning the regime for prisoners placed in disciplinary cells, namely they were still deprived of access to outdoor exercise and reading matter. Further, as in the past, inmates placed in a disciplinary cell were automatically deprived of contact with the outside world. The CPT called upon the Georgian authorities to remedy these failings.

The issue of gravest concern to the CPT was a tendency, observed in several of the prisons visited (especially in Prisons Nos. 3, 6 and 8) to make frequent use of so-called "de-escalation rooms", for up to 72 hours, as *de facto* punishment. The CPT expressed the view that "de-escalation rooms" should only be used to place, for as short a time as possible (preferably just a few hours), prisoners who are agitated and/or aggressive, and the whole procedure should be under the authority of the doctor, not the custodial staff. Any prisoner who remains agitated after several hours must be clinically assessed and, if necessary, transferred to a mental health establishment. Further, the CPT considered that prisoners who are not mentally disturbed and who violate internal regulations should be dealt with using formal disciplinary provisions.

Juvenile prisoners and those in semi-open prisons (e.g. Prison No. 15) had adequate possibilities to maintain contact with the outside world. The CPT also welcomed the fact that remand prisoners no longer required prior authorisation by the competent investigating authority or court to receive a visit. Nevertheless, the fact remained that the visiting entitlement for many prisoners (including remand prisoners and sentenced inmates in closed-type prisons, especially those classified as "high-risk") was far from generous. In this context, the CPT reiterated its view that all prisoners, irrespective of their category (whether on remand or sentenced) and regime, should be offered at least the equivalent of one hour of visiting time per week.

Psychiatric establishments

Although at Surami Psychiatric Hospital the delegation received no allegations of recent physical ill-treatment of patients, it noted that there had been several instances of serious physical ill-treatment (including striking patients with sticks) in the recent past, the staff directly involved no longer being employed at the establishment. The clear determination of the hospital's current management to prevent any such ill-treatment in the future was highlighted positively.

At Kutiri Psychiatric Hospital, the delegation received only one recent and credible allegation of physical ill-treatment (i.e. slaps) of a resident of the social care ward ("pensionat") by an orderly. By contrast, a number of allegations of recent physical ill-treatment of male acute patients (consisting of slapping and punching by orderlies) were heard at Khelvachauri Psychiatric Hospital. Further, some complaints were heard at both establishments that orderlies displayed rude and verbally abusive behaviour. Doubtless, this was linked with the very low staff complement and the poor level of training of the orderlies.

Inter-patient/resident violence did not appear to be a problem at Surami Psychiatric Hospital. However, at Khelvachauri Psychiatric Hospital and on the general psychiatric wards at Kutiri Psychiatric Hospital, the delegation heard a number of complaints regarding, and indeed witnessed, episodes of inter-patient/inter-resident conflicts and violence, which was hardly surprising considering the low staffing numbers and the chaotic environment in which the patients and residents lived. The CPT indicated that action was required at Kutiri and Khelvachauri Psychiatric Hospitals to remedy this problem, including by ensuring an adequate staff presence and supervision at all times, and by properly training staff in handling challenging situations/behaviour by patients/residents.

The three psychiatric hospitals visited were undergoing major refurbishment at the time of the visit. Meanwhile, however, many patients continued to live in woefully dilapidated and sometimes overcrowded dormitories, which lacked privacy and failed to ensure patients' dignity. At the end of the visit, the delegation requested the Georgian authorities to provide the CPT with regular and detailed update reports, on a quarterly basis, regarding the progress in completing the renovation and building works in the three psychiatric hospitals visited. In their letter dated 23 January 2019, the Georgian authorities informed the CPT that a new patient accommodation building at Kutiri Psychiatric Hospital had been brought into service and that 120 new beds had been installed on the wards, with more to be delivered in the near future. Further, the refurbishment of Khelvachauri Psychiatric Hospital was to be completed by the end of May 2019 and the refurbishment of Surami Psychiatric Hospital was at an advanced stage.

There was a shortage of psychiatrists in the three hospitals visited, in particular at Kutiri Psychiatric Hospital. Further, in the three establishments the presence of ward-based staff (nurses and orderlies) was clearly insufficient to provide adequate treatment and care for the number of patients accommodated in them. In addition, the very limited (or even almost inexistent, as in the case of Surami Psychiatric Hospital) involvement of staff qualified to provide therapeutic activities (psychologists, occupational therapists, social workers) precluded the emergence of a therapeutic milieu based on a multidisciplinary approach.

In the three hospitals visited the psychiatric treatment was based extensively on pharmacotherapy. As for psycho-social treatment and rehabilitation, some limited opportunities existed only at Khelvachauri Psychiatric Hospital. The CPT noted an absence of comprehensive individual written treatment plans which would cover both pharmacotherapy and psycho-social activities.

Psychiatric patients were not entitled to free somatic health assessments and treatments, which could have a negative impact not only on timely and proper assessment and treatment of somatic diseases, but also on the way accurate assessments of certain psychiatric disorders were carried out (e.g. organic psychiatric disorders). The fact that indigent mentally disordered in-patients were expected to fund their own somatic health care was absolutely unacceptable.

Nearly all patients in the forensic psychiatric unit at Kutiri Psychiatric Hospital remained locked in their dormitories for over 20 hours a day, often for years, except for access to a large outdoor cage and during brief meal times. Further, access to outdoor exercise for patients on the general psychiatric wards at Kutiri and Khelvachauri Psychiatric Hospitals and in the "pensionat" at Kutiri Psychiatric Hospital was very limited; some of the patients had not had access to outdoor exercise for weeks, months and even (at Kutiri Psychiatric Hospital) years. At the end of the visit, the delegation invoked Article 8, paragraph 5, of the Convention and made an immediate observation, requesting the Georgian authorities to ensure daily access to outdoor exercise to all patients of Kutiri and Khelvachauri Psychiatric Hospitals. Unfortunately, information provided by the Georgian authorities in their letter dated 23 January 2019 failed to address the CPT's concerns. Consequently, the CPT called upon the Georgian authorities to take immediate steps to ensure unrestricted daily access to the open air to all patients at Kutiri and Khelvachauri Psychiatric Hospitals (unless there are clear medical contraindications or treatment activities require them to be present on the ward), and to confirm this fact within one month.

Means of restraint were not resorted to at Surami Psychiatric Hospital. At Kutiri and Khelvachauri Psychiatric Hospitals, the means of mechanical restraint consisted of soft ties, but at the latter hospital the ties had reportedly not been used since October 2017. Both aforementioned hospitals also had rooms for individual seclusion of patients. After examination of the relevant documentation and interviews with patients, the delegation gained the impression that means of restraint were not overused in these two hospitals.

The delegation was surprised to note that of some 330 patients accommodated on various general psychiatric wards in the three hospitals visited, only four were *de jure* hospitalised against their will pursuant to the Law on Psychiatric Assistance (LPA). It should be stressed in this context that many patients interviewed by the delegation stated, expressly and insistently, that they did not consent to their (continuing) hospitalisation and treatment, and wanted to leave the hospital; they were thus *de facto* involuntary. The CPT called upon the Georgian authorities take urgent steps to ensure that the legal provisions of the LPA on "civil" involuntary hospitalisation are fully implemented in practice. In particular, persons admitted to psychiatric establishments should be provided with full, clear and accurate information, including on their right to consent or not to consent to hospitalisation, and on the possibility to withdraw their consent subsequently. Further, the CPT recommended that the legal status of all patients currently hospitalised at Kutiri, Surami and Khelvachauri Psychiatric Hospitals (as well as in all other psychiatric establishments in Georgia) and considered as "voluntary" be reviewed.

The CPT also recommended that the Georgian authorities take steps to address *lacunae* in the review procedure for forensic patients. In particular, efforts should be made to ensure that the procedure offers guarantees of independence and impartiality, as well as objective medical expertise, including by external psychiatrists. Further, patients should benefit from the assistance of a legal counsel at all stages of the procedure, including before the psychiatric commission.

Turning to consent to treatment, the practice observed in the psychiatric hospitals visited was analogous to that described in the report on the Committee's 2014 visit, namely formally voluntary "civil" patients (the procedure did not apply to *de jure* involuntary "civil" patients and to forensic patients) were asked to sign a form of "consent to placement and treatment". It was clear that, despite long-standing CPT recommendations, consent to treatment was still assimilated to consent to placement.

At Kutiri and Khelvachauri Psychiatric Hospitals, the delegation noted that most of the legally incompetent patients (there were many of them) had the Director of the establishment or another staff member appointed as their legal guardian. The CPT reiterated its view that granting guardianship to the staff of the very same establishment in which the patient concerned is placed may easily lead to a conflict of interest.

In the three psychiatric hospitals, the arrangements for patients' contact with the outside world did not seem to pose any particular problems in practice, at least as regards visits. Formal complaints mechanisms for patients (both internal and external) existed in the three psychiatric hospitals visited. That said, very few patients appeared aware of how to safely and confidentially complain to the hospital authorities or beyond.

Finally, the CPT called upon the Georgian authorities to make every effort to fully implement their 2014 de-institutionalisation Action Plan and, in this context, substantially develop psychiatric care in the community.

I. INTRODUCTION

A. The visit, the report and follow-up

1. In pursuance of Article 7 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as "the Convention"), a delegation of the CPT carried out a visit to Georgia from 10 to 21 September 2018. The visit formed part of the Committee's programme of periodic visits for 2018, and was the CPT's sixth periodic visit to Georgia.[1]

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

- Mykola Gnatovskyy, President of the CPT, Head of Delegation
- Marzena Ksel, 1st Vice-President of the CPT
- Gergely Fliegauf
- Alexander Minchev
- Ceyhun Qaracayev
- Vytautas Raškauskas.

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

- Clive Meux, forensic psychiatrist, Oxford, United Kingdom (expert)
- Kira Chokhuri (interpreter)
- Nino Gudushauri (interpreter)
- Tamar Mikadze (interpreter)
- Maria Tsakadze (interpreter).

[1] The previous periodic visits took place in May 2001, November 2003/May 2004, March/April 2007, February 2010 and December 2014. The CPT has also carried out an ad hoc visit to Georgia in November 2012 and a visit to Abkhazia, Georgia in April/May 2009. The Committee's reports on these visits, as well as the responses of the Georgian authorities, have been made public at the request of the Georgian authorities and are available on the Committee's website (https://www.coe.int/en/web/cpt/georgia).

3. The list of law enforcement, immigration detention, penitentiary and psychiatric establishments visited by the CPT's delegation can be found in Appendix I.

4. The report on the visit was adopted by the CPT at its 98th meeting, held from 4 to 8 March 2019, and transmitted to the Georgian authorities on 22 March 2019. The various recommendations, comments and requests for information made by the CPT are set out in bold type in the present report. The CPT requests the Georgian authorities to provide within six months a response containing a full account of action taken by them to implement the Committee's recommendations and replies to the comments and requests for information formulated in this report. As regards the recommendation in paragraph 130 below, the CPT requests that the Georgian authorities provide their response within one month.

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

5. In the course of the visit, the delegation held consultations with Tea Tsulukiani, Minister of Justice, Giorgi Gakharia, Minister of Internal Affairs, David Sergeenko, Minister of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, and with several other senior officials from the aforementioned Ministries and from the Prosecutor's Office.

In addition, the delegation had meetings with Nino Lomjaria, the Public Defender (Ombudsperson) and staff of the National Preventive Mechanism (NPM) Department of her Office, as well as with representatives of international and non-governmental organisations active in areas of concern to the CPT. It is noteworthy that, as had been the case during the Committee's previous periodic visit in 2014, the Georgian authorities decided to invite representatives of the NPM to attend the final meetings in Tbilisi on 21 September 2018.

A full list of the officials and other persons consulted during the visit is set out in the Appendix II to this report.

6. The CPT wishes to express its appreciation of the efficient assistance provided to its delegation before, during and after the visit, by the Liaison Officer appointed by the Georgian authorities, Elene Beradze from the Ministry of Justice.

7. The co-operation received from all of the delegation's interlocutors was generally excellent. The delegation had rapid access to all places it wished to visit, including those not notified in advance, and was able to meet in private with those persons with whom it wanted to speak. It was also provided with access to the information and documentation it required.

8. As stressed by the CPT in the past, the principle of co-operation set out in Article 3 of the Convention is not limited to steps taken to facilitate the task of visiting delegations. It also requires that decisive action be taken in response to the Committee's recommendations. During the 2018 visit, the CPT noted a number of positive developments, in particular as regards the continuing efforts to combat police ill-treatment and improve material conditions of detention in police establishments and prisons. Indeed, progress achieved in these areas since the Committee's first visit to Georgia (in 2001[2]) is most impressive.

That said, the CPT is concerned that little progress has been made in other areas, such as tackling inter-prisoner violence and the influence of informal prisoner hierarchies, eliminating prison overcrowding, developing prison regimes and activities (especially for so-called "high-risk prisoners"), improving prisoners' access to psychiatric care and psychological assistance and enabling them to maintain adequate contact with the outside world. Further, despite ongoing efforts, concerns remain in respect of psychiatric establishments, as regards living conditions, treatments available, access to outdoor exercise and the practical implementation of legal safeguards in the context of involuntary hospitalisation and treatment.

The Committee trusts that the Georgian authorities will address these outstanding issues and inform the CPT of the measures taken in their response to this report.

C. Immediate observations under Article 8, paragraph 5, of the Convention

9. At the end of the visit, the CPT's delegation met senior Government officials in order to acquaint them with the main facts found during the visit. On that occasion, the delegation made two immediate observations, in pursuance of Article 8, paragraph 5, of the Convention, on certain particularly urgent matters.

As regards the first immediate observation, the Georgian authorities were requested to replace all patients' beds on the general psychiatric wards, female forensic wards and the so-called "pensionat" at the National Mental Health Centre named after Academician Bidzina Naneishvili ("Kutiri Psychiatric Hospital"), and confirm this fact to the CPT within three months.

As regards the second immediate observation, the Georgian authorities were requested to ensure daily access to outdoor exercise to all patients of Kutiri and Khelvachauri Psychiatric Hospitals, and to inform the CPT of the steps taken within three months.

10. Further, in the light of its serious concerns regarding living conditions in Surami and Kutiri Psychiatric Hospitals and the general psychiatric wards in Khelvachauri Psychiatric Hospital, the CPT's delegation made an urgent request for the Georgian authorities to provide the Committee with regular and detailed update reports, on a quarterly basis, regarding the progress in completing the renovation and building works in the three aforementioned establishments. The CPT requested to receive the first such report within three months.

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[2] See the report on the 2001 visit (document CPT/Inf (2002) 14, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=0900001680696085), especially paragraphs 20 – 21, 57, 62 and 73.

11. The above-mentioned immediate observations and urgent request were subsequently confirmed by the CPT's President in a letter of 2 October 2018. The Georgian authorities informed the Committee of measures taken in their letter dated 23 January 2019. These measures will be assessed later in the report.

D. National Preventive Mechanism

12. As already mentioned in paragraph 5 above, the CPT's delegation met Ms Nino Lomjaria, the Public Defender (Ombudsperson) and staff of the National Preventive Mechanism (NPM) Department of her Office. The delegation was told, among other things, that since the Committee's last visit (in 2014) the NPM had been given more financial[3] and human resources, which had enabled it to increase its fast-reaction capacity and carry out more analytical and research work.[4] In addition to the core staff,[5] the NPM could rely on the assistance of 36 experts (members of the Special Preventive Group) including doctors specialised in somatic medicine and psychiatry, psychologists and social workers.

Thanks to these increased resources, the NPM could carry out frequent visits to various types of places of deprivation of liberty,[6] both scheduled and unannounced. The visit programme was adopted in consultation with members of the Advisory Council, composed of members of academia and NGO representatives. The delegation was told that the current tendency was to increase the number of visits to police and psychiatric establishments.

One issue of concern was that the NPM's budget was still not separate from the overall budget of the Public Defender's Office (contrary to the SPT Guidelines, as openly acknowledged by the delegation's interlocutors). Further, whilst the Public Defender and staff from the NPM Department remained generally satisfied with the level of co-operation with the Parliament, the Ministry of Internal Affairs and the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, they hoped to be able to maintain the level of co-operation they used to have with the former Ministry of Corrections in relation to the Ministry of Justice.[7] The delegation was also told of persisting lack of enthusiasm from the Prosecutor's Office, especially as regards the Public Defender's recommendations for steps to address the impunity problem.[8] **The CPT would welcome the observations of the Georgian authorities on the aforementioned points.**

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3 The budget had almost doubled since 2014, from approximately 500.000 GEL to 963.000 GEL in 2017.

4 Among others, thematic reports on internal complaints mechanisms in prisons and on the impact of conditions of detention on inmates' health were about to be published.

5 The NPM Department employed seven members, five of whom carried out visits to places of deprivation of liberty (the remaining two were mainly dealing with secretarial and also analytical/research tasks).

6 There had been 127 visits in 2017 and 134 in the period between 1 January and 1 September 2018 (more of them having been planned before the year's end).

7 The Ministry of Corrections was dissolved in June 2018 and merged with the Ministry of Justice (a new Special Penitentiary Service was set up at the latter Ministry). See also paragraph 45 below.

8 See below.

E. Combating impunity (independent investigation mechanism)

13. The subject of impunity (and, more precisely, effective investigations into possible ill-treatment by law enforcement and prison officials) was discussed at length in the report on the CPT's 2014 visit to Georgia.[9]

The delegation's interlocutors during the 2018 visit, including the Public Defender, staff of the NPM Department and representatives of International Organisations and NGOs expressed the view that most of the Committee's concerns set out in the report on the 2014 visit remained valid. In particular, initial investigatory steps were still as a rule performed by staff of investigative departments of the respective Ministries (i.e. by colleagues of incriminated/suspected officials, working for the same Ministry), with the Prosecutor's Office only becoming directly involved at a later stage (mostly in higher-profile cases, as from the moment the case had caused 'enough' stir in public opinion, the media and civil society). Further, there were – according to the delegation's interlocutors – still frequent delays in collecting and securing evidence (including forensic medical evidence), witnesses were often questioned too late or not questioned at all, and investigations were initiated under inappropriate sections of the Criminal Code (CC) e.g. Section 333 (exceeding official powers) instead of Section 144 (torture and ill-treatment).[10] Moreover, suspected law enforcement and prison officers were usually not suspended from their duties and no action was taken to protect potential victims (e.g. prisoners) from being pressured and intimidated, and forced to change their testimonies.

