COUNCIL OF EUROPE

CONSEIL DE L'EUROPE

CPT/Inf (2015) 42

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 1 to 11 December 2014

The Georgian Government has requested the publication of this report and of its response. The Government's response is set out in document CPT/Inf (2015) 43.

Strasbourg, 15 December 2015

Note:

In accordance with Article 11, paragraph 3, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, certain names have been deleted.

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Copy of the letter transmitting the CPT's report

Mr Konstantin Korkelia
Ambassador Extraordinary and
Plenipotentiary
Permanent Representative of Georgia
to the Council of Europe
9, rue Schubert
67000 Strasbourg

Strasbourg, 31 July 2015

Dear Ambassador,

In pursuance of Article 10, paragraph 1, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, I enclose herewith the report to the Georgian Government drawn up by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) after its visit to Georgia from 1 to 11 December 2014. The report was adopted by the CPT at its 87th meeting, held from 29 June to 3 July 2015.

The various recommendations, comments and requests for information formulated by the CPT are highlighted in bold in the body of the report. As regards more particularly the CPT's recommendations, having regard to Article 10, paragraph 1, of the Convention, the Committee requests the Georgian authorities to provide **within six months** a response giving a full account of action taken to implement them. The CPT trusts that it will also be possible for the Georgian authorities to provide in that response reactions to the comments formulated in this report as well as replies to the requests for information made.

As regards the recommendations in paragraphs 58 and 138, the CPT asks for the responses to be provided **within one month**.

The CPT would ask, in the event of the responses being forwarded in the Georgian language, that they be accompanied by an English or French translation.

I am at your entire disposal if you have any questions concerning either the CPT's visit report or the future procedure.

Yours sincerely,

Mykola Gnatovskyy
President of the European Committee for the Prevention of Torture and Inhuman
or Degrading Treatment or Punishment

EXECUTIVE SUMMARY

The CPT's 5th periodic visit to Georgia provided an opportunity to assess the extent to which the recommendations made after previous visits have been implemented. Particular attention was paid to the treatment of persons in police custody, prisoners, and psychiatric patients.

The co-operation received during the visit was, on the whole, of a high standard. The CPT noted a number of positive developments, in particular as regards the continuing improvement of material conditions of detention in police establishments, combating prison overcrowding and improving material conditions and healthcare services in prisons. That said, little or no progress has been made in other areas, such as regime, activities, and contact with the outside world in the prison system, the situation of psychiatric patients at Kutiri Psychiatric Hospital, and combating impunity.

As pointed out by the Public Defender (Ombudsman) and civil society representatives, and as illustrated by a recent case described in detail in this report, impunity continues to represent a serious problem in Georgia. The main systemic issue is that, although under the law the Prosecutor's Office is competent to investigate any allegations/complaints/indications of ill-treatment by law enforcement officials, in practice the initial inquiries and investigative acts are almost always performed by staff of the investigative departments of the respective Ministries. This poses the question about the independence of such investigations. Other problems include delays in collecting and securing evidence, failure to question witnesses, and initiating investigations under inappropriate sections of the Criminal Code. Suspected officers are usually not suspended from their duties and no action is taken to protect potential victims (e.g. prisoners) from being pressured and forced to change their testimonies. The CPT calls upon the Georgian authorities to take effective steps to ensure that possible cases of ill-treatment of persons deprived of their liberty are investigated in an independent, efficient, and transparent manner.

Establishments under the authority of the Ministry of Internal Affairs

The great majority of the persons interviewed by the delegation stated that they had been treated by police officers in a correct manner. This confirms the generally positive impression obtained during the previous periodic visit as regards the treatment of persons detained by the police in Georgia.

That said, the delegation received several allegations of excessive use of force upon apprehension. In a few cases, the delegation heard allegations (and came across some evidence) of physical ill-treatment inflicted upon detained persons after they had been brought to a police establishment, immediately prior to the beginning of the first official interview, and reportedly with the purpose of forcing the persons concerned to make a confession or another statement. Further, some allegations were received of police officers using abusive language and/or resorting to threats vis-à-vis persons in their custody. The CPT welcomes the steps taken (or being taken) by the Georgian authorities to prevent ill-treatment by the police. Nevertheless, it is clear that continuing efforts are necessary in this respect.

As regards the safeguards against ill-treatment, almost all detained persons interviewed by the delegation confirmed that they had been put in a position to promptly notify their family of their situation.

Detained persons were also generally offered access to a lawyer shortly after arrest, although the delegation did hear several allegations that access had been delayed until after the interview (and after the signature of the confession or another statement); in a few cases, detained persons alleged that they had only been able to meet their lawyer in court. Regarding access to a doctor and information on rights, the delegation's observations suggest that the relevant provisions are generally applied in practice.

Police custody in Georgia is no longer implemented in police stations, but exclusively in temporary detention isolators (TDIs). The material conditions of detention in the TDIs visited were on the whole acceptable for the maximum permitted period of police custody (i.e. 72 hours). However, none of the TDIs visited could be considered adequate for holding administrative detainees for longer than 72 hours.

Establishments under the authority of the Ministry of Corrections

The CPT's delegation carried out follow-up visits to Prison No. 3 in Batumi, Prison No. 7 in Tbilisi, Gldani Prison and Prison Hospital, as well as a first-time visit to "Matrosov Prison" in Tbilisi.

The delegation received no allegations of ill-treatment of inmates by staff at Prison No. 9 in Tbilisi and at Gldani Prison Hospital. Further, no such recent allegations were heard at Prison No. 7; however, the conditions of detention in at least some parts of the establishment were such that they could be considered as amounting to inhuman and degrading treatment. As regards Gldani Prison, several recent allegations were received according to which newly-arrived inmates had been subjected to "welcome beatings" (punches and kicks) by staff. The delegation was also informed about the incident of 12 November 2014, in the course of which two prisoners had reportedly been subjected to physical ill-treatment by custodial officers. Other similar, credible and recent allegations of physical ill-treatment by staff of Gldani Prison were heard as well.

As concerns Prison No. 3 in Batumi, the delegation received a number of recent, detailed and credible allegations according to which custodial staff resorted to punching and kicking prisoners who were already handcuffed and brought under control, while transferring them from their cells to the holding and/or punishment cells, as well as inside these cells. In this context, the delegation heard allegations – and obtained some documentary evidence – of application of handcuffs vis-à-vis such prisoners for excessively long periods (up to 20 hours). Further, similar to Gldani Prison, allegations were heard of newly-arrived prisoners having been subjected to "welcome beatings" by custodial officers.

Regarding (in particular but not exclusively) Prison No. 3, while the CPT understands that the management and staff there had to deal with many challenging and aggressive inmates, it was clear that the staff were not properly trained to cope with such high-risk situations, and that the only response they could think of was to resort to physical ill-treatment and intimidation.

It should be stressed that the delegation did not receive any direct allegations of inter-prisoner violence in the establishments visited. That said, the existence of the problem was acknowledged by senior officials of the Ministry of Corrections.

The CPT's delegation was very concerned by the situation of A, a life-sentenced prisoner accommodated at Prison No. 7 in Tbilisi. He had been diagnosed as suffering from serious mental and physical health problems and had been held in solitary confinement for over a year. The conditions under which he was kept could easily be considered as inhuman and degrading. At the end of the visit, the delegation made an immediate observation pursuant to Article 8, paragraph 5 of the Convention and requested the Georgian authorities to take urgent action to transfer the prisoner concerned to an appropriate healthcare facility and to provide him with adequate assessment, treatment and care without delay. In their letter of 25 December 2014, the Georgian authorities explained the complex legal situation of A who apparently refused any co-operation with the prison administration on this issue. The Committee takes due note of these explanations. However, it remains the case that to continue to accommodate him at Prison No. 7 is unacceptable. The CPT calls upon the Georgian authorities to do everything legally and practically possible to transfer him to an adequate treatment facility within the shortest time.

A number of inmates (especially at Prisons No. 7 and 9, but also in Batumi) were in fact subjected – sometimes for months and even years on end – to conditions akin to solitary confinement (without any possibility of association, visits and telephone calls, and without the right to listen to the radio and watch television) and, in addition, frequently subjected to constant CCTV monitoring inside their cell. This appeared to be applied vis-à-vis inmates considered difficult or disruptive but also allegedly for other reasons, e.g. to enforce co-operation with investigation. In the CPT's view, to subject inmates to such conditions could be considered as amounting to inhuman and degrading treatment. In this context, the Committee is particularly concerned by what appears to be the absence of clear, transparent written criteria and the lack of procedural safeguards for placement under such conditions.

The Committee wishes to congratulate the Georgian authorities for having succeeded in maintaining the prison population roughly at the level dramatically reduced following the large-scale amnesty and a series of Presidential pardons in the end of 2012. The CPT also notes the ongoing and planned legislative developments aimed at reducing the resort to imprisonment and facilitating early release and social rehabilitation of prisoners, as well as the Georgian authorities' ongoing efforts to refurbish, modernise and expand the prison estate.

Indeed, the material conditions of detention in all the prisons visited (with the exception of Prison No. 7) were generally acceptable, although the newly-adopted norm of 4 m² of living space per prisoner was not yet fully respected. In contrast, the CPT is concerned by the little, if any, progress in drawing up programmes of purposeful, out-of-cell, activities for prisoners. Prisoners in the establishments visited continued to be locked up in their cells for most of the day, in a state of enforced idleness. Taken together with the restrictions on contact with the outside world and association, this produced a regime which was oppressive and stultifying.

In 2013, the Ministry of Corrections had updated its Strategy for the Reform of Prison Health Care and embarked upon the implementation of a comprehensive 18-month Action Plan. The CPT fully acknowledges the important steps undertaken by the authorities to implement the above-mentioned documents and to improve the facilities, equipment, staffing and supply of medication. It is beyond doubt that the situation in this respect has much improved since the CPT's visits in 2010 and 2012. Nevertheless, the Committee does make a number of recommendations on some outstanding issues, e.g. medical confidentiality, recording and reporting injuries observed in prisoners, psychiatric care and psychological assistance to prisoners, suicide prevention, and drugs in prison.

Gldani Prison Hospital underwent substantial refurbishment (completed in mid-2014) and appeared to offer a satisfactory level of health care. However, the CPT makes recommendations to improve the living conditions, treatment, activities and access to daily outdoor exercise for patients in the psychiatric ward.

The CPT understands that there had been some progress in the implementation of the long-standing plan for the transfer of prison health care to the Ministry of Labour, Health and Social Affairs. In the light of the observations made by the delegation in the course of this visit, and especially in the context of the above-mentioned incident of 12 November 2014, the CPT is of the view that such a transfer would certainly help increase the professional independence of prison health-care staff. Therefore, the Committee strongly encourages the Georgian authorities to proceed with concrete preparations for the transfer of prison health care, comprising precise deadlines.

The CPT also makes recommendations on other issues, such as the low staffing levels in prisons, the excessively wide catalogue of "special means" (and too vague rules on their application), the inadequate rules on remand prisoners' visits (and the ban on phone calls), the insufficient visiting entitlement for sentenced prisoners, etc. In some cases restrictions on contacts with the outside world are combined with *de facto* solitary confinement and a ban on access to media, resulting in conditions that could be considered as amounting to inhuman and degrading treatment. Recommendations are also made on the disciplinary sanctions and procedure, the inefficient complaints procedures, and the lack of information provided to prisoners on their rights and the procedures applicable to them.

Establishments under the authority of the Ministry of Labour, Health and Social Affairs

The delegation carried out a follow-up visit to the National Centre of Mental Health named after Academician Bidzina Naneishvili (Kutiri Psychiatric Hospital) and visited, for the first time, Bediani Psychiatric Hospital.

Except for patients detained under the criminal legislation, nearly all patients at Kutiri Psychiatric Hospital and all at Bediani Psychiatric Hospital were formally considered as "voluntary", but were held on locked wards. Many patients were hospitalised upon request from their relatives, or because they had no other place to live, the hospitals thus *de facto* fulfilling social care functions. The majority of patients interviewed at both hospitals stated they wanted to leave them.

The CPT is concerned to note that the management of the two hospitals visited did not seem to realise that the vast majority of patients placed under their responsibility were *de facto* deprived of their liberty without benefiting from the safeguards provided for by law. The CPT calls upon the Georgian authorities to take steps to ensure that the provisions of the Law on Psychiatric Care on civil hospitalisation are fully implemented in practice.

The delegation received no allegations of ill-treatment of patients by staff at Bediani Psychiatric Hospital. As regards Kutiri Psychiatric Hospital, the delegation received a few isolated allegations of staff slapping patients and displaying rude and verbally abusive behaviour towards them. Inter-patient violence did not appear to be a problem at Bediani Psychiatric Hospital. However, on the general wards of Kutiri Psychiatric Hospital, the delegation witnessed episodes of inter-patient aggression, which was hardly surprising considering the low staffing numbers and the chaotic living environment.