The delegation's attention was also drawn to the fact that, despite reports about possible cases of ill-treatment being regularly submitted to the Prosecutor's Office by the Public Defender and NGOs, there were relatively few investigations[11] (especially as regards alleged ill-treatment said to have occurred after October 2012) and virtually no sanctions vis-à-vis police and prison officers.[12] This notably included the investigation into the incident at Gldani Prison on 12 November 2014, described in detail in paragraphs 17 and 51 of the report on the 2014 visit.[13]

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9 See paragraphs 15 to 21 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

10 It is noteworthy, however, that senior prosecutors whom the delegation met at the Prosecutor's Office referred to a recommendation to prosecutors issued in 2017 by the Chief Prosecutor, aiming at addressing this problem. Reportedly, the number of cases initiated and investigated under Section 144 had increased subsequently.

11 At the Prosecutor's Office, the delegation was told that 244 investigations had been opened in 2017 into allegations of ill-treatment, including 6 concerning prison staff and 238 concerning law enforcement officers; 10 of the investigations had been opened under Section Art 144¹ of the Criminal Code (torture), 19 under Section 144³ (inhuman and degrading treatment) and 215 under Section 333 (abuse of authority). Criminal prosecutions had been launched against 17 persons (three police officers and 14 prison officers); however, none of these prosecutions concerned misconduct after October 2012, and by the time of the visit only two of the proceedings had resulted in convictions. In 2018 (until 1 September), 276 investigations had been initiated by the Prosecutor's Office (among which 14 were criminal prosecutions – 11 against police officers and 3 against custodial staff); all of them were still pending at the time of the visit.

12 At the Public Defender's Office the delegation was told about 38 cases of alleged ill-treatment (some of them involving several persons) communicated to the Prosecutor's Office since 2015, with reportedly strong corroborating medical evidence, the investigation into which had produced no outcome (the usual reason given by the Prosecutor's Office being that it had been impossible to identify the law enforcement/prison officer(s) concerned).

13 CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

14. In this context, the CPT notes with interest the adoption – in July 2018 – of the new Act on the State Inspector's Office (independent investigation mechanism). The new Act, in force as from 1 January 2019, creates such a mechanism based on the pre-existing institution of the Office of the Personal Data Protection Inspector. According to the Minister of Justice, the new institution is truly independent and ensures effective investigations into any cases of possible ill-treatment of persons deprived of their liberty by public authorities.

While acknowledging this important new development, the Committee echoes concerns expressed by its interlocutors about several aspects of the Act on the State Inspector's Office. First, the scope of the new legislation is relatively narrow as it excludes senior (political level) officials. Second, the Prosecutor's Office retains full control over the investigation process, including on which agency should carry out the investigation (the State Inspector's Office, the Prosecutor's Office, the Ministry of Internal Affairs or the Ministry of Justice). Third, a competent prosecutor's decision to close the case can only be appealed to a more senior prosecutor but not to a court, which leaves the Prosecutor's Office in full control of the whole procedure.

In the CPT's view, it is premature to make an authoritative assessment of the new mechanism – only the practice of its implementation will show how effective it really is. Nevertheless, **the Committee requests the Georgian authorities to submit their observations on the above-mentioned issues of concern**. Further, **the CPT would like to receive additional information on the State Inspector's Office including on its budget and human resources (in particular whether it has its own detectives and/or investigators, and if yes, how many, and what are the required staff qualifications and recruitment criteria), as well as statistics of reports received, investigations initiated and transmitted to the Prosecutor's Office in the first 6 months of the State Inspector Office's functioning.**

15. Another issue brought to the delegation's attention by the Public Defender is that CCTV footage in all places of detention is still only preserved during 5 days. She stressed that this was too short a period, considering the delay with which reports of any alleged ill-treatment often reached her Office (and the time it took responsible agencies to react to her requests). The result was in many cases the destruction of potentially valuable evidence.

The Committee reiterates its recommendation that the relevant regulations and practice be modified so as to ensure that any CCTV footage is preserved for a period sufficient for it to be used as evidence in case of need. In this connection, **the law should guarantee that CCTV footage relative to the alleged incident/complaint is systematically transmitted to the competent prosecutor, in the same way as for all related written documents.**

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Police establishments

1. Preliminary remarks

16. The legal framework governing police custody has remained largely unchanged since the CPT's 2014 visit. According to the Code of Criminal Procedure (CCP), criminal suspects[14] may be held in the custody of the police for a maximum of 72 hours; in practice, such detentions take place in temporary detention isolators (TDIs), see paragraph 28 below.

Within no later than 48 hours from the moment of arrest, the arrested person shall be presented with the indictment. If during this term the arrested person is not indicted, he/she should be released immediately (Section 174 of CCP). It should be stressed as a positive fact that no violations of the above-mentioned 72-hour time-limit for police custody have been observed by the CPT's delegation in the course of the 2018 visit.

17. As regards persons subjected to administrative arrest, the Code of Administrative Offences continues to allow the application of this sanction (by court decision) for the maximum of 15 days.

In this respect, the Committee wishes to stress that there is a general trend observed by the CPT in several States-Parties to the Convention of either shortening the maximum term of administrative detention in police establishments or abolishing that type of sanction altogether. **The Committee would welcome observations of the Georgian authorities on this subject.**[15]

18. Regarding the provisions governing the detention of foreign nationals pursuant to aliens legislation in TDIs, see paragraph 33 below.

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[14] The Georgian CCP uses the uniform term "defendant" (instead of the previously used terms "suspect" and "accused"), which means a person in respect of whom there is a probability that he/she has committed a crime provided for by the Criminal Code.

[15] See also paragraph 30 below.

2. Ill-treatment

19. The delegation spoke with many persons who were or had recently been in police custody, and has received hardly any allegations of ill-treatment by police officers. As previously, no allegations were heard regarding the staff working in TDIs. Furthermore, none of the very few allegations heard could be considered credible, backed by medical evidence and/or referring to recent past.

20. Only one formal complaint was received regarding the allegedly excessive use of physical force (holding) upon apprehension of a Tunisian citizen, Ms Hamida Azuri, by patrol police officers from the 5th Division of Old Tbilisi District Police Department on 20 August 2018. Upon her arrival at the Temporary Accommodation Centre (TAC) of the Migration Department in Tbilisi,[16] several hours after apprehension, Ms Azuri displayed some injuries[17] which were recorded by the doctor working in the TAC. The CPT understands that the case is now under investigation; **the Committee looks forward to receiving, in due course, information about its outcome.**

21. Overall though, the delegation received a very positive impression of the sustained efforts of the Ministry of Internal Affairs aimed at combating police ill-treatment. These efforts included (as was explained to the delegation at the outset of the visit) further development of training curricula in the Police Academy, introduction of compulsory body cameras for patrol police officers (and ongoing installation of cameras in patrol cars) with extended period of footage preservation, and the setting up of a new Human Rights Department at the Ministry of Internal Affairs meant to reinforce internal monitoring mechanisms.

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

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16 See paragraph 32 below.

17 Haematomas on the internal sides of both arms.

3. Safeguards against ill-treatment

22. Based on the examination of relevant records and files in the TDIs visited, and on interviews with persons deprived of their liberty, the delegation gained the impression that notification of custody was performed systematically and, as a rule, soon after apprehension.

23. Further, access to a lawyer was generally granted, though some persons in police custody alleged that they had only seen their lawyer after the initial questioning[18] or (in a few cases) only in court. In this context, it appeared that information on the exact meaning and extent of the right of access to a lawyer might have been misunderstood by the persons concerned (e.g. they had thought that they would have no access to *ex officio* legal assistance).[19]

The Committee reiterates its recommendation that steps be taken to ensure that the right to have access to a lawyer (including *ex officio* lawyer) is fully effective for all detained persons, as from the outset of deprivation of liberty.

24. As regards access to a doctor, medical examinations were performed systematically upon arrival at the TDIs, either by health-care staff employed in the TDIs[20] or by ambulance doctors, and the examinations included the recording of injuries. It is interesting to note that the description of injuries was much more detailed when it was carried out by doctors employed in TDIs;[21] also the medical records by in-house TDI health-care staff were not kept in administrative files of detained persons (to which non-medical police staff had access) but instead in lockers to which only the doctors and nurses had the key, so confidentiality of medical data was much better protected.

In this context, **the CPT encourages the Georgian authorities to implement their plans to employ doctors and nurses in all TDIs. Further steps should also be taken to guarantee full confidentiality of medical documentation (and, as required, medical consultations[22]).**

25. On the positive side, the delegation observed that information on injuries was systematically reported to competent prosecutors, irrespective of whether the person concerned alleged any ill-treatment. Further, a 2017 Order by the Chief Prosecutor required regional prosecutors to immediately transmit information on injuries to the Chief Prosecutor's Office whenever the injured person made any allegations of ill-treatment.[23]

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18 It is noteworthy that in some of the apprehension protocols seen by the delegation, the entry concerning the presence of a lawyer was not filled in, or the signature of a lawyer was missing.

19 See paragraph 26 below.

20 At the time of the visit, 7 out of 29 TDIs in Georgia had their own health-care staff, but it was planned to recruit doctors and nurses for all of them by the end of 2019.

21 TDI doctors had followed special training on the Istanbul Protocol and screening for injuries, and were using "body charts" for describing any injuries found on newly-arrived detainees. The delegation was particularly impressed by the quality of screening and recording at Rustavi and Tbilisi TDIs (which had their own health-care teams).

22 Reportedly, non-medical TDI staff would sometimes be present when ambulance crews examined detainees.

23 283 such reports had been transmitted in the course of 2017, resulting in the opening of criminal investigations in 75 cases.

26. As concerns information on rights, it appeared to be generally provided quickly but – in the light of what was stated above about some problems with access to a lawyer – **the Committee invites the Georgian authorities to make further efforts to improve the oral information upon apprehension and to ensure that all persons in police custody receive the information sheet[24] and are allowed to keep it with them in the cell.** It was the case in some of the TDIs visited but not in all of them.[25]

27. In all the TDIs visited, the delegation observed that the period spent in custody was well documented. Further, as was the case during the 2014 visit, a centralised computer database enabled easy access to custody records of all TDIs in Georgia.

4. Conditions of detention

28. At the outset of the visit, senior officials of the Ministry of Internal Affairs told the delegation that material conditions in TDIs were being constantly improved. Of the total of 29 TDIs in the country, 18 had recently been thoroughly refurbished and two were entirely new; 8 further TDIs had been closed since the 2014 visit because of inadequate material conditions. The Georgian authorities also informed the delegation that a 2018 Ministerial Order had reaffirmed the standard of 4 m² of living space per detained person in TDIs.

Indeed, material conditions of detention in the TDIs visited were on the whole acceptable for the intended purpose and maximum permitted period of police custody (i.e. 72 hours).[26] The cells were generally adequately lit and ventilated, clean and in a satisfactory state of repair; detainees were provided with mattresses and blankets for the night. At all the isolators, there were arrangements in place to offer food to persons detained, though in practice most of them preferred to receive food from home. Further, administrative detainees were offered access to a shower and outdoor exercise (if they stayed at a TDI for longer than 24 hours).

29. However, several deficiencies remained: the aforementioned 4 m² norm was not yet fully and systematically implemented in practice (if one took into account the number of beds per cell)[27] and in-cell toilets were generally only partially screened. Furthermore, criminal suspects had still no access to a shower and outdoor exercise. In this context, it is noteworthy that there was no outdoor exercise yard at Dusheti TDI.

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24 Which existed in 8 languages – both for criminal suspects and for administrative detainees – and copies of which were indeed available in all the TDIs visited.

25 That said, consultation of several individual case files in the TDIs, both in paper and electronic form, revealed that detained persons were systematically given the possibility to read the information sheet – if needed in a language they understood and/or with the help of an interpreter – and were asked to confirm this fact with their signature. A copy of the signed information sheet was always enclosed with the individual file (at least in the files that the delegation had checked on a random basis).

26 It should be recalled that police custody in Georgia is no longer implemented in police stations, but exclusively in TDIs. All cells in older police stations have been taken out of service and new police stations are not equipped with any cells at all. Apprehended persons are transferred to TDIs as fast as possible and, in any case, no later than within 12 hours. Indeed, the CPT's delegation did not meet anyone who had spent more than 12 hours in a police station (and no one had been held there overnight).

27 E.g. there were two bunks (4 beds) in 12 m² cells at Mtskheta TDI.

30. **The CPT recommends that steps be taken in all TDIs to ensure that:**

- **the 4 m² norm of living space per detainee (in multi-occupancy cells) is systematically observed; there should be at least 7 m² of living space in single cells; all the excess beds should be removed;**
- **in-cell toilets in multi-occupancy cells are fully screened;**
- **anyone detained for over 24 hours (irrespective of legal status) is granted access to a shower.**

The Committee also reiterates its recommendation that steps be taken to ensure that persons obliged to stay in a TDI for over 24 hours (irrespective of legal status) are granted access to outdoor exercise on a daily basis, where available. All new TDIs should be equipped with adequate outdoor exercise yards.

As regards administrative detainees, the CPT recommends – for as long as the sanction of administrative arrest continues to be applied[28] – that more efforts be made to offer them some form of activity (e.g. access to radio/television, books, newspapers, board games).

31. The delegation was also informed of well-advanced plans to build a new TDI in Tbilisi (scheduled to open by the end of 2020), with two units of 30 places each, one for criminal suspects and one for administrative detainees. From the information provided it would appear that the new facility (with cells for up to four detainees, equipped with fully-screened sanitary annexes, offering 4 – 5 m² of living space per person; two large exercise yards and, in the unit for administrative detainees, an area for association and recreation) would have the potential of providing adequate conditions for both categories of detained persons.

The Committee would like to be informed about the progress in the construction of the new TDI in Tbilisi.

[28] See paragraph 17 above.

B. Establishments for foreign nationals deprived of their liberty under aliens legislation

1. Preliminary remarks

32. The CPT's delegation carried out a first-time visit to Georgia's only immigration detention facility (opened in 2014), the Temporary Accommodation Centre of the Migration Department of the Ministry of Internal Affairs (hereafter, TAC or the Centre). Located in Varketili district of Tbilisi, the Centre had the capacity of 96 places (in three separate units – for adult men,[29] adult women[30] and families with children[31]) and was accommodating, at the time of the visit, 18 detained foreign nationals[32] including 16 adult men and two adult women (there were no children). None of them was an asylum seeker. The longest staying detainee had been at the Centre since 3 months, the average stay was said to be 1.5 to 2 months.

33. According to the 2014 Law on the Legal Status of Aliens and Stateless Persons (the Aliens Act), a foreign national may be detained[33] by the police and held at a TDI for a maximum of 48 hours. Prolongation of detention beyond this period requires a court decision and the foreign national must be immediately transferred to the TAC. The placement decision is for 3 months maximum, and may be prolonged by a court decision for the maximum of another 6 months. If a foreign national has not been deported within 9 months, he/she must be released from the TAC. It is noteworthy that, save in exceptional circumstances where it is justified by the need to protect, for a very short period of time, the person's interests, detention of unaccompanied minors is prohibited (they are instead taken care of by child protection authorities and placed in foster families).

2. Ill-treatment

34. The delegation did not receive any allegations of ill-treatment by staff from the TAC, and most of the interviewed foreign nationals spoke positively about the staff (including custodial officers). Further, it appeared that conflicts between detained foreign nationals were rare and never of any serious nature. The overall atmosphere at the Centre was relaxed.

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29 Capacity 45.
30 Capacity 45.
31 Capacity 6.
32 From Bangladesh, Egypt, Gambia, Russia, Sri Lanka, Sudan, Tunisia and Turkey.
33 The grounds for detention include the lack of identity documents, threat to national security and public order, danger to one's or others' health or life, and the need to secure deportation.

3. Conditions of detention

35. Material conditions at the TAC were generally very good. The accommodation was spacious (rooms for three to eight persons, measuring from some 50 to approximately 80 m²), well furnished,[34] bright and had an efficient cooling/heating system[35] and ventilation. Throughout the day, foreign nationals could move freely within their living units and had unlimited access to communal toilets, washrooms, showers and laundries with new washing machines. Hygiene items were provided free of charge and warm food served three times a day.

That said, some complaints were heard about the quality of the food (absence of fresh vegetables and fruit) and the impossibility to buy fresh food in the shop.[36] **The Georgian authorities are invited to verify the quality of the food offered to foreign nationals detained at the TAC and to increase the range of food items available for sale.** Further, **offering the detainees the possibility to cook their meals by themselves should be seriously considered.**

36. As regards activities, each unit had a recreation area with sofas, chairs, tables, a TV set (with many foreign channels) and some books and board games. Further, during the day detainees had access to a large outdoor yard equipped for foot-, volley- and basketball (for at least 3 hours per day), and could play table tennis and use computers with access to the Internet.

Overall, the offer of activities could thus be considered adequate. However, **the CPT invites the Georgian authorities to make more efforts to offer some organised activities (e.g. lectures, handicraft, art and cooking classes) to foreign nationals accommodated at the Centre for extended periods (up to several months).**

4. Health care

37. The TAC employed two full-time doctors (one of whom was always present from 9 a.m. to 6 p.m.) and a full-time psychologist. In case of emergency, one of the doctors could come to the Centre at night or an ambulance was called. Although this arrangement seemed to function well in practice, and none of the detained foreign nationals complained of any delays in access to a doctor,[37] **the Committee is of the view that it would be advisable to recruit nursing staff and organise a 24/7 health-care coverage at the TAC.**

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34 Beds with full bedding, wardrobes, lockers, shelves, tables, chairs or benches.

35 Air conditioners which also worked as heaters.

36 Which mainly sold coffee/tea, sweets and cigarettes.

37 Access to outside specialists, including a dentist and a psychiatrist, also seemed relatively quick and unproblematic.

38. All newly-arrived foreign nationals were medically screened by the doctors, and injuries observed on the detainees were recorded and reported to the relevant authorities. That said, the recording was rather superficial and succinct. **The CPT recommends that the same screening, recording and reporting procedures be applied at the TAC as those already in place at the TDIs with on-site health-care staff,[38] and that the doctors (and in due course, the nurse) working at the Centre be provided with appropriate training in this respect.**

5. Safeguards

39. Upon their arrival at the Centre, foreign nationals were given information (both orally and in writing, in a range of languages[39]) about their rights, including on the right of access to a lawyer (and about the house rules). *Ex officio* legal assistance was available, and indeed the delegation witnessed a visit by an *ex officio* lawyer to one of the detainees. Furthermore, interpretation services were provided if necessary (the Ministry of Internal Affairs had signed contracts with several interpreters), although only in the context of the ongoing legal procedure (not for daily life situations such as conversations with custodial and health-care staff); **the Georgian authorities are invited to explore ways to extend the access to interpretation services at the TAC.**

However, some of the detainees appeared ill-informed of the precise scope and content of their right of access to *ex officio* legal assistance (they thought it would only be available if they appealed the placement decision). **The Committee invites the Georgian authorities to verify and make sure that foreign nationals detained at the TAC are duly and fully informed of the aforementioned right.**

40. As for contact with the outside world, detained foreign nationals could make a free telephone call to their relatives upon arrival and could then use the office phone three times per week. Calls to lawyers and NGOs were not subjected to any limitations. Further, as already mentioned (see paragraph 36 above), detainees had access to computers and could communicate with their families and friends using messenger services and VoIP (Voice over Internet Protocol). Visits were also allowed (3 times a week) and took place in suitable open-type premises.

41. Detained foreign nationals were informed of available avenues of complaint (both internal and external) and could make use of confidential complaints boxes located in the corridors beyond the CCTV coverage.[40] Further, the Centre received frequent visits by a range of bodies including the Public Defender/NPM and the relevant international[41] and non-governmental organisations.

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38 See paragraph 24 above.

39 Arabic, Bengali, English, French, Hindi, Persian, Russian and Turkish.

40 Internal complaints were possible to the Human Rights Unit of the Migration Department and to the General Inspection of the Ministry of Internal Affairs, external complaints could *inter alia* be sent to the Public Defender, the prosecutor's office and the court.

41 Especially the IOM and the UNHCR.

6. Other issues

42. The TAC employed specially trained custodial staff[42] (there were at least five men and two women on each of the three shifts), as well as a social worker and (as already mentioned in paragraph 37 above) a psychologist. Regarding language skills, most of the staff spoke Russian and some could communicate in English or French; however, communication was a problematic issue, especially for the detainees coming from Asian and Arabic-speaking countries. **The CPT invites the Georgian authorities to make further efforts to improve language skills of the staff working at the Centre.**

43. As for discipline, the TAC possessed a punishment room[43] which could be used for placements of up to 10 days (only for adult detainees) by decision of the Director of the Migration Department.[44] The disciplinary procedure included an obligatory hearing (with interpretation if needed) and the provision of a written reasoned decision (with information on the right to appeal), a copy of which was to be given to the detainee.

However, there was no specific journal to record placements in the punishment room,[45] and persons placed in it would have no access to outdoor exercise and to reading matter. **The Committee recommends that steps be taken to remedy these deficiencies. The CPT would also like to be informed whether the disciplinary procedure includes the right for the detained person to call witnesses on their own behalf and to cross-examine evidence given against them.**

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42 Recruited from the police and deployed after having received specialised training on working with foreign nationals (e.g. inter-cultural communication and conflict resolution), including courses dispensed by Frontex.

43 The room was clean, well lit and ventilated, measured some 10 m² and was equipped with an ordinary bed (with a mattress, a pillow and a blanket) and a partially screened sanitary annexe comprising a toilet and a washbasin.

44 The room had never been used so far.

45 Copies of disciplinary decisions were put in detainees' individual files and reports on each placement would be sent electronically to the Migration Department.

C. Penitentiary establishments

1. Preliminary remarks

44. The CPT's delegation carried out follow-up visits to Prison No. 3 in Batumi, Prison No. 8 in Tbilisi (Gldani), Prison No. 9 in Tbilisi ("Matrosov Prison") and the Prison Hospital (Establishment No. 18). First-time visits were carried out to Prison No. 6 in Rustavi, Prison No. 7 in Tbilisi (new site), Prison No. 11 in Avchala (for juveniles, new site) and Prison No. 15 in Ksani.

45. Since the 2014 visit, there have been several important legislative developments concerning the prison system, including new provisions in the Imprisonment Code (and in subsequent Ministerial Orders) concerning individual risk assessment and individual sentence plans (for sentenced prisoners),[46] a further increase in the visiting entitlement for prisoners[47] and further liberalisation of conditional release (including for life-sentenced prisoners). The new Juvenile Justice Code, adopted in 2015, contains a broad catalogue of alternative measures, provisions on mediation and diversion, and on the setting up of specialised juvenile courts and specialised departments dealing with juvenile cases in the police. There are also new rules concerning alternative measures,[48] preparation for release, social rehabilitation and probation for all categories of inmates. The CPT welcomes all these new provisions which should, however, be fully implemented.[49]

On the organisational level, the main recent development was the abolition of the Ministry of Corrections[50] and its merger with the Ministry of Justice, as a result of which the prison system had been renamed the Special Penitentiary Service and subordinated to the Minister of Justice. At the time of the visit, the reorganisation had not yet been fully completed which unavoidably implied a degree of disruption in the normal operation of the prison administration. The Committee hopes that this transitional period has now come to the end.

46. Regarding the prison estate, apart from the recent opening of the new site of Prison No. 7 (see paragraph 64 below) and of the open-type half-way home in Tbilisi,[51] as well as ongoing repairs in all existing establishments, there were advanced plans for building a new medium-size prison in Rustavi with extensive areas for association and activities.[52] Concerning the construction of the new prison in Laituri, the Minister of Justice informed the delegation that she had recently ordered the project to be redrafted so as to provide sufficient space for association and activities on each of the 4 floors; a new contract with the architects had just been signed and it was hoped to be able to open the redesigned new prison by early 2020.

The CPT requests the Georgian authorities to provide it, in due course, with updated information on the construction of new prisons in Laituri and Rustavi.

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46 See paragraph 73 below.

47 See paragraph 102 below.

48 Among others, the sanction of home arrest (with electronic supervision) was extended to adult male prisoners (previously it was only applicable to women and juveniles).

49 See paragraph 73 below.

50 See paragraph 12 above.

51 For low-risk prisoners who have one year left before release, and who are allowed to work outside and spend up to 3 days per week at home.

52 The tender (with the budget of approximately 40 million GEL) was being prepared, and the Ministry had secured a 26 hectare plot of land near Rustavi.

47. Overall, overcrowding was no longer a problem in the prisons visited (notably, Georgia's prison population had not increased since the 2014 visit[53]), with the exception of Prisons Nos. 8 and 15.[54] That said, the CPT is concerned that – unlike for sentenced prisoners (for whom the norm was 4 m² per person) – the norm of living space per remand prisoner had remained unchanged (3 m²). **The Committee reiterates its recommendation that the Georgian authorities ensure that the minimum standard of 4 m² of living space per prisoner in multi-occupancy cells (not counting the area taken up by any in-cell toilet facility) is duly respected in all penitentiary establishments, for all categories of prisoners; for single-occupancy cells, the standard should be at least 6 m². In newly-built prisons, the standards should preferably be even higher.**[55]

48. As had been the case during previous visits, progress had been much less impressive in drawing up programmes of purposeful, out-of-cell, activities for prisoners. The delegation again observed that prisoners in closed-type establishments visited (Prisons Nos. 3, 6, 7, 8 and 9) were locked up in their cells for most of the day, in a state of enforced idleness. For some of them (those in so-called "high-risk" category),[56] the regime could *de facto* amount to solitary confinement for years on end. The situation was not much better in the semi-open Prison No. 15 – although not locked up during the day and free to move around the prison's territory, inmates were basically left with nothing to do.[57] The only positive exception to the aforementioned situation was observed at the juvenile Prison No. 11 in Avchala, see paragraph 75 below.

The CPT once again calls upon the Georgian authorities to take decisive steps to develop the programmes of activities for both sentenced and remand prisoners. The aim should be to ensure that prisoners are able to spend a reasonable part of the day (8 hours or more) outside their cells, engaged in purposeful activities of a varied nature (work, education, sport, etc.) tailored to the needs of each category of prisoner (adult remand or sentenced prisoners, inmates serving life sentences, female prisoners, etc.).

2. Ill-treatment and inter-prisoner violence

49. The delegation heard hardly any allegations of ill-treatment of inmates by staff. Overall, there was a relaxed atmosphere and good staff-prisoner relations in the prisons visited (and in the Prison Hospital). Only a few isolated allegations were heard (and other indications gathered e.g. injuries recorded by prison health-care staff) of excessive force (mainly painful holding and too tight handcuffing) used while prisoners were transferred to so called "de-escalation rooms",[58] especially at Prison No. 6 which accommodated many challenging prisoners.[59]

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53 It stood at approximately 10,000 inmates at the time of the visit. The overall capacity of the prison system was 12,492 and the prison population rate was 258/100,000 of national population.

54 See paragraphs 57 and 68 below.

55 See document "Living space per prisoner in prison establishments: CPT standards" (CPT/Inf (2015) 44, https://rm.coe.int/16806cc449).

56 See paragraph 72 below.

57 See paragraph 72 below.

58 See paragraph 101 below.

59 Prison No. 6 was generally considered, both by inmates and prison staff members with whom the delegation spoke, as "the final stop" within the prison system i.e. an establishment where inmates considered to be unmanageable in other prisons would be transferred to. This is possibly why, alongside with Prison No. 3, it was accommodating many prisoners with mental health and behavioural problems (see paragraphs 84 and 101 below).

In the Committee's view, custodial staff in all Georgian prisons – and especially at Prison No. 6 – need more training in dealing with such high-risk situations and challenging inmates, including in verbal communication, de-escalation techniques and manual control. **The CPT recommends that efforts be stepped up accordingly.**

50. As regards inter-prisoner violence, it was not a major issue in closed-type prisons (which was to be expected in establishments where inmates remained locked in their cells for most of the day),[60] except for a few allegations and other indications – such as recorded injuries – at Prison No. 6.[61] Likewise, inter-prisoner violence appeared rare at Prison No. 11.

However, inter-prisoner violence was clearly a problem at Prison No. 15. This was hardly surprising given the very low staff presence, with slightly over 30 custodial staff attempting to control some 1,800 inmates circulating freely across the extensive territory of the prison.[62]

51. Another important factor at Prison No. 15 was the influence of the informal prisoner hierarchy. Amongst the indications of this influence, one may mention the fact that many prisoners were clearly reluctant and even afraid to speak with the delegation (although a few of them finally acknowledged, more or less explicitly, that there were so-called "watchers" in the prison, reportedly at least one on each floor). Further, there was a striking discrepancy in material conditions of different cells (some of the cells being almost luxurious)[63] and the delegation was accosted by a few of the self-appointed "prison leaders" who demonstrated their position with their attitude and demeanour.

It is noteworthy that some injuries sustained by prisoners inside Prison No. 15, and recorded by prison health-care staff, had most likely resulted from inter-prisoner violence,[64] and there was a number of inmates who had requested to be transferred to Prison No. 8 for their own safety.[65]

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60 See paragraph 72 below.

61 The delegation heard only one express allegation of inter-prisoner violence (from one of the inmates accommodated in double-occupancy cells) at Prison No. 6, and there were some injuries recorded in the relevant journal suggesting their possibly violent origin; there were also a few indications of recent incidents between inmates in the disciplinary records and the records of placement in "de-escalation rooms". However, these were rare events and none of them was of any severity.

62 See also paragraphs 72 and 94 below.

63 With high-quality non-standard furniture, wooden floors, paintings on the walls, large aquaria, big TV and hi-fi sets, etc. See also paragraph 71 below.

64 The delegation's forensic doctor found, in the relevant journal at Prison No. 15, one recent entry describing injuries ("many bruises on the back with different dimensions, a small bruise on the back and occiput region (back side) on the neck, bruises on the right side on the neck, bruises with different dimensions on the right arm and forearm, abrasion and bruise on both eyes and nose, closed head trauma, concussion") that had very likely originated from inter-prisoner violence, and another entry ("bruises on the cheek and temple area") that had probably been the outcome of such violence. However, one of the inmates concerned refused to speak with the delegation and the other denied any inter-prisoner violence.

65 17 prisoners had been transferred to Prison No. 8 upon their own request in the period between 1 January and 1 September 2018, as a rule after having spent some time (up to 2 weeks) in the punishment block of Prison No. 15, not as a disciplinary sanction but as temporary safe accommodation.

Faced with this situation, the management of Prison No. 15 acknowledged that it considered itself compelled to share a part of its responsibility for order and security with "strong prisoners" (so-called "watchers"), thus exposing weaker inmates to the risk of violence and intimidation. Needless to say, this is totally unacceptable. The (re)emergence of this phenomenon at Prison No. 15 is a troubling sign and major efforts are required to ensure that it does not spread throughout the prison system.

52. More generally, the Committee wishes to emphasise once again that the duty of care which is owed by the prison authorities to prisoners in their charge includes the responsibility to protect them from other prisoners who might wish to cause them harm. The prison authorities must act in a proactive manner to prevent violence by inmates against other inmates. Addressing the phenomenon of inter-prisoner violence and intimidation requires that prison staff be alert to signs of trouble and both resolved and properly trained to intervene when necessary. The existence of positive relations between staff and prisoners, based on the notions of dynamic security and care, is a decisive factor in this context; this will depend in large measure on staff being present in sufficient numbers and possessing appropriate interpersonal communication skills. It is also obvious that an effective strategy to tackle inter-prisoner intimidation/violence should seek to ensure that prison staff are placed in a position to exercise their authority in an appropriate manner. Both initial and ongoing training programmes for staff of all grades must address the issue of managing inter-prisoner violence.

The management must be prepared fully to support staff in the exercise of their authority; this should include reviewing the placement of individual prisoners. Addressing effectively the problems posed by inter-prisoner violence requires the effective implementation of an individualised risk and needs assessment of prisoners.[66]

53. **The CPT calls upon the Georgian authorities to instruct the management and staff of Prison No. 15 (and all the other penitentiary establishments in Georgia) to exercise constant vigilance and use all appropriate means at their disposal to prevent and combat inter-prisoner violence and intimidation.[67] This should include ongoing monitoring of prisoner behaviour (including the identification of likely perpetrators and victims), proper recording and reporting of confirmed and suspected cases of inter-prisoner intimidation/violence, and thorough investigation of all incidents.**

Steps must also be taken to protect the actual or potential victims against the actual or potential perpetrators (e.g. by transferring them to different establishments or otherwise preventing them from having any contact with each other).

Further, **an end must be put at Prison No. 15 (as well as, as applicable, in other prisons) to the practice of delegating authority to informal prisoner leaders and using them to maintain order and security among the inmate population. All informal prisoner leaders and their close circle must be deprived of privileges which other prisoners do not enjoy, including as regards material conditions; consideration might be given in this context to segregating the informal leaders and their close circle from the rest of the prison population, on the basis of a proper individual risk and needs assessment.**

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66 See also paragraph 74 below.

67 See also the recommendations in paragraphs 47 and 48 below, which are equally relevant in the context of preventing and combating inter-prisoner violence.

54. Naturally, tackling the problem of inter-prisoner violence will be impossible unless the staffing levels are sufficient (including at night-time) to enable prison officers to supervise adequately the activities of prisoners and support each other effectively in the exercise of their tasks. On this issue, **reference is made to the comments and recommendations in paragraph 96 below.**

55. In the report on the 2014 visit,[68] the Committee expressed its extreme concern about the situation of Mr David PANGANI, a life-sentenced prisoner accommodated (back then) at Prison No. 7 in Tbilisi (old site).[69] The CPT considered that conditions under which he was kept at Prison No. 7 could easily be considered as inhuman and degrading.

The delegation met Mr Pangani again during the 2018 visit. He had been transferred to Prison No. 6 where his conditions of detention were somewhat better (he was staying all the time in a spacious cell – some 20 m² including a partially-screened sanitary annexe – which had a large window). However, the cell, the bedding and his clothes were dirty. Moreover, he clearly displayed signs of a severe mental disorder (he was hardly aware of where he was) and received almost no psychiatric care as he refused to take any medication. The delegation was concerned to learn that the legal *lacuna* described in the report on the 2014 visit[70] had still not been eliminated and that some developments concerning Mr Pangani's situation had only occurred a few days before the Committee's 2018 visit: he had been seen by a forensic psychiatrist and the prison's Director had just received a copy of opinion by the Psychiatric Forensic Commission, according to which Mr Pangani suffered from paranoid schizophrenia.[71]

The CPT wishes to be informed of the current situation of Mr Pangani and, in particular, whether any steps have finally been taken to transfer him to the Prison Hospital (see paragraph 91 below) **or to Kutiri Psychiatric Hospital** (see paragraph 105 below)**.** More generally, **the Committee calls upon the Georgian authorities to amend the relevant legislation so as to ensure that all prisoners in need of psychiatric hospitalisation are transferred to an adequate treatment facility within the shortest time.**[72]

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68 See paragraph 58 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8. He had been diagnosed as suffering from serious mental and physical health problems and had been held in solitary confinement for over a year. His body and his cell at Prison No. 7 were filthy, having not been cleaned for months; he reeked of urine and his clothes, body and bedding were infested with vermin. His cell was poorly lit (with almost no access to natural light) and ventilated, and it was clear that he had not left it for a long time (staff having had great difficulty opening the cell door).

69 See paragraph 64 below.

70 Under the existing law (Section 22 (2) of the Law on Psychiatric Assistance, LPA) it was impossible to subject an already sentenced prisoner to an involuntary psychiatric assessment and treatment, and without an assessment the court could not order his/her transfer to a psychiatric hospital to undergo involuntary treatment.

71 Surprisingly, despite the above diagnosis and the lack of pharmacotherapy, the Psychiatric Forensic Commission had concluded that Mr Pangani could remain in prison.

72 See also paragraph 86 below.

3. Conditions of detention

a. material conditions

i. follow-up visit to Prison No. 3 in Batumi

56. Prison No. 3 was last visited by the CPT in 2014.[73] At the time of the 2018 visit, it had the official capacity of 92[74] and was accommodating 54 adult male prisoners, including one inmate sentenced to life imprisonment and three remand prisoners (the rest serving mostly long sentences, up to 30 years).

Material conditions were clearly better than in 2014, firstly because of the much lower population[75] but also because cells had been refurbished, water supply problems solved and air conditioners (which could also work as heaters) installed in all of the cells. As previously, cells were equipped with fully-screened sanitary annexes including showers. In short, material conditions could be considered as adequate.

ii. follow-up visit to Prison No. 8 in Gldani (Tbilisi)

57. The material conditions of detention at Prison No. 8 were described in detail in the report on the CPT's 2014 visit.[76] During the 2018 visit, the prison (with the official capacity of 3,170,[77] calculated according to the norm of 3 m² of living space per remand prisoner) was accommodating 2,879 male inmates (i.e. slightly less than in December 2014[78]), of whom 1,630 were sentenced (including 52 life-sentenced prisoners). The rest of the prisoner population were on remand, including 19 juveniles accommodated in a separate unit.

As had been the case in 2014, the prison failed to offer all the inmates individual living space according to the relevant national norms (see paragraph 47 above). For example, a typical cell for sentenced prisoners measured approximately 24 m² (fully screened sanitary annexe included) and could accommodate up to eight prisoners. More living space (at least 4 m² per person) was provided in the units for juveniles and lifers; however, the bulk of prisoner accommodation was overcrowded. In this context, **reference is made to the recommendation in paragraph 47 above.**

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73 See the description and comments in paragraphs 60 and 61 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

74 As compared with 557 (calculated on the basis of the old norm of 2.5 m² of living space per prisoner) in 2014.

75 There were 186 prisoners when the CPT visited Prison No. 3 in December 2014.

76 See paragraphs 65 to 67 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

77 3,570 in 2014 (calculated based on the old norm of 2.5 m² of living space per prisoner).