The living conditions in the general psychiatry wards and the "shelter" at Kutiri Psychiatric Hospital did not befit a health-care facility, and in some wards could well be described as inhuman an degrading. The delegation invoked Article 8, paragraph 5, of the Convention and requested the Georgian authorities to carry out a thorough review of these conditions with the aim of providing a humane, therapeutic and modern clinical environment. Unfortunately, the information provided by the Georgian authorities in their letters of 6 April and 18 May 2015 fails to address most of the Committee's concerns. The living conditions observed at Bediani Psychiatric Hospital were comparatively better.

The presence of ward-based staff was grossly insufficient to provide adequate treatment and care for the number of patients accommodated in both hospitals. In addition, the very limited involvement of staff qualified to provide therapeutic activities at both hospitals and the absence of psychologists at Bediani Psychiatric Hospital precluded the emergence of a therapeutic milieu based on a multidisciplinary approach. There were no individual treatment plans and no evidence of a multi-disciplinary clinical team approach at either hospital. The vast majority of patients at Kutiri and Bediani psychiatric hospitals, and all forensic patients at Kutiri, were left with very little do all day, for months if not years on end.

Individual seclusion was not practiced at Bediani Psychiatric Hospital and was resorted to only rarely on the forensic wards of Kutiri Psychiatric Hospital. The delegation gained the impression that means of restraint were not overused in the two establishments visited. Neither of the two hospitals visited had any formal complaints system in place, nor did they provide the patients on admission with any brochure setting out the hospital's routine and patients' rights.

Establishments under the authority of the Ministry of Defence

The delegation visited the detention facility ("Hauptvakhts") of the 2nd Regional Division of the Military Police Department in Senaki (the Senaki Hauptvakhts).

The Committee makes recommendations to amend the relevant regulations so as to authorise soldiers detained in a Hauptvakhts to receive visits (preferably once a week) and to provide administrative detainees with access to a telephone. The CPT also recommends that the current rules and practice be changed so as to allow soldiers detained at a Hauptvakhts to make confidential complaints to an outside authority and to put in place an appropriate internal complaints procedure.

I. INTRODUCTION

A. Dates of the visit and composition of the delegation

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 visited Georgia from 1 to 11 December 2014. The visit formed part of the Committee's programme of periodic visits for 2014, and was the CPT's fifth periodic visit to Georgia.[1]

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

- Marzena KSEL, 1st Vice-President of the CPT, Head of Delegation
- Mykola GNATOVSKYY, 2nd Vice-President of the CPT
- Celso DAS NEVES MANATA
- Haritini DIPLA
- Julia KOZMA
- Alexander MINCHEV.

They were supported by Borys WÓDZ, Head of Division, and Isabelle SERVOZ-GALLUCCI of the CPT's Secretariat, and assisted by:

- Clive MEUX, forensic psychiatrist, Oxford, United Kingdom (expert)
- Kira CHOKHURI (interpreter)
- Lali DOUGLAS-HAMILTON (interpreter)
- Nino GUDUSHAURI (interpreter)
- Tamar MIKADZE (interpreter)
- Nelly PITSKHELAURI (interpreter)
- Maria TSAKADZE (interpreter).

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[1] The previous periodic visits took place in May 2001, November 2003/May 2004, March/April 2007 and February 2010. 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 (www.cpt.coe.int).

B. Establishments visited

3. The delegation visited the following places:

Establishments under the authority of the Ministry of Internal Affairs

- Temporary Detention Isolator (TDI) for the Adjara and Guria regions (Batumi TDI)
- Chkhorotsku TDI
- Khobi TDI
- Kobuleti TDI
- TDI for the Imereti, Racha-Lechkhumi and Kvemo Svaneti regions (Kutaisi TDI)
- Poti TDI
- Samtredia TDI
- Senaki TDI
- TDI for the Samegrelo and Zemo Svaneti regions (Zugdidi TDI)

Establishments under the authority of the Ministry of Corrections

- Pre-trial and Closed-type Penitentiary Establishment No. 3 (Prison No. 3), Batumi
- Pre-trial and Closed-type Penitentiary Establishment No. 7 (Prison No. 7), Tbilisi
- Pre-trial and Closed-type Penitentiary Establishment No. 8 (Gldani Prison), Tbilisi
- Pre-trial, Semi-open and Closed-type Penitentiary Establishment No. 9 ("Matrosov Prison"), Tbilisi
- Prison Referral Hospital No. 18 (Gldani Prison Hospital), Tbilisi

Establishments under the Ministry of Labour, Health and Social Affairs

- Psychiatric Hospital, Bediani
- National Mental Health Centre named after Academician Bidzina Naneishvili (Kutiri Psychiatric Hospital), Khoni

Establishments under the authority of the Ministry of Defence

- Hauptvakhts of the 2nd Regional Division of the Military Police Department (Senaki Hauptvakhts), Senaki

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

4. In the course of the visit, the CPT's delegation held consultations with Aleksandre TCHIKAIDZE, Minister of Internal Affairs, Giorgi MGHEBRISHVILI, Minister of Corrections and Zaza SOPROMADZE, Deputy Minister of Labour, Health and Social Affairs, as well as with other senior officials from the above-mentioned Ministries and from the Prosecutor's Office.

The delegation also met with Ucha NANUASHVILI, Public Defender of Georgia and with the staff of his Prevention and Monitoring Department (set up for the purpose of fulfilling the functions of the National Preventive Mechanism – NPM), as well as representatives of the Georgian Young Lawyers' Association (GYLA). It is noteworthy that Georgian authorities decided to invite the Public Defender (also in his capacity as the NPM) to attend the final meeting in Tbilisi on 11 December 2014. The CPT welcomes this initiative.

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

5. 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, Ana GUTSAEVI from the Ministry of Corrections.

6. The co-operation received during the visit from all of the delegation's interlocutors was, on the whole, of a high standard. 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 generally provided with quick access to the information it required. In this context, the Committee is pleased to note that an initial misunderstanding about access to key documentation (in particular, patient's medical files) at Kutiri Psychiatric Hospital was finally resolved, in accordance with the principle of co-operation set out in Article 3 of the Convention.

One exception to this generally favourable situation was observed at Prison No. 7 in Tbilisi, where the delegation was refused access to the control room of the CCTV monitoring system, installed throughout all the cells of the prison. The CPT is of the view that access to CCTV monitoring data is necessary for its delegation to be able to perform its task, in particular whenever there is the need to verify allegations of ill-treatment or other relevant information received in the course of the visit. **The Committee recommends that the Georgian authorities take the necessary steps to ensure that its delegations will have such access on the CPT's future visits to Georgia.**

7. 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 2014 visit, the CPT noted a number of positive developments, in particular as regards the continuing improvement of material conditions of detention in police establishments, combating prison overcrowding and improving material conditions and health-care services in prisons.

That said, the Committee is concerned that little or no progress has been made in other areas, such as regime, activities and contact with the outside world in the prison system, the situation of psychiatric patients at Kutiri Psychiatric Hospital, and combating impunity.

The CPT wishes to emphasise that a persistent failure to improve the situation in the light of the Committee's recommendations could oblige it to consider having recourse to Article 10, paragraph 2, of the Convention.[2] The Committee trusts that the action taken by the Georgian authorities in response to this report will render such a step unnecessary.

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[2] "If the Party fails to co-operate or refuses to improve the situation in the light of the Committee's recommendations, the Committee may decide, after the Party has had an opportunity to make known its views, by a majority of two-thirds of its members to make a public statement on the matter."

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

8. At the end of the visit, the CPT's delegation met senior Government officials in order to acquaint them with the main facts found during the visit. On 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 confirm within two weeks that A, a life-sentenced prisoner who had been diagnosed as suffering from mental and physical health problems and had been held in solitary confinement at Prison No. 7 for over a year, had been transferred to an appropriate health-care facility and provided with adequate assessment, treatment and care.

As regards the second immediate observation, the Georgian authorities were requested to carry out a thorough review of the living conditions at general psychiatric wards and the "shelter" ("pensionat") of Kutiri Psychiatric Hospital, with the aim of providing a humane, therapeutic and modern clinical environment. The delegation requested that a detailed report and action plan setting out how the failings observed will be remedied, within a reasonable timescale, through extensive refurbishment, reconstruction or other means, and outlining the funding which will be provided, be sent to the CPT within three months.

9. The above-mentioned immediate observations were subsequently confirmed by the CPT's President in a letter of 18 December 2014. By letters of 25 December 2014, 6 April 2015 and 18 May 2015, the Georgian authorities informed the Committee of measures taken in response to the delegation's immediate observations. These measures will be assessed later in the report.

E. National Preventive Mechanism

10. Since July 2009, the tasks of the National Preventive Mechanism (NPM), pursuant to Georgia's obligations under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), have been assigned to the Public Defender (Ombudsman). As already mentioned, the CPT's delegation met the Ombudsman and members of his Prevention and Monitoring Department (NPM team) at the outset of the visit.

11. The delegation was informed that, as of October 2014, the Prevention and Monitoring Department was no longer responsible for handling individual complaints (a separate Justice Department had been created at the Public Defender's Office for this purpose) so as to focus exclusively on its preventive function, in accordance with the SPT guidelines. This had allowed using all the NPM team's resources in order to carry out frequent unannounced visits to places of deprivation of liberty. The delegation was also told that the budgetary situation of the Public Defender's Office (PDO) was entirely satisfactory (with another significant budget increase planned in 2015) and the financial resources sufficient to cover NPM staff and operational expenses.

12. Following a special competition in 2013, the NPM staff had been completely renewed and 40 experts (including lawyers, doctors, psychologists and social workers) had been recruited; meanwhile, however, seven staff members had left the NPM, most of them because of having joined various Government services.

At the time of the visit, the situation in the Public Defender's Office was rather tense (as openly acknowledged by the Public Defender and his Deputy) because of conflicts and misunderstandings between the Ombudsman and some of the members of the NPM team. In particular, the Public Defender has made reproaches that some of the team members had violated the confidentiality rules (i.e. commenting publicly on the findings of the NPM team without prior approval by the Ombudsman) and expressing views openly critical of the PDO's activities. Because of this, the Public Defender had decided to hold a new competition for the whole NPM team in the course of 2015. It was also decided no longer to recruit media professionals to the Prevention and Monitoring Department. **The CPT would like to be provided with updated information on the measures taken to ensure the NPM's functional independence, on the new competition and its outcome, as well as on the training provided to the newly recruited NPM team members.**

13. The Public Defender spoke of proposed amendments to the Act on Public Defender, which would in his view aim at increasing the efficiency of the NPM. These amendments would, in particular, grant the NPM team access to CCTV records in places of detention, permit taking photographs inside such establishments and allow disclosing information regarding possible cases of ill-treatment without being obliged to seek each time the potential victim's express consent. **The Committee would like to receive updates on these proposed amendments.**

14. As regards the implementation of his recommendations (in his capacity as NPM), the Public Defender expressed satisfaction with the level of co-operation with the Parliament (he stressed that, for the first time ever, the Parliament had adopted a special resolution with concrete steps to implement his recommendations after having heard his annual report covering the year 2013) but was less positive about the response by the Ministries and the Prosecutor's Office. The latter was reportedly particularly unenthusiastic as concerns the Ombudsman's recommendations for steps to address the impunity problem.[3] **The CPT would welcome the observations of the Georgian authorities on this subject.**

[3] See Section I.F.

F. Impunity

15. To avoid any perception of impunity, it is crucial that the investigating and prosecuting authorities take effective action when any information indicative of possible ill-treatment comes to light.

The criteria which an investigation into such cases must meet in order to be qualified as "effective" have been established through an abundant case-law of the European Court of Human Rights and are highlighted in the CPT's 14th General Report.[4] In particular, the investigation should be thorough and comprehensive, it should be conducted in a prompt and expeditious manner, and the persons responsible for carrying out the investigation should be independent of those implicated in the events. Further, there should be a sufficient element of public scrutiny of the investigation or its results, including the involvement of the alleged victims in the procedures and the provision of information to the public on the status of ongoing investigations, to secure accountability in practice as well as in theory.

In this regard, it is well-established through the case-law of the European Court of Human Rights that whenever a person was injured while in the hands of public officials, there is a strong presumption that the person concerned was ill-treated and the authorities' duty is to provide a satisfactory and convincing explanation of how the injuries were caused.

16. The Public Defender, his Deputy and members of the NPM team, as well as NGO representatives whom the delegation met at the outset of the visit expressed the unanimous view that impunity continued to represent a serious problem in Georgia, and that law enforcement bodies and prosecuting authorities did not demonstrate sufficient commitment to investigate allegations of ill-treatment.[5]

The main systemic issue in this context was that, although under the law the Prosecutor's Office was competent to investigate any such allegations/complaints/indications, the practice was quite different, i.e. the initial inquiries and investigative acts were almost always performed by staff of the investigative departments of the respective Ministries (in the great majority of cases, the Ministries of Internal Affairs and Corrections). In short, investigations were carried out by colleagues of the incriminated/suspected officials, working for the same Ministry. This obviously posed the question about the independence of such investigations. In general, only the "resonance" cases were dealt with directly by the Prosecutor's Office, and usually only as from the moment the case had caused 'enough' stir in public opinion, the media and civil society.

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4 See paragraphs 25 to 42 of CPT/Inf (2004) 28, http://www.cpt.coe.int/en/annual/rep-14.htm#impunity.