78 2,929.

58. The delegation was informed by the Director of Prison No. 8 that major refurbishment had taken place since the 2014 visit in the unit for juveniles and in the admission unit ("Smart Reception Unit"). In the rest of the prison, only small current repairs and some redecoration had been carried out. Indeed, the delegation observed signs of worsening wear-and-tear and dilapidation throughout the prisoner accommodation areas, and complaints were heard in some of the cells about infestation with cockroaches and bedbugs. **The CPT recommends that steps be taken at Prison No. 8 to refurbish all prisoner accommodation areas and to carry out disinfestation of the whole establishment.**

59. On the positive side, as had been the case in 2014, no noteworthy problems were observed as regards access to a shower (twice per week and every day for the juveniles and the few sentenced prisoners who had a job[79]) and the provision of bedding, hygiene items and food.

iii. follow-up visit to Prison No. 9 ("Matrosov Prison"[80]) in Tbilisi

60. Prison No. 9 was previously visited in 2014.[81] At the time of the 2018 visit it had an official capacity of 72 and was accommodating 37 male adult prisoners, including three on remand. All were classified as "high-risk" prisoners[82] and were former senior political officials[83] or former law enforcement officers.

Material conditions were even better than in 2014 (i.e. generally very good), thanks to the reduced population,[84] the removal of unused beds from the cells and ongoing refurbishment, with half of the cells already refurbished. Further, air conditioning (which could also work as heating) had been installed in all cells in 2016. As previously, there were no problems with the bedding, hygiene items and food, and access to a shower (in a decent communal facility) was guaranteed twice a week. In short, the CPT has no concerns regarding the material conditions at Prison No. 9, but **would like to be informed once the refurbishment of all the cells has been completed**.

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79 See paragraph 72 below.

80 This is how the prison is colloquially referred to in the public and the media because of its former address in the Soviet times.

81 See paragraphs 68 and 69 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

82 See paragraph 72 below.

83 Including a former Prime Minister and a former Minister.

84 When visited by the CPT in December 2014 the prison had 48 inmates.

iv. Prison No. 6 in Rustavi

61. Prison No. 6, a closed-type establishment located on a large territory in the village of Mtisdziri (approximately 15 km from Rustavi),[85] was built in the 1980s but renovated and extensively reconstructed as from 2005 (with several new buildings added). With an official capacity of 309[86] (divided between two detention blocks, Block I with 3 wings (A, B, C) and Block II), the establishment was accommodating 172 sentenced male adult prisoners at the time of the visit, all of them (except the 27 workers) classified as "high-risk"; approximately 60 of the inmates were accommodated in single occupancy cells and therefore *de facto* in solitary confinement.[87] Most of the prisoners were serving long sentences (between 15 years and life imprisonment).[88]

62. Material conditions at Prison No. 6 were generally good. Cells were not overcrowded (single cells measured some 12 m² and double cells approximately 30 m²)[89] and were well lit and ventilated, adequately equipped (beds with full bedding, table, benches, lockers and shelves, with TVs, DVDs, hi-fi audio equipment, electric kettles and other private items in evidence) and fitted with fully screened sanitary annexes.

There were well-appointed shower rooms on each floor of the accommodation blocks and prisoners were entitled to have two showers a week.[90] The establishment's kitchen was new and well equipped, and the food appeared sufficient in quantity and quality.

63. The only negative point was that some of the cells were quite run down and those for life-sentenced prisoners had cold concrete floors. That said, there was ongoing refurbishment work in the prison and it was planned to address these shortcomings fully in the near future. **The CPT would like to receive confirmation that all the cells at Prison No. 6 have now been refurbished.**

v. Prison No. 7 in Tbilisi (new site)

64. The old site of Prison No. 7 (i.e. the building in downtown Tbilisi also occupied by some of the services of the Ministry of Internal Affairs) had been visited by the Committee many times in the past, and conditions there were severely criticised, last time in the report on the CPT's 2014 visit.[91]

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85 Close to Prison No. 5 for women.

86 Calculated according to the norm of 4 m² of living space per prisoner.

87 See paragraph 72 below.

88 There were nine lifers at the time of the visit.

89 Working prisoners lived separately in dormitories with up to 8 beds; material conditions in these dormitories call for no particular comment.

90 Sentenced working prisoners had unlimited access to showers.

91 See especially paragraph 63 of CPT/Inf (2015) 42 (https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8, in which the CPT stated that material conditions on (especially) level 1 of the old site of Prison No. 7 were totally unacceptable and could be considered as amounting to inhuman and degrading treatment.

In this context, the Committee was pleased to note that the Georgian authorities had decided to close the old site and transfer Prison No. 7 to a new facility located adjacent to Prison No. 9. The new site (actually, a thoroughly reconstructed building previously forming part of Prison No. 9)[92] had opened 2.5 months prior to the CPT's 2018 visit. With a capacity of 29, it was accommodating nine prisoners including four sentenced working inmates and five "high-risk" prisoners, three of whom were in solitary confinement and two shared a cell. Amongst the five (who were either "thieves-in-law" or former "thieves-in-law"),[93] two were sentenced to life imprisonment and the other three were serving long sentences.

Material conditions in the new Prison No. 7 were very good, with bright and airy spacious cells (single-occupancy cells measuring some 12 m², double cells measuring some 24 m²) equipped with beds (with full bedding), tables, stools, lockers, shelves and fully-screened sanitary annexes, as well as air conditioners/heaters. Prisoners could take a shower twice a week and there were no problems with the supply of hygiene items and food. Overall, the positive contrast with the old site of Prison No. 7 was indeed striking.

vi. Prison No. 11 (Juvenile Prison) in Avchala (Tbilisi), new site

65. The CPT last visited the juvenile Prison No. 11 in Avchala (a northern suburb of Tbilisi) in 2003.[94] Since then, the establishment had moved to a new site nearby (in the same district), opened in 2013. As previously, it was the only establishment in Georgia for sentenced male juveniles.[95] With an official capacity of 106 (calculated on the basis of 4 m² of living space per prisoner), on the day of the visit Prison No. 11 was accommodating 25 boys aged between 15 and 18.[96]

66. Material conditions were generally good. Juveniles were accommodated in 18 clean, bright, airy and spacious cells for three to seven inmates,[97] measuring between 30 and 60 m² and containing beds with full bedding, tables, stools, lockers, shelves and fully screened sanitary annexes including showers; further, all the cells had large TVs with satellite channels and inmates had USB sticks on which they could record music and movies.

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92 In the period when Prison No. 9 was much larger than now and comprised a general regime colony-type zone (see paragraph 68 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

93 Under Section 223¹ of the Criminal Code, membership of the criminal underworld and, especially, being a "thief-in-law", is a criminal offence punished by imprisonment of up to 10 years, independently from any other criminal offences committed by the person concerned.

94 See paragraphs 91 to 96 of CPT/Inf (2005) 12, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961b9.

95 Female juveniles, both on remand and sentenced, are accommodated in a separate unit of Prison No. 5 (for women) near Rustavi.

96 The minimum age of criminal responsibility in Georgia is 14. Exceptionally, for a short time and upon permission by juvenile court, juveniles whose sentence is about to end (or e.g. in order to be able to complete the school year) can be allowed to remain at Prison No. 11 passed the age of 18.

97 At the time of the visit, only 8 of the cells were occupied. One 17-year old juvenile was accommodated (on his own request) alone in his cell because he could not get along with the others; however, he spent the whole day engaged in group activities, under proper staff supervision.

Hot water was available all the time, and juveniles received hygiene items and (if they needed it) appropriate clothing. All inmates stated that the food was sufficient in quantity and tasty.

The only issue of concern was that the cells (unlike the common areas and the outside grounds) had a somewhat austere, carceral appearance; there was no form of decoration or personalisation, no plants, etc. **The Committee invites the Georgian authorities to consider allowing juvenile inmates to decorate and personalise their cells.**

67. The Director of Prison No. 11 informed the delegation of plans to enlarge the establishment by adding a second detention block for juveniles on remand (presently accommodated in a special unit at Prison No. 8); the idea was to open the new block in 2021. The Committee welcomes these plans, implementation of which would likely help improve the offer of activities and facilitate professional work with this category of juvenile inmates.[98] **The CPT would like to receive more detailed information on the subject.**

vii. Prison No. 15 in Ksani

68. The CPT visited the old prison in the village of Ksani, some 30 km from Tbilisi, in February 2010.[99] Since then the old compound had been closed[100] and prisoners moved to the new site, immediately adjacent to the old one, with the main four-storey detention block comprising three wings.[101] The prison, a semi-open establishment with most inmates serving sentences of up to 12 years (although there were a few inmates serving very long sentences, up to 30 years), is located in the vicinity of Establishment No. 19 for prisoners suffering from tuberculosis.

At the time of the visit, Prison No. 15 had an official capacity of 1,388 (calculated on the basis of the 4 m² norm) and was accommodating 1,817 inmates (only sentenced adult men); it was thus officially severely overcrowded.[102] **The Committee recommends that steps be taken to reduce the prisoner population at Prison No. 15 so as to ensure the observance of the official national norm of 4 m² of living space per inmate; reference is also made to the recommendation in paragraph 47 above.**

69. In the main detention block (referred to as the "Mercedes"), inmates were accommodated in 375 cells measuring each approximately 19 m² (including a fully-screened sanitary annexe) and generally containing 3 to 6 beds.[103] The cells were mostly well lit and ventilated, clean and equipped with beds (or bunk beds) with full bedding, tables, benches or stools, lockers and shelves.

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98 See also paragraph 75 below.

99 Back then it was called Penitentiary Establishment No. 7. See paragraphs 65 to 71 of CPT/Inf (2010) 27, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961dc.

100 At least for the biggest part: some buildings from the old compound continued being used after refurbishment (administration, health-care service, workshops, etc.).

101 Because of some similarity with the logo of a known car brand, inmates called this building the "Mercedes".

102 It should be noted, however, that there was an open door regime during the day and inmates could freely move within the whole secure perimeter of the prison, including across the wings and floors of the main block.

103 There were also 5 admission cells in the old compound, measuring 32 m² (sanitary annexe included) and containing 10 beds each.

However, most of the cells were dilapidated, as were the corridors (which were also quite dirty). **The CPT recommends that steps be taken to refurbish all the cells in the main detention block of Prison No. 15 and ensure that all the prisoner accommodation areas (including the corridors) are kept clean.**

70. On the positive side, prisoners had unrestricted access to the shower during the day and were provided with necessary hygiene items. Further, the delegation heard hardly any complaints about the food, and the kitchen and central canteen were in an acceptable condition. It should be added that the prison had a bakery making bread for its own inmates and for those from Prison No. 8 and the Establishment No. 19.

71. As already mentioned (see paragraph 51 above), a few of the prisoners (presumably the "watchers") lived in far superior conditions than the rest of the population of Prison No. 15: they were accommodated alone or on twos in cells with parquet or tiled floors, expensive non-standard furniture, aquaria, large TVs and hi-fi equipment, paintings on the walls and curtains on the windows, additional household appliances (such as large fridges and electric cookers), etc.[104] On this, **reference is made to the comments and recommendations in paragraphs 51 and 53 above.**

b. regime and activities

72. The lack of any tangible, real progress regarding the development of modern prison regimes and programmes of activities for inmates is one of the CPT's main preoccupations in Georgia, as far as prisons are concerned.[105]

In all the closed-type prisons visited (Prison Nos. 3, 6, 7, 8 and 9) there was basically nothing in terms of organised activities,[106] and a very big proportion of inmates[107] (including the bulk of life-sentenced prisoners) were *de facto* held for months if not years in solitary confinement,[108] with no association and very limited human contact (apart from occasional conversations with social workers and psychologists), and often under permanent CCTV surveillance. The Committee has made its position is quite clear in the past: such factors and their combination with restrictive provisions on contact with the outside world[109] could amount to inhuman and degrading treatment.

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104 Staff explained to the delegation that prisoners concerned were allowed to improve their cells using their own financial resources.

105 The other two are the (re)emergence of the power of informal prisoner hierarchies (see paragraph 51 above) and the lack of adequate care and approach vis-à-vis mentally disturbed and/or agitated/aggressive prisoners (see paragraphs 84, 88 and 101 below).

106 Only five prisoners worked at Prison No. 3; 27 at Prison No. 6; four at Prison No. 7; 94 at Prison No. 8 and two at Prison No. 9. Schooling was only offered to juveniles on remand at Prison No. 8, to some of the lifers in Prisons No. 6 and 8 (English classes) and to inmates at Prison No. 9 (where an English class with 12 participants had ended recently). Other than that, inmates killed the time watching television, listening to the radio, reading books and newspapers, and playing board games. Further, they could use simple fitness equipment and – sometimes – table tennis in exercise yards (during the daily outdoor exercise period).

107 E.g. approximately 60 at Prison No. 6, 12 at Prison No. 9, most of the lifers at Prison No. 8 and most of the "high-risk" prisoners at Prison No. 7.

108 E.g. the former Prime Minister and the former Minister of Defence, accommodated at Prison No. 9, had already been in solitary confinement for almost 6 years; three of the "thieves-in-law" at Prison No. 7 had also spent years in solitary confinement and at Prison No. 6 the delegation spoke with a life-sentenced prisoner who had been in solitary confinement for 10 years.

109 See paragraph 102 below.

The situation was only slightly better at the semi-open Prison No. 15, mainly because (unlike in the aforementioned establishments), inmates were not locked up in their cells for up to 23 hours per day but could move freely around the detention area during the day (from 8 a.m. to 8 p.m.). Still, they had almost nothing to do: only 48 inmates had a job and approximately 60 more had access to workshops (where they could learn how to make wooden objects, pottery and enamel jewellery), to a greenhouse and to an area with chickens, guinea fowls and rabbits. Further, occasional computer and language training sessions (English and Georgian for foreigners) were organised in small groups.

In this context, **reference is made to the recommendation in paragraph 48 above.** Of course, to be able to implement this recommendation, much more staff of all categories (custodial, social workers, clinical psychologists, etc.) needs to be recruited.[110]

73. As already mentioned,[111] the introduction of individual risk assessment (for all prisoners) and individual sentence plans (for sentenced inmates) has been one of the positive legislative developments since the CPT's 2014 visit.

Unfortunately, both instruments were still far from being (properly) implemented in practice: although most of the inmates had had their first risk assessment done, it became clear in the prisons visited that the vast majority were not aware of the fact and had not been in any way involved in the process (there had been no hearing, inmates had in most cases not received written information about the risk assessment decision and about the appeal procedure). More fundamentally, although the procedure[112] foresaw the involvement of a multi-disciplinary team (operational, security, medical, psychological, social), in practice the final say was always with the security department which frequently overruled other professionals and whose recommendations, which were classified as secret (and thus not communicated to other participants in the assessment process, including the inmates and their lawyers), were almost invariably followed by the Prison Department. The impression was of a rubber-stamp procedure and of a wasted effort by the socio-medico-psychological teams. It was hardly surprising that for the vast majority of the inmates interviewed by the delegation (especially those classified as "high-risk" and thus in most cases subjected to a very restrictive regime, often amounting to solitary confinement), the new risk assessment procedure had brought no practical change to their situation.[113]

As for individual sentence plans, in practice they had not yet been drafted for most of the sentenced prisoners: all female and juvenile inmates had them (the delegation could read examples of those for the juveniles at Prison No. 11, which appeared to be quite detailed and indeed individualised) but e.g. individual sentence plans had only so far been drawn up for approximately half of the inmates at Prison No. 6. Work on drawing up individual plans for the remainder of male sentenced prisoner population was supposed to continue in the near future.

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110 See also paragraphs 86, 87 and 96 below.

111 See paragraph 45 above.

112 As set out in the implementing Ministerial Order No. 70 dated 9 July 2015.

113 As an illustration of this, one may quote the data the delegation obtained from staff at Prison No. 15 (population 1,817): from the introduction of individual risk assessment in the establishment (in the beginning of 2017), one prisoner had his classification as "high-risk" lifted while two previously not considered as "high-risk" had been classified as such.

74. **The CPT recommends that the Georgian authorities fully implement in practice the new provisions on individual risk assessment and individual sentence plans in all prisons and in respect of all inmates. In this context, particular attention should be paid to the procedural safeguards mentioned above and, in the case of individual sentence plans, to involving (to the extent possible) prisoners in the drafting and reviewing the plans, so as to secure their commitment to the implementation of the plans and to their social rehabilitation.**

As regards prisoners classified as "high-risk", there is an urgent need to completely rethink the philosophy and the approach to them, so as to ensure that any restrictions on organised activities, association, privacy and contact with the outside world are only imposed based on a genuine and frequently reviewed (at least every 6 months[114]) individual risk and needs assessment. The current blanket approach is grossly excessive.[115]

75. On a more positive note, the delegation has gained an overall good impression of the regime for juvenile inmates at Prison No. 11: during the school year, they spent mornings at school (offering general education in 8th to 12th grades, as well as individual tuition) and afternoons attending vocational training and arts classes (woodcarving, enamel, drawing, IT graphics, theatre, poetry), playing sports (on two well-equipped outdoor pitches and in a large indoor gym) and computer games; further, various shows, concerts and competitions were organised regularly. However, **more efforts could be made to provide organised activities during the school holidays.[116]**

4. Health care

a. health-care services in the prisons visited

76. The delegation has noted further improvement in prisoners' access to both primary and secondary health care in all prisons visited, with 24/7 health-care coverage ensured in all prisons. Health-care teams were generally sufficiently staffed with doctors (with the exception of psychiatrists, see paragraph 84 below) and nurses.[117] That said, **the Committee recommends that more nurses be recruited at Prisons Nos. 8 and 15**. More generally, **efforts should be made to fill all the vacant posts; in this context, consideration should be given to introducing an incentive programme for young graduate doctors and nurses (considering that many of the current health-care professionals are already formally retired or approaching retirement).**

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114 Not once a year, as currently foreseen in the above-mentioned Ministerial Order.

115 See also the comments and recommendation in paragraphs 100 and 101 below.

116 The delegation's visit took place before the beginning of the school year and it appeared that the morning gap in activities had not really been compensated for.

117 Prison No. 3 (capacity 92, population 54) had four full-time doctors (and another vacant post) and five full-time nurses; Prison No. 6 (capacity 309, population 172) had eight full-time doctors and ten full-time nurses (and another vacant post); Prison No. 7 (capacity 29, population 9) had three full-time doctors and four full-time nurses; Prison No. 8 (capacity 3,170, population 2,879) had 26 full-time doctors (and two more vacant posts) and 44 full-time nurses (and another vacant post); Prison No. 9 (capacity 72, population 37) had two full-time doctors (and another vacant post) and nine full-time nurses; Prison No. 11 (capacity 106, population 25) had two full-time doctors and four full-time nurses; Prison No. 15 (capacity 1,388, population 1,817) had ten full-time doctors (and another vacant post) and 18 full-time nurses (and two more vacant posts).

77. The CPT is generally satisfied with the access to dental treatment in the prisons visited and the availability of other (somatic) specialists,[118] both inside and outside the establishments; however, at Prison No. 15 the delegation noted that the waiting time for some specialist examinations (e.g. MRI, hearing tests and ophthalmological examinations) could be up to a year, and for some surgical procedures (e.g. cholecystectomy, operation of hernia, removal of lipoma) more than 2 years. Further, the delegation had some misgivings regarding access to somatic specialists at Prisons No. 6[119] and No. 9.[120] **The Committee recommends that steps be taken to improve access to (somatic) specialist care at Prisons Nos. 6, 9 and 15.**

As regards psychiatric care and psychological assistance, see the comments and recommendations in paragraphs 84 to 88 below.

78. Regarding the medical facilities and equipment in the prisons visited, these were found to be of a satisfactory level in all the establishments except for Prisons Nos. 6 and 15, where the premises of the health-care services were rather run down, cold, poorly lit and poorly equipped. **The CPT recommends that these failings be remedied**.

The Committee has no major concerns regarding the supply of medication in the prisons visited,[121] except for psychiatric medication (see paragraph 84 below).

79. In all the prisons visited, medical screening was performed by the doctor on duty shortly after the arrival of a new prisoner (at the latest on the following day). The initial screening involved an examination of the prisoner's body for possible injuries or skin diseases, weighing the prisoner, asking questions concerning his medical history, filling in a questionnaire on known allergies, past surgical treatments, infectious diseases including TB and hepatitis, any psychiatric treatment, addictions (tobacco, alcohol, drugs), dental problems, etc. and a clinical examination with, if needed, referrals for further specialist examinations (e.g. by a cardiologist, a lung specialist or a specialist in infectious diseases).

80. As for the screening for injuries, these were recorded in dedicated registers of traumatic lesions[122] and systematically reported to the Penitentiary Department, the Investigation Department of the Special Penitentiary Service and the competent prosecutorial authorities. In addition, a medical certificate listing the injuries was attached to the prisoner's file. A similar procedure was in principle followed after any violent incident in the prison (including self-harm).

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118 E.g. lung specialists, radiologists, endocrinologists, neurologists, ENT specialists, cardiologists, dermato-venerologists, urologists, ophthalmologists and paediatricians (for the juveniles).

119 Where it met an inmate who had been operated in a civil hospital in 2017 (a colostomy had been performed) and who claimed that he had been told that any post-operative care (by an outside proctologist) would only be provided if he paid for it.

120 Where an inmate was found to display a visible asymmetry between right and left eye (ptosis of the right upper eyelid), which could be sign of a serious medical condition; apparently nothing had been done regarding his condition apart from supplying eye drops which were ineffective. Only after the delegation's doctor alerted the prison's Head doctor the patient was taken for further medical investigations.

121 All the prisons were systematically provided with medication included in the list drawn up by the Medical Department of the Ministry of Justice and prisoners could buy additional medication if they so wished (with the approval of the doctor).

122 Including *inter alia* entries for information on the type and location of injuries.

However, detailed recording according to the Istanbul Protocol (with "body charts" and photographs) and reporting of these details was only carried out if there was an express complaint of ill-treatment and only with the inmate's written consent. **The CPT recommends that the existing procedure be amended so as to require using the "body charts" and taking photographs (and reporting this information) whenever prison doctors believe there are grounds to suspect ill-treatment/inter-prisoner violence, irrespective of whether the prisoner concerned alleged any ill-treatment and agreed to such recording and reporting.**[123]

81. There were individual medical files for prisoners in all the establishments visited, and they seemed to be generally well kept. However, as in the past, medical confidentiality was not always respected as medical examinations could still take place in the presence of custodial officers (especially at Prison No. 15); this was of particular concern as regards the medical screening on arrival and the recording of injuries. **The Committee calls upon the Georgian authorities to implement its long-standing recommendation that all medical examinations (including, in particular, in the context of medical screening on arrival and recording of injuries) be conducted out of the hearing and – unless the doctor concerned expressly requests otherwise in a particular case – out of the sight of non-medical staff.**

82. The CPT notes further significant improvement in the prevention and treatment of infectious diseases (such as tuberculosis, HIV and hepatitis) in prisons, a result of the inclusion of prisons in the relevant National Programmes.[124] Thanks to this, the TB prevalence in the prison system had been reduced by 73% since 2014.

Indeed, systematic TB screening on arrival[125] (and subsequently in regular intervals[126]) was performed in the prisons visited, and TB treatment provided in accordance with the WHO recommendations (DOTS and DOTS+). Further, if required inmates were swiftly transferred to the TB establishment in Ksani (see paragraph 68 above).[127]

83. Tangible progress had also been achieved as regards hepatitis B and C[128]: screening was systematically offered to newly-arrived prisoners and hepatitis C treatment[129] was available.[130] For example, at the time of the visit, 80 inmates were receiving such treatment at Prison No. 3 and six at Prison No. 7.

Voluntary screening for HIV was also available in the prisons visited, and those found to be seropositive were offered counseling and antiretroviral therapy (there were 91 such inmates at the time of the 2018 visit).

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123 See also paragraph 24 above.

124 See also paragraph 93 below.

125 Including filling in the initial questionnaire and, if required, a further sputum smear test and a chest X-ray.

126 E.g. a mobile X-ray was brought to Prison No. 15 every 6 months.

127 The number of prisoners requiring transfer to the aforementioned establishment had been going down steadily: from 457 in 2012 to 25 in 2017 (and 24 in the period between 1 January and 1 September 2018). Actually, the Ministry of Justice was beginning to reflect about the need of maintaining a large specialised TB establishment (capacity 698) and the possibility of transforming it into an open prison (with the remaining TB patients transferred to a smaller purpose-built facility).

128 See also paragraph 89 below.

129 Direct-acting anti-virals (DAA).

130 2,548 prisoners had successfully completed the entire course of treatment for hepatitis C in the period between 1 June 2014 and 1 June 2018.

84. By contrast with the above, the Committee is very concerned by the persistent serious shortcomings in the provision of mental health care (psychiatric care and psychological assistance). Despite some improvement since the 2014 visit, there were still not enough psychiatrists[131] (especially at Prisons Nos. 3 and 6 which accommodated numerous mentally disordered inmates)[132] and clinical psychologists.[133] Further, there was in fact almost nothing available for mentally disordered inmates but pharmacotherapy; this was partially due to the fact that prison health-care services in the prisons visited were only licensed for primary care, and were thus not authorised to provide any psychiatric treatment other than a limited range of medication.[134] The delegation also noted that "de-escalation rooms" were overused for those prisoners.[135]

85. The importance of appropriate access to psychiatric assistance was well illustrated by the situation of Mr Pangani at Prison No. 6 (see paragraph 55 above). His case also demonstrates that transferring mentally disordered prisoners to appropriate medical facilities can still be difficult,[136] despite the general improvement in this respect (especially as concerns transfers to the psychiatric ward of the Prison Hospital, see paragraph 92 below).

86. **The CPT reiterates its recommendation that the Georgian authorities continue their efforts to reinforce the provision of psychiatric care and psychological assistance to prisoners, and in particular improve access to a psychiatrist (shorten the waiting time for consultations) in all prisons (but especially at Prisons Nos. 3 and 6), offer some therapies other than medication and provide some therapeutic activities, with the active involvement of psychologists working in prisons.**

As regards the observed practice of prolonged use of benzodiazepines (which can give rise to serious problems, including drug dependence as well as the possibility of adverse effects on cognitive function, physical and mental health), **the Committee recommends that it be reviewed so as to ensure that the maximum duration of prescription of the most common types of benzodiazepines does not exceed a period of 8 to 12 weeks.[137]**

Reference is also made to the recommendation in paragraph 55 above.

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131 E.g. a psychiatrist visited Prison No. 3 twice a week, Prisons Nos. 6 and 15 once a week, Prisons Nos. 9 and 11 twice a month and Prison No. 7 once a month. Only Prison No. 8 had full-time psychiatrists on its payroll (three doctors).

132 The Head doctor at Prison No. 6 told the delegation that there were 44 prisoners registered as suffering from mental disorders, but 71 prisoners (out of the total of 172) were on sedatives, out of whom 27 had been on benzodiazepines for periods of months and even years. At Prison No. 3, the Head doctor stated that some 80% of prisoners had mental health problems, and there were 18 prisoners (out of the total of 54) with a psychiatric diagnosis (psychosis or personality disorder).

133 There were five psychologists at Prison No. 8, three at Prison No. 11, two at Prisons Nos. 6 and 15, and one at Prisons Nos. 3, 7 and 9.

134 Levomepromazine and diazepam in injections.

135 See paragraph 101 below.

136 At the Prison Hospital, the Head doctor told the delegation that it took on average 20 days to arrange the transfer of mentally ill inmates to Kutiri Psychiatric Hospital (see paragraph 105 below); during this period an inmate's mental state could significantly deteriorate as patients could not be subjected to involuntary treatment (see paragraph 55 above).

137 The periods may be longer in individual cases if required by the need to secure withdrawal.

87. As regards prison psychologists, the delegation noted that none of them were clinically trained and that their role was essentially limited to carrying out risk assessment of prisoners.[138] **The CPT recommends that the Georgian authorities reinforce the provision of psychological care in prison (in particular, better access to psychological assistance should be granted to life-sentenced and other "high-risk" inmates) and develop the training and the role of prison psychologists, especially as regards therapeutic clinical work with various categories of inmates. In this context, efforts are needed to recruit, in due course, clinically trained psychologists who should form part of the health-care team and whose work should avoid combining two different roles i.e. risk assessment and therapeutic clinical work.**

88. More generally, the Committee considers that there a lack of a national strategy of dealing with challenging mentally disordered prisoners. There is clearly an urgent need to develop adequate mental health care provision including psychological assistance, in prisons; at present, mentally ill prisoners and those with personality disorders who present challenges (of whom there are many) are held in environments and in regimes where their condition is highly likely to deteriorate. The current system is based on segregation and punishment ("de-escalation cells" used as *de facto* punishment,[139] bans on visits, calls, parcels, correspondence, etc.). A system that also allows for achievable and meaningful rewards and activities to be included, that thus provide incentives to such prisoners, would make the management of those inmates more effective. Another option would be to set up special therapeutic units for such prisoners, with appropriate staff and activities.[140] **The CPT recommends that the Georgian authorities review their approach to mentally disordered prisoners, in the light of the above remarks.**

89. The Georgian authorities acknowledged from the outset that addiction to illicit drugs and other intoxicating substances (such as alcohol) continues to be a problem affecting a significant proportion of the prisoner population, and the delegation's findings in the prisons visited only confirmed this.[141]

The delegation noted that a methadone detoxification programme was proposed to inmates at Gldani Prison (it was being followed by 98 prisoners at the time of the visit); however, nothing of the kind was available in the other prisons visited.[142] Further, there were no harm-reduction measures (e.g. substitution therapy, syringe and needle exchange programmes, provision of disinfectant and information about how to sterilise needles) and almost no specific psycho-socio-educational assistance.

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138 See paragraph 73 above. Those working with juveniles at Prison No. 11 were relatively more involved in psychological assistance, as were a few of them performing some (very limited) counselling for prisoners with substance abuse problems, especially at Prison No. 15 (see paragraph 89 below).

139 See paragraph 101 below.

140 As was apparently planned (the delegation heard about such plans when visiting the Prison Hospital, see paragraphs 91 and 92 below).

141 E.g. the Head doctor and one of the psychologists at Prison No. 15 estimated that about 40% of the inmates accommodated in the establishment had an addiction problem.

142 According to the information provided at the Ministry of Justice at the outset of the visit, methadone detoxification was also available at Prison No. 2 in Kutaisi (last visited by the CPT in 2012, see CPT/Inf (2013) 18, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961e1). Approximately 400 prisoners had followed the programme (in both prisons) in the first half of 2018.

90. The Committee must stress once again that treatment options for prisoners in withdrawal as well as opioid agonist maintenance should be available in prison to the same extent as in the outside community; this is also in line with the Opioid Dependence Treatment Guidelines issued by the WHO in 2009.[143] More generally, the CPT reiterates its view that the management of prisoners with drug dependence must be varied – eliminating the supply of drugs into prisons, dealing with drug abuse through identifying and engaging drug misusers, providing them with treatment options and ensuring that there is appropriate through care, developing standards, monitoring and research on drug issues, and the provision of staff training and development – and linked to a proper national prevention policy. This policy should also highlight the risks of HIV or hepatitis B/C infection through drug use and address methods of transmission and means of protection. It goes without saying that health-care staff must play a key role in drawing up, implementing and monitoring the programmes concerned and must co-operate closely with the other (psycho-socio-educational) staff involved.[144]

The Committee calls upon the Georgian authorities to develop and implement a comprehensive strategy for the provision of assistance to prisoners with drug-related problems (as part of a wider national drugs strategy) including harm reduction measures, in the light of the above remarks.

b. follow-up visit to the Prison Hospital (Establishment No. 18)

91. There had been no noteworthy changes in the living conditions at the Prison Hospital since the 2014 visit;[145] as previously, they could be considered adequate. On the day of the delegation's visit in 2018, the hospital had a capacity of 140 and was accommodating 106 patients (including a woman, accommodated separately from the male prisoners).

Overall, the hospital was adequately staffed, with 55 full-time doctors including four psychiatrists, 66 full-time nurses (and five additional vacant posts), 19 orderlies (nursing assistants), a full-time clinical psychologist (and another visiting psychologist) and four social workers.[146] The medical equipment and supply of materials were adequate,[147] and there was no shortage of medication. To sum up, the level of healthcare appeared to be generally satisfactory.

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143 See http://apps.who.int/iris/bitstream/10665/43948/1/9789241547543_eng.pdf.

144 See also "Drug Dependence Treatment: Interventions for Drug Users in Prison", UN Office on Drugs and Crime, www.unodc.org/docs/treatment/111_PRISON.pdf.

145 See the description in paragraphs 99 and 104 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

146 As well as various technicians, pharmacists and 46 custodial staff.

147 Since the CPT's 2014 visit a lot of new equipment had been purchased, including 3 defibrillators, equipment for laparoscopy, for endoscopy (gastroscopy, bronchoscope, colonoscopy), a GeneXpert test for TB, quick tests for HIV, Hepatitis B and C, blood analysers, and equipment for central sterilisation.

92. However, treatment options remained very limited (essentially to pharmacotherapy) on the psychiatric ward,[148] patients continuing to spend 23 hours a day in their rooms, without access to television and often without a radio. The recent and still continuing increase in the number of mentally disordered prisoners referred to the Prison Hospital (which was, in itself, a positive development) had only worsened the situation on the psychiatric ward, straining its staff resources. On the day of the delegation's visit, one nurse and one orderly (on duty on the psychiatric ward) had to care for 37 psychiatric patients.[149]

The CPT reiterates its recommendation that steps be taken on the psychiatric ward of the Prison Hospital to develop a broader range of psycho-social therapeutic activities for patients, in particular for those who remain on the ward for extended periods; occupational therapy should be an integral part of the rehabilitation programme. Further, patients should be given access to TV and radio.

The Committee also recommends that the use of available nursing staff resources be reorganised so as to increase the ongoing presence of nurses and orderlies on the psychiatric ward.

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93. The delegation was informed during its meetings at the Ministry of Justice and the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs that the issue of a possible transfer of prison health-care service from the former to the latter Ministry had been discussed a few months prior to the 2018 visit and that it was decided not to proceed with the transfer for the time being, considering the resources available to both Ministries concerned. Meanwhile, the involvement of the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs in prison health care would remain as it was, namely covering the cost of involuntary psychiatric treatment for prisoners and (in the framework of national programmes) providing treatment for inmates for TB,[150] HIV and hepatitis. Further, as previously, the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs supervised the implementation of medical standards in prisons (in terms of staffing, infrastructure and medical practices) through its State Regulatory Agency.

The CPT remains of the view that a transfer of responsibility for prison health-care services to the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs is needed to improve the quality of health care through its better integration with the public health system, and also to strengthen the professional independence of health-care staff working in prisons. **The time has come to start concrete preparations for such a transfer, comprising precise deadlines.[151]**

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148 On which the delegation focussed its attention.

149 As compared with 22 patients during the December 2014 periodic visit. The capacity of the psychiatric ward was 40.

150 Paying 100% of the cost of first-line medication and 50% of second-line drugs. See also paragraph 82 above.

151 See also the "Strasbourg Conclusions on Prisons and Health", issued at the end of the May 2014 joint World Health Organization (WHO)/Council of Europe international expert meeting "Prison Health in Europe: Missions, Roles and Responsibilities of International Organizations", http://www.euro.who.int/__data/assets/pdf_file/0005/252563/Strasbourg-Conclusions-on-Prisons-and-Health.pdf?ua=1.

5. Other issues of relevance to the CPT's mandate

a. prison staff

94. The staffing situation in the establishments visited varied.[152] While it was satisfactory or even good at Prisons Nos. 3, 6, 7, 9 and 11,[153] it was much less favourable at Prison No. 8[154] and quite poor at Prison No. 15.[155] In the latter establishment, as already mentioned in paragraph 51 above, the shortage of staff (especially combined with the open-door regime during the day, see paragraph 72 above) put at risk the security of both staff and prisoners and resulted in the management and staff considering themselves forced to rely to a certain extent on prisoners to assist them in performing custodial tasks. On this, **reference is made to the comments and recommendation in paragraph 53 above.**

95. Overall, the conclusion reached on previous visits[156] that the staffing levels in prisons were too low (especially if the Committee's recommendations concerning the development of regime and activities were to be implemented),[157] remains valid.

96. At the outset of the visit, the Deputy Minister of Justice told the delegation about the authorities' ongoing efforts to increase prison staffing levels.[158] In the light of the above, **the CPT calls upon the Georgian authorities to step up these efforts, which should concern custodial staff but also social workers[159] and psychologists.[160] As a starting point, efforts should be made to fill all the vacant posts.**

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152 As previously, the figures mentioned below did not include staff responsible for perimeter security, who were not subordinated to prison Directors but to another service responding directly to the Penitentiary Department.

153 Prison No. 3 (population 54) had 14 custodial staff on each shift (8 additional posts for junior custodial officers were vacant); Prison No. 6 (population 172) had 208 custodial officers (47 per shift) and 10 additional vacant posts; Prison No. 7 (population 9) had 36 custodial officers (at least five per shift) and 6 additional vacant posts; Prison No. 9 (population 37) had 40 custodial staff (at least six per shift); and Prison No. 11 (population 25) had 60 custodial staff (at least nine per shift) and 11 additional vacant posts.