5 According to GYLA, the organisation had received twenty complaints of prisoners regarding ill-treatment by prison staff in the period from 1 January to 1 December 2014. These allegations were sent to the Prosecutor's Office, which, however, reportedly conducted ineffective investigations. Not one person referred to in these twenty complaints was brought to justice. In some cases the facts were investigated, but reportedly there was no effort made to identify the perpetrator. The same trend could be observed regarding the police. In 2014, approximately thirty complaints of police violence had reached GYLA and were subsequently brought to the attention of the Prosecutor's Office. However, again the prosecutor's investigations had reportedly remained ineffective and not one person was indicted as a result.

In this context, the delegation's interlocutors pointed at delays in collecting and securing evidence (including forensic medical evidence), failure to question witnesses and initiating investigations under inappropriate sections of the Criminal Code (CC) e.g. Section 333 (exceeding official powers) instead of Section 144 (torture and ill-treatment). It was also pointed out that incriminated 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.

17. The incident at Gldani Prison on 12 November 2014 (see paragraph 51) provides a perfect illustration of these problems. The delegation discussed this case with the Public Defender/NPM, GYLA, the Ministry of Corrections officials, a senior prosecutor, the Director of Gldani Prison and the inmates concerned, and checked all the relevant documentation. Based on all above, the following can be stated:

NPM staff visiting Gldani Prison on 12 November 2014 heard (apparently by coincidence), at around 5.50 pm, some noise at the Smart Reception Unit (see paragraph 66). They requested to open the unit's shower room and saw two prisoners lying on the floor with wet clothes, one of them handcuffed behind his back and attached with a metal chain to ankle-cuffs[6]; a third prisoner was cleaning the floor and a custodial officer was present inside the room. Both restrained inmates were visibly injured.[7] The NPM staff spoke with the two inmates who were clearly too frightened to provide any detailed explanation of what had happened.[8] NPM staff insisted that the inmates be seen by a (prison) doctor, which reportedly happened after a certain delay and with a degree of reluctance to describe the inmates' injuries[9]; moreover, the doctor reportedly interrupted the examination and description of injuries several times and consulted with one of the prison's Deputy Directors (who was present on the scene), and the examination happened in the presence of custodial staff.[10]

According to the prison staff, the two inmates were initially found to behave loudly and in an agitated manner in their cell. The custodial staff opened the cell door and acquired a suspicion that the inmates (as well as their four cellmates) might have consumed illicit self-made alcohol ("braga"). The other inmates reportedly responded well to the staff's orders to calm down but the two in question allegedly refused to obey, which is why force and special means (handcuffs) had to be used, and they were then taken to the Smart Reception Unit (because, as explained by the Director, the unit offered a more secure environment and a permanent presence of health-care staff).

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6 Prison staff and administration denied all use of ankle-cuffs and chains, stressing that no such means were available at Gldani Prison.

7 One of them had an injury on his forehead, the other one displayed redness in the eye area.

8 The inmates were seen again by NPM representatives on the following day, but they refused to provide any further explanations.

9 It is noteworthy that the prison's journal of traumatic lesions contained the following entries concerning the two inmates: a. *"12/11 – excoriation on the right calf and laceration above the left eyebrow 4 x 1cm - obliqual. Cause: Accident"*; *"12/11 – 18,05h – hyperaemia in both wrists"*; b. *"Old excoriation on the right cheek with dry blood"*.

10 This was confirmed to the delegation by the doctor concerned, who also stated that there was nothing extraordinary about this procedure.

As regards the reason why the two prisoners were found in the shower room and the origin of their injuries, the explanation given by the prison authorities was that one of inmates had become sick and vomited on himself and the other prisoner; the two had reportedly wanted to wash the vomit off themselves and their clothes in the shower room. The inmate with the forehead injury stated (to the prison staff) that he had fallen on the floor because he was sick.[11] The other inmate explained that the redness in the eye area was caused by hypertension.

The Public Defender sent an official report on the incident to Prosecutor's Office and the Ministry of Corrections on the following morning i.e. 13 November 2014. At first, only an internal investigation was initiated by the Investigative Department of the Ministry of Corrections (but only in respect of the suspected consumption of illicit alcohol by the inmates), but eventually (on 20 November 2014, i.e. after 8 days) the Prosecutor's Office took up the case and enlarged its scope so as to investigate also the allegations of ill-treatment (under Section 333 of the CC). It was only at this stage that a forensic medical examination of the alleged victims was ordered[12], although both inmates had been sent almost immediately after the incident to the narcological laboratory in order to be examined for the presence of alcohol in their blood (as they were both accused of consumption of "braga" in the cell, a criminal offence for which they risked an additional prison term of up to 3 years).

According to the representative of the Prosecutor's Office whom the delegation met at the outset of the visit, as from 21 November 2014 prosecutors interviewed members of the NPM team, the alleged victims and their cellmates, as well as staff. They also requested the CCTV footage from the Smart Reception Unit but were told that the footage had been deleted as it was only preserved for 24 hours. It is noteworthy that the chief investigator of the Ministry of Corrections was at Gldani Prison on the evening of the event, but reportedly was only interested in the suspicion of prisoners having produced and consumed alcohol. The prisoners were told immediately that they were under investigation and warned of the additional term of imprisonment they faced for the possession and consumption of alcohol in prison.

The Ministry of Corrections later publicly blamed the Public Defender for transferring the information on the incident only after five days[13], despite the fact that at least one Deputy Director of Gldani Prison was equally present when the incident occurred; the onus should have thus been on the prison authorities to report the event. It is also noteworthy that, until the day of the delegation's visit to Gldani Prison (on 2 December 2014), the two prisoners had remained in the establishment and were accommodated in the same unit as the one where the alleged perpetrators (custodial officers) worked.

At the time of writing this report, the investigation into this case is still ongoing. **The CPT requests the Georgian authorities to inform it, as soon as possible, of the outcome of the above-mentioned investigation and of any disciplinary and/or criminal sanctions imposed in this context.**

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11 According to the delegation's forensic medical member, the inmate's facial injuries (a linear laceration localised 1 cm over the medial half of the left eyebrow, with the length of 1 cm and a violet-pink colour) had most likely resulted from a direct blow with a blunt object with limited contact surface to the forehead. It was impossible to receive such injuries from a fall from the height, because the inmate had no injuries in the convex parts of the face i.e. his nose and cheek (zygoma).

12 The delegation was told that the results of that examination would not be available before a month or two.

13 As already mentioned, the Public Defender stressed that the Prosecutor's Office and the Ministry had been informed on the second day after the incident.

18. Without wishing to prejudge and anticipate in any way the results of the investigation, the Committee must express the view that the above-mentioned case again demonstrates the flaws of the current system of investigations into ill-treatment by prison staff, and in particular:

- the lack of independence of investigators (at least initially, for the first and crucial 8 days);

- the slow response by the Prosecutors Office despite urgent requests by the Public Defender;

- evidence (including the forensic medical one and the CCTV records) not being secured in time;

- inmates left exposed to potential pressure (including the threat of additional prison sentence) and returned to the unit where the staff concerned continued to work;

- prison health-care staff acting in the way that put into question their professional independence, and

- recording/reporting the injuries in a manner that left a lot to be desired.

19. Following the visit (in March 2015), the CPT was informed of the setting up of a specialised department at the Prosecutor's Office (Department of Investigation of Offenses Committed in Legal Proceedings). According to the information at the Committee's disposal, the task of the new Department would be to deal initially with some 52,000 complaints concerning alleged violations committed before October 2012. However, in the future, the Department would also be tasked with investigating "new" cases.

The main focus of the Department identified after the analysis of the complaints would be: crimes against property; cases of ill-treatment; any crimes committed by law enforcement officials and crimes committed by the central and local government representatives. Reportedly, after only two weeks of its operation, the Department had already succeeded in investigating some 70 cases.

The Committee would like to receive more information concerning the new Department (staff resources, case selection criteria, ways to ensure transparency and accountability to the public, etc.).

20. More generally, it is not the CPT's task to dictate to the Georgian authorities how exactly (in terms of precise mechanisms and institutions) they should ensure the independence and efficiency of investigations into ill-treatment, and how to ensure public scrutiny. However, the Committee notes that the setting up of an independent investigation mechanism is foreseen in the already adopted (in June 2014) Government's Human Rights Action Plan, and that the new Department at the Prosecutor's Office has attracted some criticism from the civil society[14], especially for the alleged lack of transparency as regards the selection of staff and cases, and the absence of clear terms of reference.

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[14] See, for example, a joint statement by several NGOs (including GYLA, Human Rights Center and Article 42) of 31 March 2015, https://gyla.ge/eng/news?info=2462.

Whatever the model finally chosen, **the CPT calls upon the Georgian authorities to take effective steps to ensure that possible cases of ill-treatment of persons deprived of their liberty are investigated in accordance with the criteria enumerated in paragraph 15 above.**

Pending that, **urgent steps should be taken to ensure that any investigations into allegations of ill-treatment of persons deprived of their liberty (and whenever there is a suspicion that ill-treatment might have occurred, even without an allegation) be investigated *ex officio*, as from the outset, by Prosecutor's Office.**

21. In addition, in order to facilitate the investigation of instances of possible ill-treatment, more consideration should be given to CCTV coverage (ensuring *inter alia* that all devices work), which may also help to reduce the incidence of ill-treatment (as well as to confirm or refute allegations).

The Committee recommends 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, and in any case for longer than 24 hours. In this connection, **the law should guarantee that relevant CCTV footage 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. Establishments under the authority of the Ministry of Internal Affairs

1. Preliminary remarks

22. Since the CPT's last periodic visit (in 2010), a number of legislative developments has taken place. The new Code of Criminal Procedure (hereinafter - CCP) adopted in 2009, entered into force on 1 October 2010. It provides a number of safeguards against torture and ill-treatment (see paragraphs 31 to 35 below).

Further, in the context of on-going reforms of the police, new laws, regulations and instructions have been promulgated, including a Law on Police which entered into force in January 2014, and specific instructions for the border police, patrol police and staff working in temporary detention isolators (TDIs).

23. The new CCP maintains the 72-hour time limit on police custody, but abolishes the status of "suspect" and "accused" and introduces the uniform status of "defendant".[15] 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 2014 visit.

24. In July 2014, the Parliament adopted amendments to the Code of Administrative Offences which reduced the maximum term for administrative arrest from 90 days to 15 days. This is certainly a positive development.

Even more noteworthy is that, as the delegation was informed at the outset of the visit by representatives of the Ministries of Internal Affairs and Justice, a special inter-agency commission is currently looking into a complete abolition of the sanction of administrative arrest, in the context of the planned comprehensive overhaul of the Code of Administrative Offences. Given the conditions of detention in TDIs (see paragraphs 41 to 43), the CPT cannot but express its support for this idea. **The Committee would like to be informed, in due course, whether the sanction of administrative arrest has been abolished.**

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[15] A person shall be considered a defendant if there is a probable cause that he/she has committed a crime provided for by the Criminal Code.

2. Ill-treatment

25. The great majority of the persons interviewed by the delegation, who were or had recently been in police custody, stated that they had been treated by police officers in a correct manner. This confirms the generally positive impression obtained during the previous periodic visit as regards the treatment of persons detained by the police in Georgia.

That said, the delegation received several allegations of excessive use of force upon apprehension, consisting of punching and kicking persons who were already brought under control.

In a few cases, the delegation heard allegations (and came across some evidence, including of medical nature) of physical ill-treatment (in the main, punches and kicks, but also blows with plastic bottles filled with water and with gun butts) inflicted upon detained persons after they had been brought to a police establishment, immediately prior to the beginning of the first official interview, and reportedly with the purpose of forcing the persons concerned to make a confession or another statement. Further, some allegations were received of police officers using abusive language and/or resorting to threats vis-à-vis persons in their custody.

It is noteworthy that no allegations were heard concerning custodial staff working in TDIs.

26. At the outset of the visit, the Deputy Minister of Internal Affairs informed the CPT's delegation of measures taken to enhance the professionalism of police officers. In the first place, human rights were featuring prominently in the Police Academy curriculum, both for the initial and ongoing training. Further, the Ministry was in the process of studying the recommendations by the Council of Europe experts in order to further improve the recently adopted Code of Police Ethics. New instructions for the border police, patrol police and TDI staff placed a great emphasis on human rights and fundamental freedoms, and there was a new requirement to carry out audio-visual surveillance in TDIs as a safeguard against ill-treatment.

The CPT welcomes the above-mentioned steps taken (or being taken) by the Georgian authorities to prevent ill-treatment by the police. Nevertheless, it is clear in the light of the delegation's findings that continuing efforts (including in the context of recruitment, training and monitoring) are necessary in this respect.