154 Population 2,879. The prison had 251 custodial staff including 174 junior custodial officers (and 20 additional vacant posts). There were some 60 custodial staff present on any given shift (approximately one custodial officer per 48 inmates).

155 Population 1,817. The prison had 117 custodial officers (and 3 additional vacant posts). There were 34 custodial staff per shift (approximately one custodial officer per 54 inmates).

156 See e.g. paragraph 106 of the report on the 2014 visit (CPT/Inf (2015) 42), https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

157 See paragraphs 48 and 72 above.

158 Among others, prison staff salaries had recently been increased (with the starting monthly salary of a junior custodial officer being 800 GEL plus a health insurance package) in order to render work in the prison system more attractive. That said, several prison Directors expressed the view that these salaries were still quite low as compared with salaries in the private sector (and in the police).

159 There were social workers in all prisons visited, but their complements were not always very generous (e.g. one at Prison No. 7; four at Prison No. 9; six at Prison No. 11; nine at Prison No. 6; and 18 at Prisons Nos. 8 and 15). It is noteworthy that, at the end of the visit, the Minister of Justice informed the delegation that 64 additional posts for social workers had recently been created in the prison system (recruitment on those new posts had not yet begun).

160 See also paragraph 87 above.

In this context, **the Committee is of the view that any significant staff increase will be impossible unless staff salaries are made more competitive with those offered in the police and in the private sector.**

97. As during previous visits, the delegation observed that some custodial staff at the establishments visited worked on 24-hour shifts followed by three days off. The CPT can only reiterate its opinion that such a shift pattern has an inevitable negative effect on professional performance; no-one can perform in a satisfactory manner the difficult tasks expected of a prison officer for such a length of time. **The Committee calls upon the Georgian authorities to discontinue this practice.**

98. As regards prison staff training, **reference is made to the comments and recommendation in paragraph 49 above.** Further, **the CPT recommends that continuous efforts be made to increase the number of prison staff trained in dynamic security[161] and deployed in prisoner accommodation areas.**

b. discipline and isolation

99. With the exception of Prison No. 3,[162] formal disciplinary sanctions (including placement in disciplinary cells) were resorted to (very) rarely.[163] This is to be welcomed in principle, see however paragraph 101 below.

The disciplinary procedure was described in detail in previous reports;[164] it had remained satisfactory and so had the relevant documentation in the prisons visited. In those cases when it was resorted to, it appeared that the formal procedural safeguards were generally respected.

As for the material conditions in disciplinary cells, these were found to be acceptable in all prisons that had them (there were no such cells at Prisons Nos. 7, 9 and 11). The disciplinary cells were sufficient in size (between 8 and 16 m²), were well lit and ventilated and equipped with a bed or a wooden sleeping platform (with a mattress and a blanket), a table, a bench, a toilet, a washbasin and a call system.

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161 Dynamic security also implies an adequate offer of constructive activities, see paragraph 48 above.

162 Where there had been 441 disciplinary punishments including 15 placements in a disciplinary cell (for 3 to 14 days) between 1 January and 1 September 2018. Further, there had been 42 preliminary placements of up to 24 hours, pending the outcome of disciplinary procedure.

163 This was especially striking at Prison No. 6, where there had been no placements in disciplinary cells for at least 2 years, and the disciplinary unit appeared completely unused. Placements in disciplinary cells were also very rare at Prison No. 15 (26 placements between 1 January and 18 September 2018, never for longer than 10 days). At Prison No. 8, there had been 50 placements between 1 January and 1 September 2018 (usually for 4 – 5 days, maximum 14 days), which is also not a large number considering the size (and the important turnover) of the prisoner population.

164 See e.g. paragraph 113 of CPT/Inf (2010) 27, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961dc. Prisoners concerned had the right to be informed of the charges in a language they understood, to have sufficient time and possibility to prepare their defence, to have an oral hearing, to be represented by a lawyer (including the possibility to have free-of-charge legal aid), to request the questioning of witnesses, and to use an interpreter. Further, inmates had to be given a copy of the disciplinary decision and could appeal the sanction to the court within 10 working days (the appeal having no suspensive effect).

That said, the delegation was told that there had been no change to the rules concerning the regime for prisoners placed in disciplinary cells, namely inmates were still deprived of access to outdoor exercise and reading matter. Further, as in the past, inmates placed in a disciplinary cell were automatically deprived of contact with the outside world.[165] **The Committee calls upon the Georgian authorities to remedy the above failings.**

100. Despite the CPT's recommendation in the report on the 2014 visit,[166] Section 82 of the Imprisonment Code still contains restrictions/bans on visits, phone calls, correspondence and access to media (TV/radio) as part of the catalogue of disciplinary sanctions. In this context, the Committee must reiterate its view that any restrictions on family contacts as a form of punishment should be used only where the offence relates to such contacts and only for the shortest time possible (days, rather than weeks or months). **The CPT calls upon the Georgian authorities to amend the Imprisonment Code accordingly.**

101. The issue of the Committee's gravest concern is a tendency, observed in several of the prisons visited (especially in Prisons Nos. 3, 6 and 8)[167] to make frequent use of so-called "de-escalation rooms",[168] for up to 72 hours,[169] as *de facto* punishment. Indeed, many prisoners the delegation spoke with, who were or had recently been placed in a "de-escalation room", perceived it as a form of punishment for their (often challenging) behaviour.[170]

In the Committee's view, "de-escalation rooms"[171] should only be used to place, for as short a time as possible (preferably just a few hours), prisoners who are agitated and/or aggressive, and the whole procedure should be under the authority of the doctor, not the custodial staff.[172] Any prisoner who remains agitated after several hours must be clinically assessed and, if necessary, transferred to a mental health establishment.[173] The current procedure is a hybrid between security and medical elements and, considering the absence of procedural safeguards,[174] it is all too tempting for prison Directors to apply it as a means of ensuring order and discipline in the establishment.

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165 See also paragraph 104 below.

166 See paragraph 119 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168069 61f8.

167 There were no "de-escalation rooms" at Prisons Nos. 9, 11 and 15.

168 E.g. there had been 136 placements in "de-escalation rooms" at Prison No. 3 between 1 January and 1 September 2018; and 376 placements at Prison No. 8, between 26 June and 11 September 2018 alone. At Prison No. 6, the 12 "de-escalation rooms" were in daily use, with two to four inmates placed there on any given day; some inmates were placed in "de-escalation rooms" repeatedly (though intermittently).

169 According to the relevant provision of the Imprisonment Code, amended recently (it used to be up to 96 hours during the 2014 visit).

170 See also paragraph 84 above.

171 It is noteworthy that conditions in the "de-escalation rooms" seen by the delegation could be considered as adequate on the whole (the rooms were sufficient in size e.g. 12 m², well lit and ventilated, equipped with a mattress placed on the floor or on a concrete sleeping platform and a stainless steel toilet and sink, as well as CCTV which did not cover the toilet area).

172 Presently, the placement decision rests with custodial staff, although a doctor is involved in the decision-making process (he/she must examine the prisoner prior to placement and the doctor's signature must be put on the decision, together with that of the custodial officer); the CPT has made clear many times in the past that such an involvement of a doctor in isolation on security (and often *de facto* disciplinary) grounds is unacceptable.

173 See also paragraphs 55 and 86 above.

174 Placement in a "de-escalation room" requires merely a decision by the duty officer, to be approved as soon as possible by the prison Director or one of his/her Deputies, and there are no procedural safeguards analogous to those foreseen in case of placement in a disciplinary cell (see paragraph 99 above).

Further, the CPT considers that prisoners who are not mentally disturbed and who violate internal regulations should be dealt with using disciplinary provisions; those who repeatedly violate order and discipline may be subjected to administrative segregation (not isolation) including transfer to a higher-security regime, but also this procedure should contain all the relevant safeguards, which is not the case at present.

The Committee recommends that the Imprisonment Code and all other relevant provisions governing the use of "de-escalation rooms" be amended in the light of the above remarks. Further, **reference is made to the standards on solitary confinement of prisoners set out in the substantive section of the CPT's 21st General Report,[175] and in particular those mentioned in paragraphs 56 (c), 57 (c) and 61 (c) of the General Report.**

c. contact with the outside world

102. Since the 2014 visit the Imprisonment Code has been amended, further extending the rights to visits[176] for several categories of prisoners, including lifers; the delegation also noted that, unlike in 2014,[177] inmates at Prison No. 9 had access to long-term visits.

Indeed, juvenile prisoners and those in semi-open prisons (e.g. Prison No. 15) had adequate possibilities to maintain contact with their families and friends,[178] including through VoIP (Voice over Internet Protocol). The CPT also welcomes the fact that remand prisoners no longer require prior authorisation by the competent investigating authority or court to receive a visit;[179] instead, any restrictions on visits (and telephone calls) must be imposed by the prosecutor for a specific period by means of a reasoned decision which can be appealed in court.

Nevertheless, the fact remains that the visiting entitlement for many prisoners (including remand prisoners[180] and sentenced inmates in closed-type prisons,[181] especially those classified as "high-risk"[182]) is far from generous. In this context, the CPT must reiterate its view that all prisoners, irrespective of their category (whether on remand or sentenced) and regime, should be offered at least the equivalent of one hour of visiting time per week. **The Committee calls upon the Georgian authorities to amend the Imprisonment Code accordingly.**

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175 CPT/Inf (2011) 28, https://rm.coe.int/1680696a88.

176 Correspondence was unrestricted for all prisoners.

177 See paragraph 116 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

178 They could receive up to four short-term (1.5 hours maximum) visits per month and up to three long-term (24 hours) visits per year, with two additional long-term visits possible as a reward for good behaviour.

179 Their normal visiting entitlement is one short-term visit per month, with one additional visit per month possible as a reward for good behaviour.

180 See above.

181 Two short-term visits per month and one long-term visit per year (with one additional long-term visit possible as a reward for good behaviour).

182 One short-term visit per month and one long-term visit per year (with one additional long-term visit possible as a reward for good behaviour).

As for access to a telephone, it varied between unlimited at Prisons Nos. 8, 11 and 15, three to four times per month at Prison No. 9, twice per month at Prisons Nos. 3 and 6, and once a month at Prison No. 7. In this respect, **the CPT reiterates its recommendation that the Georgian authorities take steps to improve access to a telephone for all categories of prisoners, especially those classified as "high-risk".**

103. The Committee is also concerned by the fact that, as a rule (except for sentenced juveniles at Prison No. 11), short-term visits still took place in small booths with a plexi-glass or glass partition, preventing any possibility for prisoners to have physical contact with their relatives, including young children.[183]

The CPT reiterates its long-standing recommendation that short-term visiting facilities be modified in all prisons so as to enable prisoners to receive visits under reasonably open conditions. Visits under closed conditions should be exceptional, only if there is a well-founded and reasoned decision following individual assessment of the potential risk posed by a particular prisoner or visitor.

104. As regards restrictions on visits, phone calls and correspondence in the context of disciplinary sanctions, **reference is made to the recommendation in paragraph 100 above.**

[183] By contrast, long-term visit premises were found to be fully adequate in all the prisons visited.

D. Psychiatric establishments

1. Preliminary remarks

105. The delegation carried out a follow-up visit to the National Centre of Mental Health named after Academician Bidzina Naneishvili (hereafter: Kutiri Psychiatric Hospital) and visited for the first time the East Georgia Mental Health Centre (hereafter: Surami Psychiatric Hospital) and Batumi Health Care Centre (hereafter: Khelvachauri Psychiatric Hospital).

Kutiri Psychiatric Hospital had previously been visited by the CPT in 2014.[184] With an official capacity of 650 beds, at the time of the visit the hospital was accommodating 492 persons, of whom 110 were women. Of the 148 "civil" psychiatric patients (including 38 women), four men were formally subject to "civil" involuntary hospitalisation[185] and of the 245 forensic psychiatric patients (including 22 women), 187 were under court orders (including 18 women) and 58 (including four women) were sentenced prisoners transferred to the hospital to undergo treatment. In addition, there were 99 social care residents with mental disorders (including 50 women), accommodated separately in the hospital's shelter ("pensionat").

Surami Psychiatric Hospital was located towards the edge of the small town of Surami in Shida Kartli region, some 112 kilometres from Tbilisi.[186] It consisted of a number of buildings, the main patient accommodation building being fully re-constructed at the time of the visit.[187] With an official capacity of 90 beds, the hospital was accommodating 63 adult patients (of whom 19 were women).[188] Most patients were diagnosed as suffering from paranoid schizophrenia but there were also nine patients with a learning disability. None of the patients were formally subjected to involuntary hospitalisation.[189]

Khelvachauri Psychiatric Hospital was located in a small town 8 km southeast of Batumi. With an official capacity of 150 general psychiatry beds, the number of patients at the time of the visit was 111 (including 44 women). The hospital also had a separate "pensionat" for elderly people with mental disorders, which had a capacity of 50 and was accommodating 45 residents (including 28 women) at the time of the visit. Regarding the patients' diagnostic profile, 35% were diagnosed with schizophrenia, 15% with affective disorders and 15% had learning disabilities; further, there were some patients with dementia/organic conditions.

106. The main legislative provisions governing involuntary psychiatric hospitalisation and treatment, contained in the Law on Psychiatric Assistance (LPA), have remained generally unchanged.[190]

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184 See paragraphs 130 to 162 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

185 See, however, paragraph 138 below.

186 The catchment areas of the hospital were Samtskhe-Javakheti and Shida Kartli, plus part of Imereti regions.

187 See paragraph 112 below.

188 According to the Director, the capacity would be reduced to 84 persons (60 in-patients and 24 "pensionat" residents) upon completion of the refurbishment work (see paragraphs 113 and 118 below).

189 See, however, paragraph 138 below.

190 See paragraph 132 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8. See also paragraphs 137 to 148 below.

That said, since the 2014 visit the sector of psychiatry has undergone a series of developments. Among others, new Ministerial Orders relating to compulsory psychiatric treatment were adopted, introducing risk assessment and risk reduction tools in respect of forensic patients. Further, a step-by-step de-institutionalisation process, through the development of available mental health services and the introduction of modern community care, was initiated in 2015 pursuant to a Governmental Action Plan adopted on 31 December 2014.[191]

In order to improve the quality of life of patients and reduce the risk of ill-treatment, **the Committee calls upon the Georgian authorities to make every effort to fully implement the aforementioned Action Plan and, in this context, substantially develop psychiatric care in the community.**[192] Community accommodation should be provided in small living units, ideally located in towns, with all the relevant facilities close at hand, and not larger units situated in the grounds of long standing psychiatric establishments.[193] The latter solution cannot be considered as representing true de-institutionalisation or proper re-integration of patients into the community.

2. Ill-treatment

107. Although at *Surami Psychiatric Hospital* the delegation received no allegations of recent physical ill-treatment of patients, it noted that there had been several instances of serious physical ill-treatment (including striking patients with sticks) in the recent past, the staff directly involved no longer being employed at the establishment. The position of the hospital's current management, which is clearly determined to prevent any such ill-treatment in the future, is to be highlighted positively.

At *Kutiri Psychiatric Hospital*, the delegation received only one recent and credible allegation of physical ill-treatment (i.e. slaps) of a resident of the "pensionat" by an orderly. By contrast, a number of allegations of recent physical ill-treatment of male acute patients (consisting of slapping and punching by orderlies) were heard at *Khelvachauri Psychiatric Hospital*. Further, some complaints were heard at both establishments that orderlies displayed rude and verbally abusive behaviour. Doubtless, this was linked with the very low staff complement and the poor level of training of the orderlies.[194]

The CPT recommends that the management of the three hospitals visited (in particular at Kutiri and Khelvachauri Psychiatric Hospitals) exercise continuous vigilance and remind all staff at regular and frequent intervals that any form of ill-treatment of patients, whether verbal or physical, is totally unacceptable and will be punished accordingly. Moreover, **it is essential that orderlies be carefully selected and given suitable training on managing patients humanely and safely, receive regular supervision and be provided with appropriate support and counselling to avoid burn-out and ensure good quality care.**[195]

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191 Decree of the Government of Georgia No. 762 implementing the Mental Health Development Strategy for the period from 2015 to 2020.

192 This should also be seen in the context of the UN Convention on the Rights of Persons with Disabilities, ratified by Georgia in 2014.

193 As was the case in the three hospitals visited by the delegation.

194 See paragraphs 119 and 121 below.

195 See also paragraph 122 below.

108. Inter-patient/resident violence did not appear to be a problem at *Surami Psychiatric Hospital*. However, at *Khelvachauri Psychiatric Hospital* and on the general psychiatric wards at *Kutiri Psychiatric Hospital*, the delegation heard a number of complaints regarding, and indeed witnessed,[196] episodes of inter-patient/inter-resident conflicts and violence, which was hardly surprising considering the low staffing numbers and the chaotic environment in which the patients and residents lived. Such violence (which had led to several instances of injuries directly observed by the delegation's doctors) obviously also represented serious risks for staff working there. Indeed, the Head doctor at *Khelvachauri Psychiatric Hospital* had been attacked several times by patients in the recent past, including having his arm broken.

The Committee must stress once again that the duty of care which is owed by staff in a psychiatric establishment to those in their charge includes the responsibility to protect them from other patients/residents who might cause them harm. This requires not only adequate staff presence and supervision at all times, but also that staff be properly trained in handling challenging situations/behaviour by patients. **The CPT trusts that appropriate action will be taken at Kutiri and Khelvachauri Psychiatric Hospitals to remedy the problem, in the light of the above remarks**.

3. Patients' living conditions

109. It should be noted from the outset that the three psychiatric hospitals visited were undergoing major refurbishment at the time of the delegation's visit. Meanwhile, however, patients in many parts of the three hospitals continued to live in woefully dilapidated and sometimes overcrowded dormitories, which lacked privacy and failed to ensure patients' dignity.

a. follow-up visit to Kutiri Psychiatric Hospital

110. Kutiri Psychiatric Hospital continued to consist of a "civil" section (the general psychiatric wards and the "pensionat") and a separate male forensic psychiatric unit.[197]

The male forensic wards[198] were in a slightly worse state of repair than in 2014, due to continued deterioration. For example, some of the dormitories on the ground floor had significant water damage to the ceilings, walls and floors, and electric lighting was not working in at least one of them.

The conditions on the remaining wards were basically unchanged i.e. unfit for a health care institution. Dormitories were overcrowded (with some beds in the corridors), dilapidated, dirty and infested with flies, with no privacy and no furniture except for damaged beds with thin mattresses and threadbare blankets and bed sheets.[199]

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196 E.g. two patients violently punching each other in front of the delegation members.

197 See the detailed description of the wards in paragraph 135 of the report on the 2014 visit (CPT/Inf (2015) 42), https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

198 I.e. Ward 12 accommodating 54 mentally disordered prisoners transferred from prison, and Wards 9, 10 and 11 accommodating forensic psychiatric patients who had been declared criminally irresponsible and subjected to compulsory psychiatric treatment by court order.

199 Some lockers and personal items (e.g. pictures and photos) were only seen on female wards.

The building containing the general psychiatric wards was cold, some of the barred doors at the end of the corridors being open to the elements. Some male residents in the "pensionat" were found lying on their beds half-naked, a number of them apparently incontinent. Further, communal sanitary facilities were invariably run down and dirty. In general, the conclusion reached by the CPT's delegation after the 2014 visit[200] that the living conditions on the general psychiatric wards and the "shelter" at Kutiri Psychiatric Hospital could well be described as inhuman and degrading remains valid.

111. The Director of Kutiri Psychiatric Hospital informed the delegation that the hospital's new main shareholder[201] had been obliged by the State to build a new facility of 100 beds with the surface area of 2,400 m^2. The new building[202] had just been completed but was not yet formally commissioned and occupied (see also paragraph 118 below).

Further engagements of the main shareholder included the construction of four 24-bedded cottages (on an identified site adjacent to the new accommodation building) for the "pensionat" residents, as well as renovation of the wards on the existing premises.

b. Surami Psychiatric Hospital

112. The hospital's large two-storey main accommodation building was empty and undergoing comprehensive refurbishment at the time of the visit.[203] Pending its completion, patients were accommodated in another single storey building (which had previously functioned as "pensionat") with a female and a male ward.

The female ward was permanently unlocked (including at night) and consisted of a dilapidated, scruffy, very crowded single large dormitory,[204] with beds touching and barred windows (with partly missing glass), within which resided 19 patients, sleeping on only 16 beds, with six patients sharing beds.

The male ward was accommodating 44 patients at the time of the visit and consisted of a dilapidated large single area (with some broken windows and missing radiators) divided into bays; further, there were two smaller closed dormitories with slightly better conditions (e.g. there were carpets on the floors) and one single room. The ward was overcrowded,[205] with some beds touching.

The delegation was particularly concerned by the living conditions of two patients who were obliged to sleep in a smelly, darkened vestibule area next to the ward toilet.

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200 See paragraph 137 of of the report on the 2014 visit (CPT/Inf (2015) 42), https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

201 In January 2016, 95% of the shares in the hospital were sold to a private company pursuant to a public-private partnership arrangement.

202 Built of bricks with thermal insulation and comprising two wards (on two levels) and a secure outdoor exercise area measuring approximately 500 m².

203 New plumbing, electrical wiring, windows and a new roof had already been installed.

204 Measuring approximately 48 m².

205 E.g. a bay measuring some 40 m² and containing 11 beds and another one measuring some 30 m² and containing 8 beds.

Adjacent to the accommodation building there was another dilapidated block with showers, a kitchen and a small dining room (with tables and benches).

113. On the second day of the visit to Surami Psychiatric Hospital, the Director informed the delegation that he had discharged three female patients and two male patients so that no patients were now sharing beds or sleeping in the toilet vestibule area. He assured the delegation that he would not accommodate patients in the latter area in the future and that he would have all the missing window panes fixed.

The Director also told the delegation that the refurbishment of the hospital would be finished by the end of October 2018 and that, once the work was completed, all patients would have at least 8 m² of living space.

c. Khelvachauri Psychiatric Hospital

114. As already mentioned in paragraph 109 above, at the time of the visit Khelvachauri Psychiatric Hospital was undergoing extensive refurbishment, as a result of which the establishment's official capacity was to be reduced to 100 psychiatric beds and an additional 50 beds in the "pensionat". There was a plan to further enlarge the hospital's scope of medical services through the opening of other medical wards such as maternity, emergency, neuro-surgery, intensive care, neonatology, internal medicine and general surgery. Due to ongoing reconstruction work (an additional, third level was being added to the main psychiatric accommodation building), living conditions were rather chaotic, entrances were difficult to reach and the surrounding territory was full of building materials and rubble. The delegation was told that 11 psychiatric patients had to be temporarily moved to the adjoining "pensionat" (see below) because of the works.

115. The male ward was situated on the ground floor of the main psychiatric accommodation building and consisted of two sections (for acute and longer-stay patients), with clinical offices located between them. Despite some evidence of recent renovation inside the building (e.g. new floors, windows and radiators in some of the rooms, refurbished dining rooms, showers and some of the communal toilets), the patient accommodation areas were generally overcrowded (with beds touching in some areas) and most of them were dilapidated, chaotic and noisy. The worst, indeed unacceptable, conditions were observed on the male longer-stay ward, where patients (some of whom were learning disabled) lived in dirty rooms with broken furniture, torn mattresses and swarms of flies.

Conditions were only marginally better on the female ward which was somewhat less dirty and dilapidated; however, as one of the ward's two sections was closed for refurbishment, four patients were temporarily obliged to sleep in the ward's corridor.

The best (i.e. generally good) conditions were observed in the "pensionat" for elderly persons with mental disorders, situated on the top floor of the adjacent modern medical facility[206] and funded by the regional social care agency.[207] The residents' rooms and furniture (including the beds and bedding) were in a good state of repair and cleanliness.

116. The Director of Khelvachauri Psychiatric Hospital informed the delegation that after the completion of the refurbishment work, a new mixed-sex rehabilitation ward would be opened on the main psychiatric accommodation building's additional (third) level.

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117. As already mentioned in paragraphs 9 and 10 above, at the end of the visit the delegation requested the Georgian authorities to provide the CPT with regular and detailed update reports, on a quarterly basis, regarding the progress in completing the renovation and building works in the three psychiatric hospitals visited, thus ensuring that patients there are provided with a humane, therapeutic and modern clinical environment. The Committee requested to receive the first such report within three months.

Further, the delegation made an immediate observation under Article 8, paragraph 5, of the Convention and requested the Georgian authorities to confirm, within three months, that all patients' beds on the general psychiatric and female forensic wards, and in the "pensionat", have been replaced at Kutiri Psychiatric Hospital.

118. In their letter dated 23 January 2019, the Georgian authorities informed the CPT that the new patient accommodation building at Kutiri Psychiatric Hospital[208] had been brought into service and that 120 new beds had been installed on the wards, with more to be delivered in the near future. Further, the refurbishment of Khelvachauri Psychiatric Hospital was to be completed by the end of May 2019 and the refurbishment of Surami Psychiatric Hospital was at an advanced stage.[209]

The Committee welcomes these positive developments and looks forward to receiving further updates on the progress and completion of refurbishment work in the three hospitals visited (in particular regarding the general psychiatric wards and the "pensionat" at Kutiri Psychiatric Hospital). The CPT would also like to receive confirmation that all the patients' beds have been replaced at the latter establishment, and would like to be informed on the number of patients currently accommodated in the new building (and from which wards they had been transferred).

In due course (i.e. once the refurbishment has been completed), the Committee would like to receive detailed information on the new capacities, layout and infrastructure of the three hospitals.

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206 With a new and operational lift.

207 Under the authority of the Regional Department of Social Affairs of the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs.

208 See paragraph 111 above.

209 The roof of the main accommodation building had been fully replaced and new windows, doors, central heating, electric installation, plumbing and toilet and washing facilities had already been installed.

4. Staff and treatment

119. *Kutiri Psychiatric Hospital* had a total staff complement of 429, comprising 11 full-time psychiatrists (and 6 additional vacant posts), four full-time psychologists (and an additional vacant post), six social workers, two general practitioners and one dentist, plus 93 nurses and 110 orderlies (all working full-time); there were also a few vacant posts for nurses and orderlies.

On the general psychiatry wards (with up to 60 patients), the daily shift (from 10 a.m. to 4 p.m.) consisted of one psychiatrist, up to two nurses and two orderlies; after 4 p.m. and on weekends and at night, there was one nurse and one orderly, as well as one psychiatrist on duty for the whole hospital (including the forensic unit).

In the forensic unit, each ward had, during the day, one psychiatrist, two nurses, two orderlies and two security staff;[210] after 4 p.m., on weekends and at night, one nurse, two orderlies and two security staff were on duty. It should be noted that the staff who worked at night (including the psychiatrist on duty) actually worked under a 24-hour shift system.

120. The staff complement at *Surami Psychiatric Hospital* comprised three psychiatrists (and an additional vacant post), one general practitioner, ten nurses, twelve orderlies and three canteen workers, all working full time. Four outside medical specialists[211] regularly visited the hospital. During the week, the daily shift (from 9.00 a.m. to 4 p.m.) comprised one psychiatrist, four nurses, two orderlies and two cleaning staff.[212] On weekends and at night staff worked on 24-hour shifts, which comprised a psychiatrist, two nurses and two orderlies.

121. At *Khelvachauri Psychiatric Hospital* there were 8 full-time posts for psychiatrists, five of which were filled at the time of the visit; further, there were 25 full-time nurses (and an additional vacant post); 42 full-time orderlies (and 4 additional vacant posts) and ten full-time orderlies (plus 2 additional vacant posts). The therapeutic team also included a full-time psychologist, three occupational therapists and two social workers.

122. To sum up, there was a shortage of psychiatrists in the three hospitals visited, in particular at *Kutiri Psychiatric Hospital*. Further, in the three establishments the presence of ward-based staff (nurses and orderlies) was clearly insufficient to provide adequate treatment and care for the number of patients accommodated in them.

In addition, the very limited (or even almost inexistent, as in the case of *Surami Psychiatric Hospital*) involvement of staff qualified to provide therapeutic activities (psychologists, occupational therapists, social workers) precluded the emergence of a therapeutic milieu based on a multidisciplinary approach, offering a full range of bio-psycho-social treatments.[213]

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210 See paragraph 123 below.

211 Including a surgeon, a dentist, a neurologist and a gynaecologist.

212 One doctor worked on a 24-hour shift basis.

213 See paragraph 125 below.

The CPT recommends that steps be taken to fill the vacant psychiatrists' posts in the three psychiatric hospitals visited, especially at Kutiri Psychiatric Hospital. Efforts must also be made in the three hospitals to fill the vacant posts of nurses and orderlies, and more generally to increase the presence of ward-based staff. Further, **the Committee recommends that more specialists qualified to provide therapeutic and rehabilitation activities (psychologists, occupational therapists and social workers) be recruited.**[214]

123. As had been the case in the past,[215] *Kutiri Psychiatric Hospital* employed 57 uniformed security staff who were deployed inside the forensic unit and reportedly acted exclusively upon instructions by health-care staff. However, the presence of security officers on the wards appeared to be perceived by both the patients and the nurses (and orderlies) as a *de facto* substitute for health-care staff.

Whilst recognising that adequate security must be maintained when caring for potentially dangerous psychiatric patients and realising that health-care staff may need to call upon nearby security staff in case of an untoward incident (and that security staff might then intervene, in the presence of and in consultation with qualified health-care staff), the Committee is of the view that the core security in patient accommodation areas should be provided by health-care staff, using appropriate environmental and dynamic security means. The routine presence of security staff not just on the perimeter but actually within patient accommodation areas is unnecessarily intimidating to patients and not conducive to the establishment of a therapeutic environment. **The CPT recommends that the role of security staff at Kutiri Psychiatric Hospital be reviewed accordingly.**

124. In the three hospitals visited the psychiatric treatment was based extensively on pharmacotherapy, predominantly using first-generation antipsychotic medication. In this context, the delegation noted that patients at *Kutiri and Surami Psychiatric Hospitals* were prescribed Clozapine without carrying out blood tests on a regular/systematic basis. Clozapine can have as a side-effect a potentially lethal reduction of white blood cells (granulocytopenia). Therefore, **the CPT recommends that the Georgian authorities take urgent steps to render regular blood tests mandatory in all psychiatric establishments whenever Clozapine is used; staff should be trained to recognise the early signs of the potentially lethal side effects of Clozapine.**

125. As for psycho-social treatment and rehabilitation, some limited opportunities (including a social enterprise offering activities on an *ad hoc* basis, e.g. baking classes) existed only at *Khelvachauri Psychiatric Hospital*. By contrast, hardly any patients were involved in psycho-social treatment and rehabilitation at *Kutiri Psychiatric Hospital*, and at *Surami Psychiatric Hospital* the female patients did not even have access to a TV or radio (as the TV and radio sets were broken and no steps were being taken to repair or replace them).

126. The delegation noted an absence of comprehensive individual written treatment plans which would cover both pharmacotherapy and psycho-social activities.

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214 See also paragraph 126 below.

215 See paragraph 143 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

In this respect, the Committee wishes to stress once again that psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient (taking into account the special needs of acute, long-term and forensic patients, including, with respect to the latter, the need to reduce any risk they may pose), indicating the diagnosis, the goals of treatment, the therapeutic means used and the staff member responsible with timescales. The treatment plan should also contain the outcome of a regular review of the patient's mental health condition and a review of the patient's medication. Patients should be involved in the drafting of their individual treatment plans and be informed of their progress.

127. In the light of the comments in paragraphs 125 and 126 above, **the CPT recommends that the Georgian authorities take the necessary steps at the three hospitals visited to:**

- **develop a range of therapeutic options and involve patients in rehabilitative psycho-social activities, in order to prepare them for more independent living and/or return to their families; occupational therapy should be an important part of the long-term treatment programme, providing for motivation, development of learning and relationship skills, acquisition of specific competences and improvement of self- image;**

- **draw up and review regularly an individual treatment plan for each patient.**

128. The Committee understands that under current regulations, psychiatric patients are not entitled to free somatic health assessments and treatments. At *Kutiri Psychiatric Hospital* for instance, patients had to pay 25 GEL for a consultation with a GP and also had to pay for any somatic medication. The issue was of even more concern regarding psychiatric patients who were not Georgian nationals, as they were expected to pay 150% of the cost of any somatic treatment and/or surgery/hospitalisation.

The CPT must stress that the aforementioned regulations can have a negative impact not only on timely and proper assessment and treatment of somatic diseases, but also on the way accurate assessments of certain psychiatric disorders are carried out (e.g. organic psychiatric disorders). The fact that indigent mentally disordered in-patients are expected to fund their own somatic health care is absolutely unacceptable. **The Committee recommends that urgent action be taken to remedy this.**

129. As found during the CPT's previous visit,[216] nearly all patients in the forensic psychiatric unit at *Kutiri Psychiatric Hospital* remained locked in their dormitories for over 20 hours a day, often for years, except for access to a large outdoor cage and during brief meal times.

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[216] See paragraph 145 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

Further, access to outdoor exercise for patients on the general psychiatric wards at *Kutiri and Khelvachauri Psychiatric Hospitals* and in the "pensionat" at *Kutiri Psychiatric Hospital* was very limited; some of the patients had not had access to outdoor exercise for weeks, months and even (at *Kutiri Psychiatric Hospital*) years. The situation was somewhat better at *Surami Psychiatric Hospital*, where many patients were seen milling around outside the main accommodation building in a grassed area with chairs and benches (and with some trees), there being an invisible boundary understood by patients as the area that they should not stray beyond.

130. As already mentioned in paragraph 9 above, at the end of the visit, the delegation invoked Article 8, paragraph 5, of the Convention and made an immediate observation, requesting the Georgian authorities to ensure daily access to outdoor exercise to all patients of *Kutiri and Khelvachauri Psychiatric Hospitals*. The Georgian authorities were requested to inform the Committee of the steps taken within three months.

Unfortunately, information provided by the Georgian authorities in their letter dated 23 January 2019 fails to address the CPT's concerns. Consequently, **the Committee calls upon the Georgian authorities to take immediate steps to ensure unrestricted daily access to the open air to all patients at Kutiri and Khelvachauri Psychiatric Hospitals (unless there are clear medical contraindications or treatment activities require them to be present on the ward), and to confirm this fact within one month.**

131. In the three psychiatric hospitals visited, the delegation observed that mentally-ill patients were accommodated together with learning disabled patients in the same dormitories. **The Committee has serious misgivings about this practice and recommends that steps be taken to ensure a better allocation of patients, so that those suffering from mental illnesses are separated from those suffering from learning disabilities and that both categories benefit from tailored individualised treatment**.

5. Means of restraint

132. The formal procedure and legal safeguards surrounding the resort to means of restraint have remained as described in the report on the CPT's 2014 visit.[217]

Means of restraint were not resorted to at *Surami Psychiatric Hospital*. At *Kutiri and Khelvachauri Psychiatric Hospitals*, the means of mechanical restraint consisted of soft ties, but at the latter hospital the ties had reportedly not been used since October 2017.[218] Both aforementioned hospitals also had rooms for individual seclusion of patients.[219]

After examination of the relevant documentation and interviews with patients, the delegation gained the impression that means of restraint were not overused in the two above-mentioned hospitals.

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217 See paragraph 151 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

218 *Kutiri Psychiatric Hospital* also had some modern restraint smocks, but they had never been used so far.

219 Conditions in these rooms were found to be acceptable; they do not call for any particular comment.

133. Dedicated registers of use of mechanical restraint and seclusion existed and contained entries on the circumstances, the time of beginning and the end of the measures, and a doctor's signature. That said, a few discrepancies were found at *Kutiri Psychiatric Hospital* when comparing the relevant register with patients' individual medical files, especially as regards the duration of the measures. It also appeared that some restraint instances reported by patients were not systematically recorded in the registers. Further, patients were sometimes mechanically restrained in front of other patients and not subject to continuous personal supervision by health-care staff.

134. The CPT has stressed many times in the past that the use of physical/mechanical restraint measures should be the subject of a comprehensive, carefully developed, policy (guidelines) on restraint.[220] The involvement and support of both staff and management in elaborating the policy is essential. Such a policy should specify which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated. It should be understood that such comprehensive guidelines are not only a major support for staff, but are also helpful in ensuring that patients and their legal representatives understand the rationale behind a measure of restraint that may be imposed.

In particular, the guidelines on the use of restraint should include the following points:

- patients may only be restrained as a measure of last resort to prevent imminent harm to themselves or others and restraints should always be used for the shortest possible time. When the emergency situation resulting in the application of restraint ceases to exist, the patient should be released immediately;

- means of restraint should never be used as punishment, for convenience, because of staff shortages or to replace proper care or treatment;

- every resort to means of restraint must always be expressly ordered by a doctor after an individual assessment, or immediately brought to the attention of a doctor with a view to seeking his/her approval. To this end, the doctor should examine the patient concerned as soon as possible. No blanket authorisation should be accepted;

- means of restraint must always be applied with skill and care, in order not to endanger the health of the patient and minimise the risk of causing pain to the patient. Staff should be properly trained before taking part in the practical application of means of restraint;

- patients must 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;

- staff must not be assisted by other patients when applying means of restraint to a patient;

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

- the duration of the use of means of mechanical restraint and seclusion should be for the shortest possible time (usually minutes to a few hours), and must always be terminated when the underlying reasons for their use have ceased;

- every patient who is subjected to mechanical restraint or seclusion must be subjected to continuous supervision. In the case of mechanical restraint, a qualified member of staff should be permanently present in the room in order to maintain a therapeutic alliance with the patient and provide him/her with assistance. If patients are held in seclusion, the staff member may be outside the patient's room (or in an adjacent room with a connecting window), provided that the patient can fully see the staff member and the latter can continuously observe and hear the patient. Clearly, video surveillance cannot replace continuous staff presence;

- once means of restraint have been removed, a debriefing of the patient must take place, both to explain to the patient why they have been subjected to restraint and to offer the patient an opportunity to explain his/her emotions prior to the restraint, which may improve both the patient's own and the staff's understanding of his/her behaviour;

- a specific register must be established to record all instances of recourse to means of restraint. This is in addition to the records contained within the patient's personal medical file. The entries in the register should include the time at which the measure began and ended; the circumstances of the case; the reasons for resorting to the measure; the name of the doctor who ordered or approved it; and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this entitlement; at their request, they should receive a copy of the full entry.