Consequently, **the Committee reiterates its recommendation that the Georgian authorities continue to deliver a firm message of "zero tolerance" of ill-treatment, including through ongoing training activities, to all police staff. As part of this message, it should be made clear that the perpetrators of ill-treatment and those condoning or encouraging such acts will be punished adequately.** Further, **more attention must be paid to the training for police officers in preventing and minimising violence in the context of an apprehension.**

27. According to the data provided by the Prosecutor's Office as regards investigations into possible ill-treatment by police officers, three investigations had been initiated in 2013 under Section 144[1] of the Criminal Code (torture), four under Section 144[3] (inhuman or degrading treatment), 21 under Section 332 (abuse of official authority) and 174 under Section 333 (exceeding official powers); 29 police officers had been formally charged. In the course of that year, three police officers were convicted by courts for the treatment inflicted upon persons in their custody (one under Section 332 and two under Section 333) and five acquitted.

In the period from 1 January to 1 November 2014, 83 investigations were initiated under Sections 332 and 333, and 27 police officers charged. Investigations initiated the previous year continued in respect of four officers charged under Section 144[1] and 25 charged under Section 333. By 1 November 2014, courts had acquitted two police officers and convicted three under Section 144[1], three under Section 144[3] and another three under Section 333 of the Criminal Code[16]; **the CPT would like to be informed of the details of these convictions (nature and duration), as well as those of 2013.**

Further, in order to be able to form a view of the current situation, **the Committee requests to be provided with analogous information in respect of the first half of 2015. The CPT would also like to receive information about the number of complaints of ill-treatment by the police received by the Ministry of Internal Affairs' General Inspection Service (in respect of the years 2013, 2014 and the first half of 2015) and the number and type of disciplinary sanctions imposed as a result.**

The Committee also wishes to stress that the credibility of the prohibition of torture and other forms of ill-treatment is undermined each time officials responsible for such offences are not held to account for their actions. In this context, reference is made to the comments and recommendations in Section I.F of this report.

28. The role to be played by medical doctors in the prevention of ill-treatment has been repeatedly emphasised by the CPT in the past. The procedure for screening newly arrived persons at TDIs remained broadly similar to that described in the report on the visit in 2010.[17] At the TDIs visited, a (medically untrained) duty officer performed an initial external body check, after which a doctor from the emergency service (independent of the Ministry of Internal Affairs) was called in.

Examinations by the doctors generally took place in the presence of police officers. As stressed in the past, such a practice could clearly inhibit the person concerned from making a truthful statement about what had happened to him/her, and in particular from giving an account of ill-treatment allegedly inflicted by the police. In addition, the delegation noted that the results of the medical examinations (including any statements made by the person concerned) were accessible to police officers.

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16 It is to be stressed that in most cases police officers were charged under more than one Section of the Criminal Code.

17 See paragraph 23 of CPT/Inf (2010) 27.

The CPT reiterates its recommendations that further steps be taken to improve the screening for injuries at TDIs, in particular by ensuring that:

- **all medical examinations are 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;**

- **the confidentiality of medical documentation is strictly observed.**

Health-care staff may inform custodial officers on a need-to-know basis about the state of health of a detained person; however, the information provided should be limited to that necessary to prevent a serious risk for the detained person or other persons, unless the detained person consents to additional information being given.

29. The quality of the recording of injuries (and, as would seem, of the examinations) was very uneven and sometimes the descriptions made by duty officers were actually more detailed than those made by emergency doctors. Detainees' explanations of the origin of their injuries were recorded in a brief standardised manner ("prior to apprehension", "upon arrest", "by a third person", "after arrest") and doctors did not attempt to make any conclusion as to the consistency of the injuries described with the explanation provided.

As already stressed several times in the past, if the procedure for medical examination of persons admitted to TDIs is genuinely to contribute to the prevention of ill-treatment, steps must be taken to ensure that the examination of persons admitted to such facilities is performed by qualified health-care personnel and in a systematic and thorough manner. **The CPT reiterates its recommendation that steps be taken to ensure that the records drawn up following the medical examination of detained persons in TDIs contain: (i) an account of statements made by the persons concerned which are relevant to the medical examination (including their description of their state of health and any allegations of ill-treatment), (ii) a full account of objective medical findings based on a thorough examination, and (iii) the health-care professional's observations in the light of (i) and (ii), indicating the consistency between any allegations made and the objective medical findings.**[18]

30. According to the newly issued (November 2014) Order No. 879 by the Minister of Internal Affairs, any injuries observed on newly-arrived detainees were to be reported to the competent prosecutor, irrespective of whether the person alleged any ill-treatment. That said, it was clear that the new Order was not yet (fully and consistently) applied in practice. For example, at Kobuleti TDI, the practice was to report injuries only if the detainee complained of ill-treatment by the police. **The Committee recommends that steps be taken to ensure that the Order No. 879 is properly and fully implemented in all TDIs.** Further, **the Order should be amended so as to make clear that detained persons and their lawyers are entitled to receive a copy of the report sent to the prosecutor.**

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18 See also paragraphs 71 to 84 of the CPT's 23rd General Report, www.cpt.coe.int/en/annual/rep-23.pdf.

3. Safeguards against ill-treatment

31. Pursuant to Section 38 (10) of the CCP, immediately upon being detained, a defendant is entitled to notify his/her family member or a close relative of the fact of detention, his/her whereabouts and his/her state of condition.

Almost all detained persons interviewed by the delegation confirmed that they had indeed been put in a position to promptly notify their family of their situation. Detained persons usually provided police officers with a phone number and the latter called that number in the presence of the detainee. The CPT welcomes this positive practice.

32. In Batumi TDI, the CPT's delegation was told that if the person detained was a foreign national (without residence in Georgia and/or without relatives living in the country), the notification of custody would be considered as performed if the relevant diplomatic and/or consular representation was informed of the person's arrest. In the Committee's view, this (provided it happens with the foreign national's consent) represents an additional safeguard for persons who are not Georgian citizens, but cannot be considered as a substitute for notification of custody to the person's next-of-kin. **The CPT recommends that the above-mentioned practice be modified accordingly.**

33. According to Section 38 (2) of the CCP, the defendant should be informed of his/her right to have a lawyer at the moment of detention as well as before any questioning.

In practice, detained persons were generally offered access to a lawyer shortly after arrest, although the delegation did hear several allegations that access had been delayed until after the interview (and after the signature of the confession or another statement); in a few cases, detained persons alleged that they had only been able to meet their lawyer in court. **The CPT reiterates its recommendation that steps be taken to ensure that the right to have access to a lawyer is fully effective for all detained persons, as from the outset of deprivation of liberty.**

Pursuant to Sections 38 (5) and 46 of the CCP, persons detained by the police who are indigent are entitled to free legal aid. The delegation gained the impression that the *ex officio* legal aid system operated well. It is noteworthy in this context that the Legal Aid Service was separated from the Ministry of Corrections in December 2013 and became a fully independent agency.

Section 43 of the CCP guarantees the confidentiality of communication between a lawyer and a defendant, even before the person is declared a defendant.[19] That said, the delegation did hear some allegations that confidentiality was not systematically respected in practice in the TDIs. **The Committee invites the Georgian authorities to ensure that this is always the case.**

34. Regarding access to a doctor, pursuant to the CCP (Section 38 (2)), the defendant has the right to undergo free of charge medical examination immediately upon his/her detention. The delegation's observations during the 2014 visit suggest that these provisions are generally applied in practice; however, see the comments and recommendations made in paragraphs 28 to 30.

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[19] Video surveillance (without sound recording) can be applied though.

In addition to the above, the CCP (Section 38 (9)) grants the defendant the right to undergo a medical examination by a doctor/expert of his/her choice (this including a forensic doctor), any time and at his/her own expense. The delegation did not come across such a case during the visit but was told that arranging such an examination could be difficult in practice and – in the case of forensic doctors – extremely expensive (allegedly some 5,000 GEL, equivalent of some 2,000 EUR) and therefore inaccessible to the vast majority of persons detained. **The CPT would welcome the Georgian authorities' observations on this subject.**

35. Concerning information on rights, in accordance with amendments to Sections 174 and 175 of the CCP in force since August 2014, a defendant has to be informed of his/her rights from the outset of deprivation of liberty. Formerly, this obligation only applied as from the moment of drawing up the detention protocol. The CPT welcomes these amendments.

It would appear that detained persons are now as a rule given a copy of the detention protocol, which lists all the relevant rights, and are asked to confirm having been informed of their rights with a signature on the protocol.[20] That said, it is still not a routine practice for police officers to provide verbal information on rights immediately upon apprehension. **The CPT reiterates its recommendation that the Georgian authorities take further steps to ensure that all persons detained by the police are fully informed of their rights. This should involve the provision of clear verbal information at the very outset of deprivation of liberty (i.e. when the persons concerned are obliged to remain with the police), to be supplemented at the earliest opportunity (that is, immediately upon first entry into police premises) by written information.**

36. The CPT notes as a positive fact that posters with information on rights of defendants and administrative detainees (in five languages: Armenian, Azerbaijani, English, Georgian and Russian) were seen in the corridors of all the TDIs visited. However, such posters cannot substitute for the provision of written information to each person detained individually before any questioning has taken place. This applies especially to foreign nationals (and other persons not fluent in Georgian), some of whom complained to the delegation that they had not been able to understand the information (in Georgian) that they had been provided with. **The CPT recommends that steps be taken to ensure that written information on rights (to be provided individually to persons detained by the police) is available in an appropriate range of languages.**

37. At the outset of the visit, senior officials of the Ministry of Internal Affairs told the delegation that recent amendments to the Code of Administrative Offences extended the safeguards mentioned in paragraphs 31 to 35 above to administrative detainees. The Committee welcomes this positive development. That said, several of the individual files of persons on administrative arrest in the TDIs visited missed any reference to the exercise of these rights, especially notification of custody and access to a lawyer. It was not clear to the delegation whether this was just an omission in the system or whether such safeguards had not been offered in those cases. **The CPT would like to receive clarification of this issue from the Georgian authorities.**

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[20] Although when examining files and protocols in the TDIs, the delegation found several exceptions, e.g. protocols without the detained person's signature or (more frequently) a note by the police officer that the person "refused to sign".

38. As regards juveniles (i.e. persons aged below 18, according to Section 3 of the CCP), the presence of a lawyer is obligatory during their questioning (Section 45 (a) of the CCP), and pursuant to Section 116 of the CCP, the attendance of a legal representative (i.e. close relative, guardian or trustee) or a psychologist is also required whenever a juvenile is being interviewed.

It would seem that these provisions were duly applied in practice. While welcoming this, **the CPT must again invite the Georgian authorities to introduce a specific information form on the rights of juveniles, which is easy to understand and includes a reference to the right to have a lawyer and a legal representative present during questioning. Special care should be taken to explain the information carefully to ensure comprehension.**

39. At all the TDIs visited in 2014, the delegation observed that the period spent in custody was well documented. Further, a centralised computer database enabled access to the custody records of all temporary detention isolators in the country. This is indeed positive.

4. Conditions of detention

40. 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 a few hours in a police station (and no one had been held there overnight). The Committee welcomes this.

41. 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 39 TDIs in the country, four had been renovated completely and two new ones were under construction in Western Georgia (including one in Zugdidi). The authorities also informed the delegation that a recent instruction required the management of all TDIs to observe the standard of 4 m² of living space per detained person.

The material conditions of detention in the TDIs visited were on the whole acceptable for the maximum permitted period of police custody (i.e. 72 hours). The cells were generally 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.

However, although none of the TDIs was overcrowded at the time of the visit, the intended cell occupancy was way too high[21] and failed to respect the above-mentioned norm of 4 m² of living space per detainee. There was limited (e.g. in Kutaisi and Samtredia) or no access to natural light in some of the cells (e.g. in Chkhorotsku and Zugdidi), and problems with ventilation in certain of the cells at Zugdidi TDI.

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[21] E.g. cells for six persons measuring some 8 m² at Khobi TDI and some 11 m² at Zugdidi TDI; a 7 m² cell for four at Chkhorotsku TDI; cells measuring some 9 m² and intended for four persons at Batumi and Senaki TDIs; cells for four measuring some 11 m² (Kobuleti) and 14 m² (Poti); a 21 m² cell for six at Kutaisi TDI.

In those of the TDIs where there were in-cell toilets, these were only partially screened.[22] Although all the isolators visited were fitted with decent shower facilities, access to a shower was still reserved for administrative detainees, and only if they stayed in the TDI for longer than a week. On a more positive note, detainees were systematically offered some personal hygiene items (soap, towel, toilet paper) and could receive more from home (or ask the staff to buy them in a shop).

42. Although the Ministry officials were adamant that anyone staying in a TDI for longer than 24 hours would be offered daily outdoor exercise, this was not confirmed in most of the TDIs visited, first of all because they were not equipped with exercise yards (Chkhorotsku; Khobi, Kobuleti and Kutaisi). Admittedly, some administrative detainees (and only this category of detained persons) were occasionally authorised by TDI commanders to take a walk outside the establishment (after having been warned of criminal responsibility in case of absconding); however, this was clearly a small minority. Even in those TDIs which did have a yard (Poti, Samtredia, Senaki), outdoor exercise was not systematically offered. It is also noteworthy that only the TDI in Senaki was equipped with a suitable outdoor exercise area (measuring some 70 m², with seating and a shelter against inclement weather) while those in Poti and Samtredia were small (under 20 m²) and completely inadequate (in Samtredia TDI, the "yard" was in fact a semi-covered cell).

43. Even if one assumes that the above-mentioned problem with outdoor exercise is addressed, it is clear that none of the TDIs visited offered conditions adequate for holding administrative detainees for longer than 72 hours, because of the material conditions and the total absence of any activities (there was not even always access to reading matter).

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

- **there is at least 4 m² of living space per detainee in multi-occupancy cells (not counting sanitary annexe) and at least 7 m² in single cells; all the excess beds should be removed;**
- **all the cells have adequate lighting (including, preferably, access to natural light) and ventilation;**
- **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 to ensure that anyone obliged to stay in a TDI for over 24 hours (irrespective of legal status) is granted access to outdoor exercise on a daily basis. All 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[23] - that they be offered some form of activity (e.g. books, newspapers, board games).

Finally, **the Committee recommends that the small (less than 4 m²) cell seen at Khobi TDI only be used for short-term holding purposes (no more than a few hours) and never for overnight detention.**

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22 There were no in-cell toilets at the TDIs in Chkhorotsku, Khobi, Senaki and Zugdidi. No complaints were heard as regards access to communal toilets in those TDIs.

23 See paragraph 24 above.

B. Establishments under the authority of the Ministry of Corrections

1. Preliminary remarks

45. The CPT's delegation carried out follow-up visits to Prison No. 3 in Batumi, Prison No. 7 in Tbilisi, Gldani Prison and Prison Hospital, as well as a first-time visit to "Matrosov Prison" in Tbilisi.

46. From the outset, the Committee wishes to congratulate the Georgian authorities for having succeeded in maintaining the prison population roughly at the level dramatically reduced following the large-scale amnesty and a series of Presidential pardons in the end of 2012.[24] At the time of the 2014 visit, the prison population stood at approximately 10,000 (with the incarceration rate of 230/100,000), down from over 25,000 inmates in mid-2012 and an incarceration rate of 550/100,000.

47. The CPT also notes the ongoing and planned legislative developments aimed at reducing the resort to imprisonment and facilitating early release and social rehabilitation of prisoners. This includes: removing from the Criminal Code (CC), in April 2013, the principle of consecutive (cumulative) sentencing[25]; introduction of the mechanism of diversion (from criminal to other proceedings) to the CC[26]; reform of the mechanism of early conditional release[27]; liberalisation of the provisions on conditional release and pardon for prisoners sentenced to life imprisonment[28], and issuing guidelines for prosecutors and judges to better motivate their requests to courts for applying the preventive measure of remand in custody and to make more frequent requests for non-custodial preventive measures (such as bail and personal guarantee).[29]

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24 Measures described in the report on the November 2012 ad hoc visit to Georgia, see paragraphs 21 and 22 of CPT/Inf (2013) 18.

25 It was replaced by the rule of absorption of sentences. Inmates convicted on the basis of the consecutive sentencing principle prior to the entry into force of this amendment could apply for a reduction of their sentence.

26 New Section 168 bis.

27 Sections 40 (7), 42 and 43 of the Imprisonment Code were amended so as to clarify and liberalise the rules on early/conditional release.

28 Pursuant to an amendment to Section 72 (7) of the CC, conditional release for lifers is now possible after 20 years of sentence (instead of the previous 25). Further, the Presidential Order of 27 March 2014 stipulates that life-sentenced prisoners may request pardon after having served 15 years of their sentence (25 years previously).

29 In January 2014, the Council of Europe Commissioner for Human Rights received information that the rate of approval by judges of preventive measures requested by prosecutors, including pre-trial detention, had declined significantly from the first half of 2012 to the first half of 2013. Prosecutors themselves had become somewhat less likely to request detention as a restrictive measure and, in cases where they had done so, their requests tended to be better substantiated than was previously the case. See the Report by Mr Nils Muižnieks, Council of Europe Commissioner for Human Rights, following his visit to Georgia, from 20 to 25 January 2014, CommDH (2014) 9.

The delegation was also informed of ongoing work to review comprehensively the CC with a view to further liberalise and modernise it, by enlarging the catalogue of alternative sanctions and providing more grounds for early release. It was planned to send these amendments to the Parliament in the spring of 2015, after having received and analysed the comments from the Council of Europe. Further, a new Juvenile Justice Code was being drafted with the support of UNICEF and the EU, and the first discussion of the draft in the Parliament was likewise expected to take place in the spring of 2015.

The Ministry of Justice representatives informed the delegation of the new (2013) Strategy and Action Plan on drugs, in which prevention, health care, and law enforcement were important inter-related pillars. Among others, illicit drug use would become a criminal offence only as from the third time (currently, the first time use of drugs constituted an administrative offence, while the second time was criminalised) and in all cases drug users would first be offered the option of undergoing rehabilitation prior to initiating criminal proceedings. However, the implementation of these plans would require significant additional resources for the public health-care system and it was not yet clear whether it would be possible in the near future.

The CPT welcomes all the above-mentioned measures (already taken and planned) and **requests to be kept informed by the Georgian authorities on their implementation**.

48. The Committee also notes the Georgian authorities' ongoing efforts to refurbish, modernise and expand the prison estate. At the outset of the visit, the Deputy Minister of Corrections told the delegation that several establishments (including Prison No. 1 in Tbilisi, Prison No. 4 in Zugdidi and Penitentiary establishment (for women) No. 16 in Rustavi) had recently closed due to inadequate conditions. Three other establishments were currently undergoing refurbishment, and some others (including Prison No. 3, Gldani Prison Hospital, TB Establishment in Ksani and the Juvenile Establishment in Avchala) had reopened after complete refurbishment.[30] There was also ongoing progress with the construction of a new high-security prison in Laituri (capacity 650)[31] and a low-security prison on the site of the former establishment No. 16. **The CPT requests the Georgian authorities to provide it, in due course, with updated information on all these plans and measures.**

Indeed, the material conditions of detention in all the prisons visited (with the exception of Prison No. 7, see paragraphs 62 to 64) were generally acceptable, although the newly-adopted norm of 4 m² of living space per prisoner was not yet fully respected. **The Committee recommends that the Georgian authorities continue their efforts to 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.**

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30 On Prison No. 3 and Gldani Prison Hospital, see paragraphs 60 – 61 and 99 to 104 below.

31 The opening was planned by the end of 2016.

49. In contrast with the planned and already implemented measures concerning the prison population and estate, the CPT is concerned by the little, if any, progress in drawing up programmes of purposeful, out-of-cell, activities for prisoners. Similar to the situation observed during the 2010 periodic and 2012 ad hoc visits, prisoners in the establishments visited in 2014 (both those on remand and sentenced) were locked up in their cells for most of the day, in a state of enforced idleness. Taken together with the restrictions on contact with the outside world and association[32], this produced a regime which was oppressive and stultifying.

The Committee 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, juveniles, etc.).

2. Ill-treatment and inter-prisoner violence

50. The delegation received no allegations of ill-treatment of inmates by staff at *Prison No. 9 in Tbilisi* and at *Gldani Prison Hospital*. Further, no such recent allegations were heard at *Prison No. 7*; however, the conditions of detention in at least some parts of the establishment were such that they could be considered as amounting to inhuman and degrading treatment (see paragraphs 63 and 64 below).

51. As regards *Gldani Prison*, several recent allegations were received according to which newly-arrived inmates had been subjected to "welcome beatings" (punches and kicks) by staff. Further, a prisoner interviewed in another establishment alleged having been struck with a water-filled plastic bottle, while being handcuffed, prior to his transfer from Gldani Prison several days before the CPT's visit.

The delegation was also informed about the incident of 12 November 2014, in the course of which two prisoners had reportedly been subjected to physical ill-treatment (punched and kicked while being handcuffed and allegedly also ankle-cuffed and chained behind their backs) by custodial officers.[33] It should be added that the delegation heard other similar, credible and recent allegations of physical ill-treatment by staff of Gldani Prison.[34]

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32 See also paragraphs 59, 118 and 124 below.

33 See further details in paragraphs 17 and 18 above.

34 In particular, an inmate interviewed at Gldani Prison Hospital alleged that he had been punched and kicked by several custodial staff at Gldani Prison in the beginning of October 2014, after having been taken to the "smart reception unit" of the prison (see paragraph 66) following his act of self-injury committed as a form of protest against having been deprived of a TV set. He also alleged that he had lost consciousness after the beating and that, when he regained consciousness, he was hand- and ankle-cuffed.

52. As concerns *Prison No. 3 in Batumi*, the delegation received a number of recent, detailed and credible allegations according to which custodial staff resorted to punching and kicking prisoners who were already handcuffed and brought under control, while transferring them from their cells to the holding and/or punishment cells, as well as inside these cells. In this context, the delegation heard allegations – and obtained some documentary evidence – of application of handcuffs vis-à-vis such prisoners for excessively long periods (up to 20 hours).

Further, similar to Gldani Prison, allegations were heard of newly-arrived prisoners having been subjected to "welcome beatings" by custodial officers.

53. **The CPT recommends that the management of Gldani Prison and Prison No. 3 in Batumi take appropriate steps to ensure that prison staff do not abuse their authority and resort to ill-treatment. As part of their training, staff should be delivered the clear message that the ill-treatment of inmates is not acceptable and will be punished accordingly. Concerning Prison No. 3, staff should be instructed that where it is deemed essential to handcuff a given inmate, the handcuffs should be applied only for as long as is strictly necessary.**

54. Regarding (in particular but not exclusively[35]) Prison No. 3, while the CPT understands that the management and staff there had to deal with many challenging and aggressive inmates, it was clear that the staff were not properly trained to cope with such high-risk situations, and that the only response they could think of was to resort to physical ill-treatment and intimidation, in order to break the prisoners' resistance and enforce compliance.[36]

This should be seen in the general context of the prison administration's ongoing efforts to regain full control over the situation in penitentiary establishments.[37] While in itself a legitimate objective (which can help prevent inter-prisoner violence, among other things), the methods currently applied to attain it contribute to creating an atmosphere of conflict and tension between the prison management and staff on one side and certain groups of inmates on the other.

Further, the lack of a genuine de-escalation strategy results in some inmates finding no other means of communicating their grievances than through hunger strikes, acts of severe self-harm and even attempted suicides.[38] **The Committee would welcome the observations by the Georgian authorities on these subjects.**

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35 To a certain degree, a similar situation was observed at Gldani Prison and Prison No. 7, see also paragraphs 91, 120 and 126.

36 See also paragraph 108.

37 See also paragraph 56 below.

38 See paragraph 126.

55. According to the statistics provided during the visit by the Prosecutor's Office regarding the investigation of complaints of ill-treatment by prison staff, 48 prison officers had been indicted in the course of 2013 under Section 144 of the CC, including two heads of department, two deputy heads, eight directors of establishments and eight deputy directors; 28 prison officials were convicted. In the first 8 months of 2014, six prison staff had been prosecuted, nine convicted and nine others concluded a plea bargain.[39]

Many cases were still under investigation or in court (concerning approximately 100 staff) and the Prosecutor's Office had appealed several first instance acquittals.[40] It is noteworthy that all the above-mentioned cases concerned facts from before September-October 2012 and were related with the "prison video scandal".[41] No investigations under Section 144 of the CC had been initiated in respect of any subsequent facts of ill-treatment of inmates by prison staff (there were some ongoing investigations pursuant to Section 333). **The CPT would like to receive the Georgian authorities' observations on this issue.**

As for disciplinary proceedings against prison staff for misconduct vis-à-vis prisoners, the Ministry of Corrections officials mentioned 232 cases in 2013 and 146 in 2014 (until 1 December). No information on the outcome of these proceedings was provided.

In order to obtain a nationwide view of the situation concerning the treatment of prisoners by prison staff, **the CPT would like to receive the following information for the whole of 2014 and the first half of 2015 in respect of all prisons in Georgia:**

- **the number of complaints of torture or other forms of ill-treatment lodged against prison staff;**

- **the number of criminal or disciplinary proceedings opened following such complaints and an account of sanctions imposed.**

Concerning, more generally, the issue of investigations into possible ill-treatment of inmates by prison staff, **reference is made to the comments and recommendations in Section I.F**.

56. The CPT's mandate is not limited to assessing the ill-treatment of prisoners by staff. The Committee is also concerned with the phenomenon of inter-prisoner violence and of informal power structures existing within a prison, which can sometimes generate risks of intimidation or extortion, and possibly contribute to inter-prisoner violence.

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39 One of them, B (author of some of the videos at the origin of the "prison video scandal" in September 2012) was freed of criminal responsibility for having fully co-operated with the investigation.

40 The acquittals were reportedly due to lack of evidence.

41 The description of this scandal can be found in the report on the 2012 ad hoc visit (CPT/Inf (2013) 18), especially in paragraphs 2 and 12 to 16.

It should be stressed that the delegation did not receive any direct allegations of inter-prisoner violence in the establishments visited. That said, the existence of the problem was pointed out by several of the delegation's interlocutors (including the Public Defender and GYLA) and acknowledged by senior officials of the Ministry of Corrections. Possible indication could also be found in some cases of violent deaths of inmates in the course of 2013 and 2014. The delegation's interlocutors linked this problem with the alleged resurgence of traditional informal prisoner hierarchies involving crime bosses ("thieves in law") and so-called "watchers"[42], following the authorities' strategic decision to depart from the previous prison policy based on excessive control and security (to the detriment of prisoners' rights).