The Committee recommends that the above-mentioned principles as regards resort to restraint be applied at Kutiri and Khelvachauri Psychiatric Hospitals, as well as in all other psychiatric establishments in Georgia. **The adoption of the guidelines described above should be accompanied by practical training on approved control and restraint techniques, which must involve all staff concerned (doctors, nurses, orderlies, etc.) and be regularly updated**.

135. The use of chemical restraint had not been recorded in the dedicated restraint register in any of the hospitals visited, making it impossible for the delegation to obtain a clear overview of the frequency and duration of its use.

In the CPT's view, if recourse is had to chemical restraint such as sedatives, antipsychotics, hypnotics and tranquillisers, it should be subject to appropriate safeguards. Only approved, well-established and short-acting drugs should be used. Most importantly, chemical restraint should always be applied with prior authorisation by a doctor. The side-effects that such medication may have on a particular patient need to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion. Further, patients subjected to mechanical restraint should never be medicated without consent, except in situations where they may be in danger of suffering serious health consequences if medication is not administered and then only with appropriate safeguards.

The Committee recommends that the Georgian authorities take the necessary measures to ensure that the above-mentioned principles are respected. Further, **a dedicated register on the use of chemical restraint should be created in all psychiatric establishments.**

136. The delegation was informed by doctors at *Kutiri and Khelvachauri Psychiatric Hospitals* that formally voluntary patients[221] were occasionally subjected to mechanical restraint or seclusion. In this context, the CPT wishes to stress that if it is deemed necessary to restrain a voluntary patient, the procedure for re-examination of his/her legal status should be initiated immediately. **The Committee recommends that this precept be effectively implemented in practice at Kutiri and Khelvachauri Psychiatric Hospitals and, where applicable, in other psychiatric establishments in Georgia.**

6. Safeguards

137. The legal framework governing "civil" involuntary placement in psychiatric hospitals in Georgia had remained unchanged since the visits carried out in 2010 and 2014[222]; it offers important safeguards to involuntary patients.[223]

138. That said, the delegation was surprised to note that of some 330 patients accommodated on various general psychiatric wards in the three hospitals visited, only four were *de jure* hospitalised against their will pursuant to the LPA. It should be stressed in this context that many patients interviewed by the delegation stated, expressly and insistently, that they did not consent to their (continuing) hospitalisation and treatment, and wanted to leave the hospital; they were thus *de facto* involuntary.

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221 It should be recalled here that, formally speaking, there were very few involuntary patients in the two hospitals at the time of the delegation's visit; see however paragraph 138 below.

222 See paragraph 153 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

223 As regards the initial placement procedure, the law provides for an examination by a commission of psychiatrists within 48 hours of the moment of involuntary hospitalisation (Section 18 (5) of the LPA). If the commission concludes that there are grounds for continued hospitalisation (on the basis of criteria specified in Section 18 (1) of the law), the administration of the hospital should apply within 48 hours to the competent court which, within the next 24 hours, should issue a decision concerning the provision of involuntary inpatient care. The law also provides for the presence of the person concerned and his/her legal representative (a relative, a lawyer or a court-appointed lawyer) at the court hearing and the possibility of appealing against the court's decision for involuntary hospitalisation. If a patient is unable to hire a lawyer, the court is obliged to provide him/her with free legal assistance. In cases where it is impossible for a patient to attend the court hearing for health or other compelling reasons, a court session should be held at the psychiatric institution. Pursuant to Section 18 (9) of the LPA, the initial involuntary hospitalisation cannot exceed six months, and there is a monthly review for the prolongation of inpatient psychiatric care by the psychiatric commission (Section 18 (10) of the LPA). If the commission finds such a prolongation advisable (i.e. above six months), the hospital management should apply to the court 72 hours prior to the expiry of the court's decision for placement, and the court should issue a new decision within 72 hours (Section 18 (12) of the LPA). Once the criteria for involuntary placement have ceased to exist, the patient should be discharged from the hospital by decision of the psychiatric commission, and the court should be informed (Section 18 (11) of the LPA). These decisions can be appealed (Section 18 (14) of the LPA).

Such patients were often not even allowed to leave the ward to exercise in the grounds, let alone exit the hospital, and were sometimes given forced medication[224] and were mechanically restrained (or placed in seclusion),[225] despite being formally "voluntary" (and having thus lost the protection offered by the aforementioned formal legal safeguards contained in the LPA).

Many patients had seemingly just succumbed to paternalistic control by staff. Indeed, signing consent to admission and treatment forms was generally presented to patients as a mere formality that they should fulfill, without fully informing them of their rights and the applicable legal framework. A significant number of the signed consent forms at the hospitals visited were not properly completed (with missing signatures and dates). This, unfortunately, was very much the same situation as that observed during the 2014 visit.[226]

Furthermore, it appeared (after the examination of personal files, interviews with patients and also with staff) that many patients had been hospitalised without their consent, sometimes upon request from their relatives, or because they had no other place to live, the hospitals thus *de facto* fulfilling social care functions in such cases due to the lack of alternative solutions.

139. **The CPT calls upon the Georgian authorities take urgent steps to ensure that the legal provisions of the LPA on "civil" involuntary hospitalisation are fully implemented in practice and that proper information and training is given, as a matter of priority, to all structures and persons involved (in particular, psychiatrists, hospital managements and judges).**

In particular, **persons admitted to psychiatric establishments should be provided with full, clear and accurate information, including on their right to consent or not to consent to hospitalisation, and on the possibility to withdraw their consent subsequently.**

Further, **the Committee recommends that the legal status of all patients currently hospitalised at Kutiri, Surami and Khelvachauri Psychiatric Hospitals (as well as in all other psychiatric establishments in Georgia) and considered as "voluntary" be reviewed.**

140. As regards the few formally involuntary "civil" patients at the hospitals visited, the examination of patients' files revealed that in those rare cases the legal procedure set out in Section 18 of the LPC had been followed. That said, it transpired from interviews with patients that initial and review court hearings continued to be very brief and perceived as a mere formality, as had been the case during the CPT's 2014 visit.[227]

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224 See paragraph 142 below.

225 See paragraph 136 above.

226 See paragraphs 154 and 156 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

227 See paragraph 155 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

141. The legal provisions governing compulsory medical measures in respect of persons found to be criminally irresponsible (forensic patients) were described in detail in paragraph 158 of the report on the 2014 visit.[228]

The delegation examined a number of individual files of forensic patients at *Kutiri Psychiatric Hospital*[229] and found that the above-mentioned provisions were on the whole applied in practice. However, it transpired that external independent psychiatrists were in practice never part of the psychiatric commissions. Further, most of the interviewed forensic patients told the delegation that they had not been given a copy of the recommendation of the psychiatric commission and of the court decision, had not been informed of the existing appeal possibilities and had not benefited from legal assistance during the review process. Many of the patients perceived the hearings before the commission and the court as a mere formality, focussing more on the nature of the crime committed by them than on their psychiatric assessment/progress.[230]

The CPT recommends that the Georgian authorities take steps to address the aforementioned *lacunae* of the procedure in respect of forensic patients. In particular, efforts should be made to ensure that the review procedure offers guarantees of independence and impartiality, as well as objective medical expertise, including by external psychiatrists. Further, patients should benefit from the assistance of a legal counsel at all stages of the procedure, including before the psychiatric commission.

142. Turning to consent to treatment,[231] the practice observed in the psychiatric hospitals visited was analogous to that described in the report on the Committee's 2014 visit,[232] namely formally voluntary "civil" patients (the procedure did not apply to *de jure* involuntary "civil" patients and to forensic patients) were asked to sign a form of "consent to placement and treatment".

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228 CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8. Compulsory in-patient psychiatric treatment may be ordered by a court based on forensic psychiatric expertise, for any initial period up to four years (Section 221 of the LPA). The court decision can be appealed against by the patient, his/her lawyer or legal representative, and the forced psychiatric treatment can be interrupted (Section 221 (3) of the LPA). Annual court reviews of such decisions are performed in the light of recommendations by the psychiatric commission (consisting of five members: the Head doctor, the patient's treating psychiatrist, a social worker, the head of the treatment department and an external specialist i.e. a psychiatrist or a psychologist). The treating psychiatrist can recommend any time the interruption of the treatment (Section 221 (4) of the LPA) and the patient can be discharged by the hospital based on the commission's recommendation, without the need to have this decision confirmed by court. The patient should also be discharged at the expiration of the measure of compulsory psychiatric treatment (Section 221 (6) of the LPA). Should involuntary treatment be considered necessary after the expiration of the measure, the hospital's administration should initiate the "civil" involuntary placement procedure pursuant to Section 18 of the LPA.

229 There were no forensic patients at Surami and Khelvachauri Psychiatric Hospitals.

230 Despite the fact that the LPA clearly states that psychiatric commissions should base themselves on a formal risk assessment and an assessment of the progress of the patient's psycho-social rehabilitation.

231 As a reminder, patients' consent to treatment is regulated by Order No. 108/09 of 19 March 2009 by the then-Ministry of Labour, Health and Social Affairs (now Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs). Pursuant to Section 14 of this Order, a form on consent to treatment is jointly filled in by the doctor and the patient after the provision of comprehensive information on the treatment. If the patient is not capable of giving consent, the form is completed by his relative or legal representative.

232 See paragraph 156 of CPT/Inf (2015) 42, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961f8.

It was clear that consent to treatment was still assimilated to consent to placement, despite earlier long-standing CPT's recommendations. Further, some patients told the delegation that they believed they would automatically be forcibly medicated if they refused to sign the aforementioned consent form.

143. The Committee wishes to stress once again that psychiatric patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment as well as to withdraw it at any time. The admission of a person to a psychiatric establishment on an involuntary basis – whether in the context of civil or criminal proceedings – should not preclude seeking informed consent to treatment, which is a distinct issue from consent to hospitalisation. Every patient, whether voluntary or involuntary, should be informed about the intended treatment. Further, every patient capable of discernment should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.

The CPT calls upon the Georgian authorities to ensure that the above-mentioned precepts are effectively implemented in practice. If necessary, the relevant legal provisions should be amended.

144. At *Kutiri and Khelvachauri Psychiatric Hospitals*, the delegation noted that most of the legally incompetent patients (there were many of them) had the Director of the establishment or another staff member appointed as their legal guardian.[233]

At *Surami Psychiatric Hospital*, only a few patients lacked legal capacity and had court-appointed guardians, who were mostly their parents or, in the case of two patients, their neighbours. At the time of the visit, no member of the hospital's staff acted as a guardian for any patient. However, several doctors and other care staff members told the delegation that they considered the practice (of the Director or other staff members being appointed guardians for patients) to be positive and would like to have it reintroduced.

The CPT must reiterate here its view that granting guardianship to the staff of the very same establishment in which the patient concerned is placed may easily lead to a conflict of interest. **The Committee calls upon the Georgian authorities to find alternative solutions which would better guarantee the independence and impartiality of guardians.**

145. In the three psychiatric hospitals, the arrangements for patients' contact with the outside world did not seem to pose any particular problems in practice, at least as regards visits.

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233 Or "caretaker", the term applied in the Georgian legislation

However, unlike at *Surami Psychiatric Hospital*, daily access to a telephone for patients was not always possible at *Kutiri and Khelvachauri Psychiatric Hospitals*, and if allowed, did not always ensure privacy as most of the time patients were using private mobile phones of the staff, in the presence of the latter. **The Committee invites the Georgian authorities to seek to improve patients' access to a telephone at Kutiri and Khelvachauri Psychiatric Hospitals, and to allow patients to make telephone calls under conditions respectful of their privacy** (unless contraindicated for safety/security reasons, as may in particular be the case with the forensic patients)**.**

146. Formal complaints mechanisms for patients (both internal[234] and external[235]) existed in the three psychiatric hospitals visited. That said, very few patients appeared aware of how to safely and confidentially complain to the hospital authorities or beyond. **The CPT once again calls upon the Georgian authorities to ensure that a brochure on patients' rights (including information about complaints bodies and procedures, and access to legal assistance) be drawn up and systematically provided to patients and their families on admission to all psychiatric establishments in Georgia. Any patients unable to understand such a brochure should receive appropriate assistance**.[236]

147. As regards external supervision, the three psychiatric establishments received regular visits from staff of the Public Defender's Office and/or the NPM and were also visited by a number of NGOs. Patients could meet the Public Defender's/NPM representatives in private and some had indeed lodged complaints with the Public Defender. The Committee welcomes this.

148. Finally, as regards the legal framework and safeguards for social care residents accommodated in the "pensionats" at *Kutiri and Khelvachauri Psychiatric Hospitals*, **reference is made to the comments and recommendations in paragraphs 159 and 160 of the report on the CPT's 2010 visit,[237] which apply *mutatis mutandis*.**

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234 To the hospital's Director and to the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs.

235 E.g. to the Public Defender and to the court.

236 See also Article 16 (3) of the UN Convention on the Rights of Persons with Disabilities.

237 CPT/Inf (2010) 27, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806961dc. See, in particular, the following passage of paragraph 160 of the said report: "The Committee also considers that persons involuntarily placed in an institution must have the right to bring proceedings by which the lawfulness of their placement is speedily decided by a court. In this respect, the CPT recommends that the Georgian authorities take steps to ensure that persons placed in specialised institutions are notified in writing of decisions on involuntary placement in a social care home, and informed about the reasons for the decision and the avenues/deadlines for lodging an appeal. It is also crucial that the need for placement be regularly reviewed and that this review afford the same guarantees as those surrounding the placement procedure."

APPENDIX I

List of the establishments visited by the CPT's delegation

Establishments under the responsibility of the Ministry of Internal Affairs

- Temporary Detention Isolator (TDI) in Batumi
- TDI in Dusheti
- TDI in Khashuri
- TDI in Gori
- TDI in Kobuleti
- TDI in Mtskheta
- TDI in Rustavi
- TDI in Samtredia
- TDI in Tbilisi
- Old Tbilisi Police Department Division No. 7

- Temporary Accommodation Centre of the Migration Department, Tbilisi

Establishments under the responsibility of the Ministry of Justice

- Pre-trial and High-Risk Penitentiary Establishment No. 3 (Prison No. 3), Batumi
- Pre-trial and High-Risk Penitentiary Establishment No. 6 (Prison No. 6), Rustavi
- Pre-trial and High-Risk Penitentiary Establishment No. 7 (Prison No. 7), Tbilisi
- Pre-trial and Closed-Type Penitentiary Establishment No. 8 (Prison No. 8), Tbilisi (Gldani)
- Pre-Trial and Closed-Type Penitentiary Establishment No. 9 (Prison No. 9), Tbilisi
- Rehabilitation Establishment for Juveniles No. 11 (Juvenile Prison), Tbilisi (Avchala)
- Semi-Open and Closed-Type Penitentiary Establishment No. 15 (Prison No. 15), Ksani
- Medical Establishment for Pre-trial and Sentenced Inmates No. 18 (Prison Hospital), Tbilisi (Gldani)

Establishments under the responsibility of the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs

- Batumi Health Care Centre (Khevalchauri Psychiatric Hospital)
- National Centre of Mental Health named after Academician Bidzina Naneishvili (Kutiri Psychiatric Hospital)
- East Georgia Mental Health Centre (Surami Psychiatric Hospital)

APPENDIX II:

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

A. National authorities

Ministry of Internal Affairs

Giorgi Gakharia	Minister
Nino Javakhadze	Deputy Minister
Natia Mezvrishvili	Deputy Minister
Giorgi Mosashvili	Head of Temporary Detention Department
Nino Gakharia	Deputy Head of International Relations Department
Badri Cherkezishvili	Deputy Head of Migration Department

Ministry of Justice

Thea Tsulukiani	Minister
Mikheil Sarjveladze	First Deputy Minister
Gocha Lordkipanidze	Deputy Minister
Giorgi Pataridze	Deputy Minister
Zviad Mikhanashvili	Deputy Minister, General Director of the Special Penitentiary Service
Mikheil Abashishvili	First Deputy General Director of the Special Penitentiary Service
Tamta Demurishvili	Head of Medical Department of the Special Penitentiary Service
Elene Beradze	Head of International Relations Department of the Special Penitentiary Service
Beka Dzamashvili	Head of Department of the State Representation to International Courts

Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs

David Sergeenko	Minister
Tamila Barkalaia	Deputy Minister
Maia Lagvilava	Deputy Minister
Marina Darakhvelidze	Head of Health Care Department
Ekaterine Adamia	Head of Public Health and Health Programmes Division of Health Care Department
Ketevan Goginashvili	Head of Health Policy Division of Health Care Department
Nino Odisharia	Head of Social Care Department
Meri Maglapheridze	Director of the State Fund for Protection and Assistance of (Statutory) Victims of Human Trafficking

Chief Prosecutor's Office

Giorgi Gabitashvili	Deputy Chief Prosecutor
Merab Jeranashvili	Deputy Prosecutor of Tbilisi, Head of Investigation Unit
Jarji Tsiklauri	Deputy Head of Investigation Unit
Mikheil Gogorishvili	Deputy Head of Department of Procedural Guidance of Investigation in the Ministry of Defence and the Special Penitentiary Service
Salome Shengelia	Head of Division of Human Rights Protection

Office of the Public Defender (Ombudsperson)

Nino Lomjaria	Public Defender
Nika Kvaratskhelia	Head of the National Preventive Mechanism (NPM) Department
Akaki Kukhaleishvili	Deputy Head of the NPM Department
Eka Khutsishvili	Head of Criminal Justice Department

Rusudan Kokhodze	Deputy Head of the Department on the Rights of Persons with Disabilities

B. International Organisations

European Union Delegation to Georgia

ICRC Georgia Delegation

Office of the UNHCR Representative in Georgia
UNICEF Country Office in Georgia

Council of Europe Office in Georgia

C. Non-Governmental organisations

Georgian Young Lawyers' Association (GYLA)

Global Initiative on Psychiatry - Tbilisi

Human Rights Institute

Penal Reform International (PRI) South Caucasus Regional Office

RCT/EMPATHY