The Director of Gldani Prison told the delegation that there had indeed been a drop in the level of control by the management and staff after the "prison video scandal" but stressed that the situation had been rectified since, and "the right balance between rights and order" found. Also the Director of Prison No. 3 mentioned recent attempts to introduce informal power structures in his establishment, and quoted the mass action of self-injuries and hunger strikes (after the 12 November incident in Gldani) as an example. He assured the delegation, however, that the attempt had been thwarted although, in the process, he and his staff had reportedly been "unjustly accused of ill-treating prisoners" by the media and NPM representatives.

57. The CPT wishes to emphasise 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 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.

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 implementation of an individualised risk and needs assessment of prisoners.

In the light of the above comments, **the Committee recommends that the management and staff of all the penitentiary establishments in Georgia be instructed to exercise constant vigilance and use all appropriate means at their disposal to prevent and combat inter-prisoner violence and intimidation. 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.**

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42 "Makurebeli" in Georgian. These are prisoners who report to "thieves in law" and other criminal bosses (some of whom live outside prison) on what is happening inside prisons, and who pass on orders from those bosses to fellow prisoners.

Steps must also be taken to protect the actual or potential victims against the actual or potential perpetrators.

58. As already mentioned in paragraph 8 above, the CPT's delegation was very concerned by the situation of A, a life-sentenced prisoner accommodated at Prison No. 7 in Tbilisi. He had been diagnosed as suffering from serious mental and physical health problems[43] and had been held in solitary confinement for over a year. His body and his cell were filthy, having not been cleaned for months; he reeked of urine[44] 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). **The conditions under which he was kept could easily be considered as inhuman and degrading.**

At the end of the visit, the delegation made an immediate observation pursuant to Article 8, paragraph 5 of the Convention and requested the Georgian authorities to take urgent action to transfer the prisoner concerned to an appropriate health-care facility and to provide him with adequate assessment, treatment and care without delay. The delegation asked to receive confirmation within two weeks that this has indeed happened.

In their letter of 25 December 2014, the Georgian authorities explained the complex legal situation of A (under the existing law[45], it was reportedly impossible to subject an already sentenced prisoner to undergo involuntary psychiatric assessment, and without such an assessment the court could not order his transfer to a psychiatric hospital to undergo involuntary treatment), who apparently refused any co-operation with the prison administration on this issue.

Nevertheless, following the CPT's visit, the Director of Prison No. 7 again requested the court to authorise such transfer and, pending that, A was temporarily moved to another cell and his cell was cleaned and disinfested. At the same time, the Ministry of Corrections initiated work on legal amendments to eliminate the *lacuna* referred to above.[46]

The Committee takes due note of these explanations. However, while understanding the legal complexity of A's situation, it remains the case that to continue to accommodate him at Prison No. 7 (even in a clean cell) is unacceptable. **The CPT calls upon the Georgian authorities to do everything legally and practically possible to transfer him to an adequate treatment facility within the shortest time. The Committee would like to receive confirmation that this has indeed happened within one month from the reception of this report. The CPT also requests to be informed of the progress of legislative amendments referred to in the Georgian authorities' letter of 25 December 2014.**

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43 As acknowledged by the prison's Director, the head doctor and an external specialist.

44 He appeared to have a suprapubic fistula following cystostomy.

45 Section 22 (2) of the Law on Psychiatric Care.

46 In addition, amendments would be proposed to Section 22 (1) of the Law on Psychiatric Care which reportedly prevented prison doctors from treating A in a prison setting against his will.

59. A number of inmates (especially at Prisons No. 7 and 9, but also in Batumi) were in fact subjected – sometimes for months and even years on end – to conditions akin to solitary confinement (without any possibility of association, visits and telephone calls[47], and without the right to listen to the radio and watch television) and, in addition, frequently subjected to constant CCTV monitoring inside their cell. [48]

This appeared to be applied vis-à-vis inmates considered difficult/disruptive (e.g. those constantly challenging the administration with complaints and protests in the form of hunger strikes, acts of self-harm, etc.) but also allegedly to enforce co-operation with investigation (in the case of former senior officials) or for other reasons (see paragraph 62). **In the CPT's view, to subject inmates to such conditions could be considered as amounting to inhuman and degrading treatment.**

In this context, the Committee is particularly concerned by what appears to be the absence of clear, transparent written criteria (set out in law and/or implementing regulations) and the lack of procedural safeguards (absence of oral hearing, lack of information for inmates on the grounds for the decision and on their right to appeal, absence of clear time-limits and of a mechanism for regular review) for placement under such conditions. The overall impression – for the inmates concerned and also for the delegation – was that of arbitrariness. **The CPT calls upon the Georgian authorities to stop the above-mentioned practices and to review their rules and policy, in the light of the above remarks.**

Further, it is the Committee's view that providing prisoners with the possibility of listening to the radio and watching television should not be considered a "privilege" but a normal entitlement for every prisoner.[49] Any bans on access to information (via radio and TV) should be justified duly and in detail by exceptional circumstances related to the requirements of the investigation or the behaviour of the prisoner in question, and be of a limited, clearly specified duration. Inmates should be informed of the reason for the ban in writing, and of the right to appeal to a competent authority. **The CPT recommends that the relevant provisions be amended accordingly.**

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47 See paragraphs 77 and 118 below.

48 Just as an illustration, examples of three former senior Government officials could be quoted (information based on their own statements given to the CPT's delegation): C (former Minister of Internal Affairs, Minister of Defence and Head of Penitentiary Department) had spent approximately 2 years under such conditions; D (former Prime Minister and Minister of Internal Affairs) had been subjected to such conditions for some 18 months (in both cases, their regime had become somewhat less strict after they had received their first convictions); as for E, former Mayor of Tbilisi, his regime (that had already been imposed on him for approximately 6 months) was relatively the most strict and could even be considered as approaching sensory deprivation. This was allegedly due to the fact that he was not yet convicted of any of the offences he was accused of. Regarding Prison No. 7, see paragraph 124.

49 See also paragraph 73.

3. Conditions of detention

a. material conditions

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

60. Prison No. 3 in Batumi, a closed-regime establishment, was last visited by the CPT in 2004.[50] On the day of the delegation's visit, it was accommodating 186 adult inmates (65 on remand and 121 sentenced, including six women[51]) for a capacity of 557 (calculated on the basis of the old norm of 2.5 m² of living space per prisoner). The prison's Director told the delegation that the capacity would be 224 if calculated under the new 4 m² norm, and added that currently inmates had between 3 and 3.5 m² of living space per person. 23 of the inmates were foreign nationals.[52]

61. The prison had reopened in May 2014 after a year of extensive refurbishment. Most of the inmates were accommodated in cells for four, six or eight, but there were also some in solitary confinement, including a number held in cells with CCTV.[53] Conditions in the majority of the cells were cramped (e.g. a cell for four prisoners measuring some 13 m², sanitary annexe included; a cell for six inmates measuring some 16 m²; a cell for eight prisoners measuring some 24 m²) and there were too many beds in the cells. **Reference is made here to the recommendation in paragraph 48 above.** Further, **the CPT recommends that all excess beds (as compared with the new legal norm of living space) be removed from the cells.**

Apart from this, material conditions were found to be quite adequate (the cells were generally well lit and ventilated, clean, in a good state of repair, suitably furnished[54] and fitted with fully screened sanitary annexes comprising a shower[55]). No major problems were observed as regards the bedding and the provision of hygiene items and food.

The only major problematic issue (as acknowledged by the Director) was water supply, especially in the summer, though admittedly things were not made any better by the prisoners' habit of letting the water run all day (reportedly to make the water more 'clean' and 'fresh'). **The Committee recommends that the Georgian authorities reflect upon ways of addressing this issue, e.g. by fitting the prison with a water filtration system and the cells with water-saving installations.**

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50 See paragraphs 76 to 82 of CPT/Inf (2005) 12.
51 One of the women was also on remand in another case.
52 Mostly from Turkey, Iran and Central Asia.
53 See paragraphs 59 and 77.
54 Bunk or single beds, a table, benches or stools, lockers. There was a functioning call system in the cells too.
55 Hot water was switched on twice a week.

ii. follow-up visit to Prison No. 7 in Tbilisi

62. Prison No. 7, a strict-regime[56] cell-type establishment located in Tbilisi in the building also occupied by some of the services of the Ministry of Internal Affairs, was previously visited by the CPT in 2007[57] and 2010[58]; the description of material conditions made in the reports on those visits remains generally valid.

Based on the old standard of 2.5 m² of living space per person, the prison's capacity was 108; there were 102 beds. The establishment was officially accommodating 72 adult male prisoners on the day of the delegation's visit[59], including six "thieves-in-law" and three former "thieves-in-law"[60]; some other prisoners were "watchers" or former "watchers".[61] In addition, there were three lifers and two remand prisoners; in fact, the latter were also convicted prisoners, but were in pre-trial detention for other offences. Some of the inmates had been temporarily transferred from Prison No. 6 in Rustavi which was closed for refurbishment (see above).

At the time of the visit the prison was overcrowded, taking into account the new national legal minimum standard of 4 m² of living space per prisoner. For example, cells measuring some 10 m² (fully screened sanitary annexe included) could accommodate as many as four inmates. In this context, **reference is made to the recommendations in paragraph 48 and 61, which are fully applicable here.**

63. The delegation observed certain improvements since the 2010 visit: cells had been repainted and furnished with tables, chairs and lockers, toilets fitted with full partitions, the communal showers refurbished and arrangements made for washing the bedding once a week. In addition, some improvements were made to the ventilation and heating in the cells by installing pipes that provided cool air in summer and hot air in winter (see, however, below).

As previously, the best material conditions were observed on level 3, which was in a good state of repair; the cells on that level had large windows not obstructed by any devices except for reasonably spaced-out bars, and access to natural light, artificial lighting and ventilation were satisfactory. However, access to natural light had remained virtually non-existent in the cells on levels 1 and 2 (which still had small windows covered by dense wiring), and cells on level 1 were also damp and dilapidated. Further, some of the cells on level 2 did not have either glass or cellophane in the windows, which left them quite cold.

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56 At the time of the visit, this was the only operational strict-regime penitentiary establishment in Georgia, given that Prison No. 6 in Rustavi was temporarily closed for refurbishment (see also paragraph 48). One of the characteristics of a strict-regime prison was that communication between inmates from different cells was strictly prohibited and all the cells were under CCTV surveillance. That said, prisoners in some of the cells had recently either broken or covered the cameras.

57 See paragraphs 61, 64 and 65 of CPT/Inf (2007) 42.

58 See paragraphs 53 to 56 of CPT/Inf (2010) 27.

59 However, 70 were physically present, one undergoing treatment at Gldani Prison Hospital and the other undergoing forensic psychiatric assessment in another facility.

60 These prisoners were there on court order; their strict regime was a result of their having committed offences described in Sections 223 or 226 of the CC. See also paragraph 59 above.

61 See also paragraph 56. They had been transferred to Prison No. 7 from other penitentiary establishments (according to the Director, usually for some eight months but in any case for no longer than a year) by decision of the Head of Penitentiary Department after having been caught attempting to set up and/or run informal prisoner hierarchies there.

In short, the material conditions on (especially) level 1 were totally unacceptable and, as already mentioned in paragraph 50 above, could be considered as amounting to inhuman and degrading treatment. **The CPT calls upon the Georgian authorities to take the cells at level 1 of Prison No. 7 out of service as prisoner accommodation at the earliest opportunity (i.e. as soon as the refurbishment of Prison No. 6 is completed and inmates moved back there). Cells on level 2 should be refurbished urgently, paying particular attention to access to natural light and ventilation. Preferably, all inmates should be accommodated on level 3.**

64. More generally, the Committee has come to the conclusion that Prison No. 7 is structurally unsuitable for any long-term detention.[62] In this context, **the CPT would like to be informed whether it is planned to close Prison No. 7 once the new Laituri Prison opens.[63]** In the light of what its delegation saw at Prison No. 7, **the Committee cannot but encourage any such plans and requests the Georgian authorities to treat them as a matter of high priority.**

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

65. The material conditions of detention at Gldani Prison were described in detail in the reports on the CPT's 2010[64] periodic and 2012[65] ad hoc visits. On the day of the delegation's visit, there were 2,929 male inmates in the prison (i.e. slightly more than in November 2012), of which 1,719 were sentenced and 1,210 on remand; 24 of the latter were juveniles and 63 of the sentenced prisoners were lifers.

The prison had an operating capacity of 3,570 (calculated based on the old norm of 2.5 m² of living space per prisoner and corresponding to the actual number of beds); the Director told the delegation that "in an ideal situation" the capacity would be reduced to 1,200 (only remand prisoners), which would allow to observe the new norm of 4 m² of living space per prisoner.[66] The Director also stressed that overcrowding was temporary because, due to the on-going refurbishment of Prisons No. 6 and 16, a number of prisoners from these prisons had to be accommodated in his establishment. According to him, once Prison No. 16 re-opened, the number of sentenced prisoners in Gldani would be cut by half. **The CPT would like to receive confirmation of this from the Georgian authorities.** Further, **reference is made to the recommendation in paragraph 48.**

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62 See also paragraph 75.

63 The Director of Prison No. 7 expressed the view that there should be no valid reason for keeping his establishment open once the new strict-regime prison is operational.

64 See paragraphs 58 to 61 of CPT/Inf (2010) 27.

65 See paragraphs 32 to 36 of CPT/Inf (2013) 18.

66 According to this calculation, Gldani Prison was operating at over 240% of its capacity.

66. The main improvements since the 2012 visit were as follows:

The old *admission ("quarantine") unit* was replaced by the new so-called "Smart Reception Unit"[67] comprising *inter alia* 11 cells measuring some 18 m² each and equipped with three bunk beds, a table, benches and fully screened sanitary annexes. While the conditions could generally be considered adequate, including as regards access to natural light and ventilation, it should be stressed that **the new norm of living space was still not respected**.[68] Furthermore, some of the cells were already infested with cockroaches; **the Committee recommends that these cells be disinfested.**

The bar-fronted *cubicles* which used to be located in the "quarantine" unit, had been withdrawn from service. Wherever technically possible, they had been enlarged, fitted with proper windows and turned into cells; otherwise they had been transformed into storage rooms.

The *juvenile unit* had been refurbished and the number of beds, each measuring 82 cm in width, had decreased in the cells so as to provide for more space. As a result, juveniles had 4 m² of living space per person.

The CPT welcomes these positive developments.

67. As for the *main/general accommodation*, the conditions had not changed significantly since the 2012 visit[69], and could still be considered as generally acceptable. Cells measuring some 20 m² were usually accommodating six inmates each (as in 2012), which means that conditions remained cramped (see also paragraph 65 above); that said, excess beds[70] were being gradually removed.

No noteworthy problems were observed as regards access to a shower (twice per week) and the provision of bedding, hygiene items and food.

One issue of concern worth mentioning here was that the general wear-and-tear – already visible throughout the establishment back in November 2012 – had become worse. It could also be added that the call system was out of order in most of the cells. **The Committee recommends that steps be taken to remedy the above-mentioned shortcomings.**

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67 See also paragraph 70.

68 See on this the recommendation in paragraph 48.

69 See paragraphs 32 to 36 of CPT/Inf (2013) 18.

70 Originally, the 20 m² cells had been designed for eight prisoners each. See also the recommendation in paragraph 61.

iv. Penitentiary establishment No. 9 ("Matrosov Prison") in Tbilisi

68. Penitentiary establishment No. 9 ("Matrosov Prison"[71]) is located in the Samgori district of Tbilisi. Its official capacity was 1,142 (based, again, on the old norm of 2.5 m² of living space per prisoner); however, only the closed ("cellular regime") unit – capacity 88 – was operational, the rest of the establishment having recently been closed down due to inadequate conditions. As explained by the Director, the capacity in the closed unit had already been (re-)calculated on the basis of the new 4 m² norm.

At the time of the visit, the prison was accommodating 48 adult male inmates, including two on remand, 37 sentenced and nine sentenced who were also on remand (facing additional charges). As already mentioned in paragraph 59, "Matrosov Prison" was the main establishment for former law enforcement officers and former senior Government officials.[72] The delegation was told that it functioned as a high-security establishment which implied ongoing CCTV surveillance in more than half of the cells[73], particularly strict oversight by the staff, twice-daily cell searches and individual searches (frisking and checks with a metal detector) of any prisoner leaving the detention area.

69. Material conditions in the prison were generally good, even though the intended capacity – as per number of beds per cell – was still sometimes too high.[74] The cells measured between 10 and 20 m² and were supposed to accommodate from two to eight inmates, with most of the cells accommodating two, three or four prisoners. Further, there were several inmates *de facto* on solitary confinement, sometimes for months on end.[75]

The cells had satisfactory access to natural light, artificial lighting and ventilation, and were adequately heated. The equipment consisted of bunk beds, tables, benches, lockers and fully-partitioned sanitary annexes. There were no problems with the bedding, hygiene items and food. Access to a shower (in a decent communal facility) was guaranteed twice a week.

In short, the only issue of concern as regards material conditions was the number of beds and the fact that the new 4 m² norm of living space was not systematically observed. **Reference is thus made to the recommendations in paragraphs 48 and 61.**

b. regime and activities

70. According to recent amendments to Chapter VII of the Imprisonment Code, prisoner allocation should be based on *individual risk assessment* ("in accordance with the individual specifications of a convict, *inter alia*, crime motive, personal traits, conduct in the penitentiary and other personal characteristics") and be carried out by a "multi-disciplinary group". Implementing provisions are to be set out in a relevant Ministerial Order.

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

72 Including the former Prime Minister, a former Minister and former Mayor of Tbilisi.

73 See paragraph 59.

74 E.g. six beds (three bunks) in a cell measuring some 14 m² (including the sanitary annexe); four beds (two bunks) in a cell measuring some 11 m²; eight beds in a cell of 20 m².

75 See paragraph 59 above and paragraph 77 below.

The delegation could observe the first attempts to implement these new principles at the "Smart Reception Unit" in Gldani Prison.[76] Newly-arrived prisoners were seen, during a period of approximately up to a week following admission, by professionals representing different specialities among the establishment's staff (operational and security officers, psychologists, social workers, medical staff) with a view to reaching an informed decision on where to allocate the inmate within the establishment. The delegation was assured that the opinion of psychologists, social workers and doctors would play a major role in this context. That said, it was clear that – for the time being at least – this was all somewhat improvised as the above-mentioned Ministerial Order was not yet issued.

As a matter of principle, the CPT welcomes the new provisions and the efforts to set up a new-style reception unit and procedure in Gldani Prison; the Committee also notes that the Georgian authorities plan to set up similar units in other penitentiary establishments. **The CPT would like to be informed of the progress in this respect, and to be provided (in due course) with the text of the Ministerial Order referred to above.**

71. On a related issue, the delegation was told at Prison No. 7[77] that for some categories of prisoners (in particular the "thieves-in-law"), the choice of *regime* and the actual allocation within the prison system was not within the authority of the Ministry of Corrections but of the sentencing court. After one year of serving the sentence under the strict regime, the prisoners concerned were allowed to request the Head of Penitentiary Department to be transferred to a more open regime (and to a different prison); however, this decision too required approval by the court.

The CPT wishes to stress that whenever the sentencing court is given a leading role in deciding the detention conditions of a prisoner, this consigns the penitentiary service to an executive (i.e. passive) role, divesting it of the role of assessing cases and designing individualised sentence plans, which is a key role of a modern penitentiary system. In turn, this reduces the role of prison staff to the maintenance of security and good order and may diminish the professionalism of such staff. Further, this approach determines a prisoner's treatment on the basis of his offence, i.e. of a "picture" taken when the crime was committed. In addition, it ensures that the sanction of imprisonment is not seen as a sanction in itself, with the particular conditions of imprisonment forming extra punishment in some cases and not in others.

Consequently, the Committee considers that decisions concerning the type of regime should be the responsibility of the penitentiary administration and not be made part of the catalogue of criminal sanctions to be imposed by courts. Further, progression from one regime level to another (and consequent transfer from one type of establishment to another) should be based on the prisoner's attitude, behaviour, participation in activities (educational, vocational, or work-related), and in general adherence to reasonable pre-established targets set out in a sentence plan. For this purpose, regular individual reviews should be carried out.

The CPT recommends that the relevant legislation be amended in the light of the above remarks.

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[76] See also paragraph 66 above.

[77] As already mentioned in paragraph 62 above.

72. As already mentioned (see paragraph 49), the almost total absence of anything even remotely resembling a programme of *activities* in any of the prisons visited is an issue of the CPT's ongoing and serious concern. For some of the inmates, this was additionally aggravated by restrictions and even total bans on visits and telephone calls, as was the case with most of the remand prisoners.[78]

73. Work continued to be offered only to a limited number of sentenced prisoners assigned to perform various housekeeping tasks in the establishments visited (e.g. nine inmates in Batumi, 124 in Gldani and four both at Prison No. 7 and "Matrosov Prison"). Similarly, access to education and vocational training continued to be extremely limited, if not virtually non-existent. The only positive exception to this grim overall picture was Gldani Prison, where juveniles were now provided with schooling (by teachers coming from an outside educational facility).

As to recreational activities, they were in fact limited to reading (all the establishments possessed libraries, and most of the inmates were allowed to buy or receive books and newspapers/magazines from outside[79]) and playing board games. Not every prisoner had access to radio and television, either because it was not allowed[80] or because he/she could not afford to buy a TV and/or radio set.[81]

In the light of the above, **reference is made to the recommendations in paragraphs 49, 59 and 120.**

74. As regards outdoor exercise, the positive development since the previous CPT's visits was that (almost) all prisoners were now offered the possibility of taking exercise for one hour each day, including on weekends and holidays. However, there were still some exceptions to this rule: daily outdoor exercise was not available in admission units (including, which is of particular concern, in the new "Smart Reception Unit" at Gldani Prison) and in the punishment units (for inmates placed in the "kartzers" i.e. disciplinary cells).[82] **The CPT calls upon the Georgian authorities to ensure that all prisoners are offered the possibility to take outdoor exercise of at least one hour every day.**

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78 See also paragraph 59.

79 Albeit with some notable exceptions, see paragraph 59.

80 See paragraph 59. At Prison No. 3 in Batumi, the delegation spoke with a prisoner who had been accommodated alone in a cell (and *de facto* held in solitary confinement) since 9 months; he had no TV and claimed that his and his lawyer's repeated requests for one had been rejected by the prison's administration without specifying grounds for the refusal.

81 It was prohibited to receive/bring a TV or a radio set from outside, and inmates were required to purchase these in the prison shop. The price of a TV set in Batumi was reportedly 130 GEL.

82 See also paragraph 123 below.

75. Exercise yards had not improved in Batumi[83], Gldani[84] and at Prison No. 7[85], and were too small at "Matrosov Prison" (measuring barely some 30 m²). **The Committee calls upon the Georgian authorities to improve the outdoor exercise facilities in all the prisons visited, in order to allow prisoners to physically exert themselves. Immediate steps should be taken to equip all exercise yards with some means or rest and protection against inclement weather.**

The CPT also reiterates its recommendations that in all newly built (or renovated) prisons:

- **outdoor exercise facilities be located at ground level and be sufficiently large to allow prisoners to exert themselves physically (as opposed to pacing around an enclosed space);**

- **indoor and outdoor sports facilities (including gyms) be installed and made available to prisoners with an appropriate frequency.**

76. At Gldani Prison, the delegation was particularly concerned to note that newly-arrived inmates accommodated in the "Smart Reception Unit" had no access to any means of diversion whatsoever (TV, radio, books, etc.). Although (as already mentioned) they spent only a few days there (up to a week), this complete lack of any activity is unduly harsh for newly-arrived prisoners who may be particularly vulnerable at the outset of their imprisonment. **The Committee recommends that steps be taken to remedy this *lacuna*.**

77. The situation with respect to activities was even worse for those inmates who were *de facto* in solitary confinement, sometimes for months on end (see paragraph 59). The delegation met such inmates in Batumi, at Prison No. 7 and at "Matrosov Prison". In this context, **reference is made to the comments and recommendation in paragraphs 59 and 124.**

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83 Small (18 to 34 m²) and of an oppressive design: enclosed areas surrounded by high walls topped with a wire mesh, without benches or any other equipment.

84 Almost without exception, those yards were small, bare and of an oppressive design (high walls with sky-view only, topped by a metal grid). Further, some of the yards had no shelter against inclement weather.

85 High-walled concrete areas, measuring some 12.5 m², topped with wire netting and fitted with a bench.

4. Health care

78. At the outset of the visit, the Deputy Minister of Corrections informed the delegation of the steps already taken and still planned as regards the improvement of the quality of the prison health-care services. In particular, it was stressed that the prison health-care budget had increased by 60% in the course of 2013 and by a further 40% in the first half of 2014, while the health-care expenditure per inmate increased by 450%.[86] The Deputy Minister stated that there had been a significant decrease of mortality in prisons[87] and an increase in the proportion of prisoners transferred to hospitals[88]; this had been facilitated by the signing of contracts with 62 civilian hospitals/clinics.

In 2013, the Ministry of Corrections had updated its Strategy for the Reform of Prison Health Care and embarked upon the implementation of a comprehensive 18-month Action Plan comprising 13 strategic objectives. According to the Deputy Minister, the following had *inter alia* been achieved by the time of the CPT's visit: the health-care staff complement in prisons had increased by 30%[89] and the ratio of health-care staff to prisoners had improved dramatically[90]; new health-care units had been set up in 9 establishments and new medical equipment supplied to all prisons; the Gldani Prison Hospital[91] obtained an operating license from the Ministry of Health, Labour and Social Affairs in July 2014, following a comprehensive refurbishment; access to outside specialist consultations for inmates had improved (with approximately 2000 visits by outside consultants in the course of 2013); pharmacies in all prisons had been officially licensed by the above-mentioned Ministry; individual medical files had been introduced in all establishments[92]; regular screening for transmissible diseases was now performed in all prisons[93]; a new TB establishment had opened in Ksani in January 2014; all prisons were now covered by the National Programme for Prevention of Tuberculosis[94], and methadone substitution programme had been introduced in the prison system.[95]

Further, the Ministry of Corrections had initiated a programme of screening, vaccination and treatment for hepatitis C[96] and had begun work on elaborating drug treatment and rehabilitation programmes for prisoners.[97]

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86 Which was made possible by the combined effects of the above-mentioned budget increase and the 60% drop in prison population.

87 From 63 to 25 for every 10,000 sentenced prisoners per year, and in absolute numbers, from 65 in 2012 to 25 in 2013.

88 From November 2012 to March 2014 there had been some 8,200 referrals, as compared with 400 to 1,280 annually before October 2012.

89 Thanks, among others, to a 50% rise in salaries.

90 Throughout the prison system, there was now one doctor per 90 inmates and one nurse per 60 prisoners, not counting the doctors and nurses employed at Gldani Prison Hospital and the TB establishment in Ksani.

91 See paragraphs 99 to 104 below.

92 See paragraph 88.

93 See paragraphs 89 and 90.

94 See paragraph 89.

95 See paragraph 97.

96 See paragraph 90. According to the Ministry, three out of ten prisoners in Georgia had hepatitis C. The plan was to offer voluntary screening to all prisoners, vaccination to up to 5,000 inmates and treatment to up to 1,000. For this purpose, the Ministry had recruited additional staff (15 doctors, including 6 infectious diseases specialists, and 20 nurses).

97 See paragraph 98.

79. The CPT fully acknowledges the important efforts that the Georgian authorities have undertaken in order to improve the facilities, equipment, staffing and supply of medication, and all the other steps taken in implementation of the Strategy for the Reform of Prison Health Care and the Action Plan. It is beyond doubt that the situation in this respect has much improved since the CPT's visits in 2010 and 2012. Having said that, a number of issues of concern remain; they are discussed in paragraphs 80 to 105 below.

a. health-care services in the prisons visited

i. staff, facilities and medication

80. The health-care team at *Prison No. 3 in Batumi* consisted of four full-time doctors (the head doctor – anaesthesiologist by training – and three general practitioners), a full-time pharmacist and several part-time specialists (a dentist working three days per week, a radiologist performing ultra-sound examinations once a week, and a psychiatrist coming twice a week). Other specialists (e.g. a cardiologist, a lung specialist and an intensive care specialist) were available to be called. The prison had signed contracts with three civilian hospitals in town and there were reportedly no problems with arranging transfers of inmates to those hospitals whenever required.

The nursing staff consisted of seven full-time nurses; two further nurses' posts were vacant. The normal working time for the health-care staff was from 10 a.m. to 6 p.m. At night and on weekends, one of the doctors was on call and a nurse was always present in the establishment (ensuring a 24-hour nursing cover).

81. At *Prison No. 7 in Tbilisi*, positive changes to the health-care staff situation had taken place since the visit in 2010: there were now two full-time doctors (the head doctor – a specialist in public health – and an emergency doctor) and four full-time nurses (instead of two in 2010). The nurses provided 24-hour cover. The head doctor was on call during weekends and the emergency doctor worked also on Saturdays until 2 p.m.

Further, there was a part-time pharmacist and a dentist (both coming twice a week). The prison had a roster of consulting specialists (e.g. a dermatologist and a cardiologist) who could be invited in case of need[98], and an ambulance would be called in case of emergency. Transfers to Gldani Prison Hospital and to civilian hospitals in Tbilisi did not appear to pose a problem.

82. The health-care staffing levels had improved significantly at *Gldani Prison*, which now employed 30 doctors[99] (as compared with 19 in 2012) and 48 nurses (17 in 2012). They worked every week day from 10 a.m. to 6 p.m.; in addition, two GPs and a surgeon were on duty at night and on weekends, and there was a 24-hour nursing presence in each accommodation block. The prison was also visited on a weekly basis by a range of specialists (a neurologist, an urologist, a narcologist, a cardiologist, an endocrinologist, a radiologist and an ultra-sound specialist).

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98 Reportedly, they usually came very quickly, within a day at most.

99 Including GPs, surgeons, lung specialists, psychiatrists, dentists and a paediatrician.

83. As regards "*Matrosov Prison"*, the health-care team was composed of the full-time head doctor, four further full-time doctors (a GP, a surgeon, a lung specialist and a dentist), a full-time pharmacist and nine full-time nurses. A 24-hour nursing cover was ensured, including on weekends.

Further, a psychiatrist came once a week and there were several consultant specialists available on call (e.g. an urologist, a neurologist and a radiologist). As could be seen in the relevant registers, transfers to outside hospitals for examinations and treatment were relatively frequent.[100]

84. To sum up, the resources in terms of medical doctors were fully adequate in all the prisons visited, and particularly good at "Matrosov Prison". The same could generally be said of the nurses; however, **the CPT recommends that efforts be made to fill the two vacant posts for nurses at Prison No. 3 in Batumi.**

As regards Gldani Prison, **the current nursing staff complement, though admittedly much higher than in 2012, remains insufficient for the establishment's present population.** It would need to be significantly reinforced were the population to remain at the present level. On the other hand, if the information provided by the establishment's Director is indeed confirmed (see paragraph 65 above) and the population drops following the completion of refurbishment of Prisons Nos. 6 and 16, the existing nursing team will be sufficient.

The CPT is generally satisfied with the access to dental treatment in the prisons visited and the availability of other specialists, both inside and outside the establishments.[101]

85. Regarding the medical facilities and equipment in the prisons visited, these were found to be of a satisfactory level in all the establishments[102] except for Prison No. 3, where all the premises of the health-care service were cramped, poorly ventilated and badly furnished; the delegation also noted the poor standard of dental equipment at this establishment. **The CPT recommends that these failings be remedied**.

The Committee has no concerns regarding the supply of medication in the prisons visited[103]; however, the medication storage at Prison No. 3 was very small and poorly ventilated.

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100 E.g. in September 2014, there had been: one referral to a psychiatric hospital; three consultations with a dermatologist; one with a specialist in infectious diseases; and four outpatient psychiatric consultations. In October 2014, there had been eight consultations with outside psychiatrists and two with an endocrinologist. There had also been five external MRI investigations in 2014.

101 See, however, paragraphs 85 and 91 below.

102 There was no in-patient infirmary at Prison No. 7 but the premises used for consultations had been refurbished recently.

103 All the prisons were systematically provided with medication included in the list drawn up by the Medical Department of the Ministry of Corrections (which comprised some 400 drugs) and prisoners could buy additional medication if they so wished (with the approval of the doctor).

ii. medical screening on admission

86. 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). That said, the delegation was informed at Prison No. 7 that inmates who arrived on Saturday after 2 p.m. would have to wait until Monday morning before being seen by a doctor. **The CPT invites the Georgian authorities to take steps to ensure that medical screening of newly arrived prisoners at Prison No. 7 is carried out systematically within 24 hours from arrival. In the absence of a doctor, such a medical screening could be performed by a nurse reporting to a doctor.**

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).

That said, a number of prisoners interviewed at Gldani Prison told the delegation that the medical screening had been quite superficial; in particular, they had reportedly only been asked to lift their T-shirt or to roll up their sleeves (and not to undress). **The Committee recommends that steps be taken to ensure that the medical screening at Gldani Prison is performed in a thorough manner.**

It was also clear that medical confidentiality was not respected during medical screening in any of the establishments visited, as custodial staff were systematically present and/or had unrestricted access to the rooms where the screening was performed.[104] On this issue, see also paragraph 88 below.

87. The CPT has repeatedly emphasized in the past the role that should be played by prison health-care services in the prevention of ill-treatment.[105]

Doctors in the prisons visited told the delegation (and this was confirmed by most of the prisoners interviewed) that the above-mentioned procedure of medical screening on arrival also involved the screening for injuries. The injuries were recorded in dedicated registers of traumatic lesions[106] and systematically reported to the Penitentiary Department, the Investigation Department of the Ministry of Corrections 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).

The delegation noted that these registers contained more or less detailed descriptions of lesions and brief, standardised mentions of the origins of the injuries as declared by the inmate.[107]

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104 The delegation witnessed this e.g. in Gldani Prison.

105 See paragraphs 41 to 45 of CPT/Inf (2013) 18; paragraphs 23 and 91 of CPT/Inf (2010) 27, and paragraph 16 of CPT/Inf (2007) 42.

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

107 Similar to the manner already described in paragraph 29 i.e. with boxes to be ticked stating as origin: "self-harm", "inflicted by another person", "accidental" or "not specified", as well as "before/during/after apprehension".

However, observations of the health-care staff as to the consistency of the allegations with the medical findings were systematically missing and prison doctors explained to the delegation that they did not consider making such observations as belonging to their tasks.

In the light of the above, **the CPT calls upon the Georgian authorities to take immediate steps to ensure that prison health-care staff receive appropriate training and clear instructions on the drawing-up of medical records. In particular, such records should contain: (i) a detailed account of statements made by the person concerned which are relevant to the medical examination (including his/her description of his/her state of health and any allegations of ill-treatment), (ii) a full account of objective medical findings based on a thorough examination, and (iii) the health-care professional's observations in the light of (i) and (ii), indicating the consistency between any allegations made and the objective medical findings.**

The record should also contain the results of any additional examinations performed, detailed conclusions of any specialised consultations and an account of treatment given for injuries and of any further procedures conducted.

The recording of the medical examination in cases of traumatic injuries should be made on a special form provided for this purpose, with "body charts" for marking traumatic injuries that will be kept in the medical file of the prisoner. If any photographs are made, they should be filed in the medical record of the inmate concerned. This should take place in addition to the recording of injuries in the special trauma register.

Reference is also made to the recommendation in paragraph 29 above and to the comments in paragraph 18.

The results of the examination should also be made available to the prisoner concerned and his or her lawyer.

iii. medical records and confidentiality

88. There were individual medical files for prisoners in all the establishments visited, and they seemed to be generally well kept. The CPT welcomes this positive development.

However, as in the past, medical confidentiality was not respected as the files and other medical documentation were accessible to non-medical custodial staff (except in Batumi and at Prison No. 7). Furthermore, medical consultations and examinations generally continued to take place in the presence of custodial officers[108]; this was of particular concern as regards the medical screening on arrival and the recording of injuries (see paragraph 86 above). **The CPT 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.**

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[108] It was also the case at Gldani Prison Hospital, with the exception of consultations by the psychiatrist and the psychologist.

iv. transmissible diseases

89. As already mentioned (see paragraph 78 above), at the outset of the visit the delegation was informed that all prisons were now covered by the National Programme for Prevention of Tuberculosis and that, as a result, the TB prevalence in the prison system had been reduced by 52% since 2012.[109] The number of TB-related deaths had also reportedly diminished significantly.

Indeed, systematic TB screening on arrival[110] (and subsequently in regular and frequent intervals[111]) 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 newly re-opened TB establishment in Ksani (see paragraph 78). The CPT welcomes these very positive developments, which are particularly appreciated when compared with the situation observed in the past.[112]

90. Tangible progress had also been achieved as regards hepatitis C[113]: all newly-arrived prisoners were tested for the presence of this virus (with their prior written and informed consent) and, since recently, appropriate treatment was being offered to them.[114] For example, at the time of the visit, 80 inmates were receiving such treatment at Prison No. 3 and six at Prison No. 7. This too is to be welcomed.

Voluntary screening for HIV was also available in the prisons visited, and those found to be seropositive were offered counselling and antiretroviral therapy (e.g. there were two such prisoners at Prison No. 3).

v. psychiatric and psychological care

91. The provision of psychiatric care to prisoners had improved since the 2012 visit, with all prisons now being visited by psychiatrists on a regular basis (at least once a week, but more frequently in Gldani[115] and Batumi); however, the delegation heard some complaints from inmates about long delays (reportedly up to 3 months) in access to a psychiatrist at Prison No. 3, and observed that there was a lack of therapeutic options other than pharmacotherapy in all the prisons visited (despite the presence of psychologists).

As already mentioned in paragraph 70, the new admission procedure applied at Gldani Prison involved the participation of psychiatrists and psychologists in the evaluation of the condition and treatment needs of newly-arrived inmates. The delegation was also told (and was able to verify) that the provision of psychotropic drugs was now adequate in all the prisons visited.

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109 82 new TB cases (including 8 cases of multi-drug resistant TB) had been detected in prisons in 2014 (until 1 December) as compared with 801 (including 68 cases of MDR-TB) in 2012.

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

111 E.g. a mobile X-ray was brought to Prison No. 3 every two months.

112 For example, during the visits in 2007 (paragraph 81 of CPT/Inf (2007) 42), 2003/4 (paragraphs 118 to 120 of CPT/Inf (2005) 12) and 2001 (paragraphs 109 to 113 of CPT/Inf (2002) 14).

113 See also paragraph 78 above.

114 Interferon weekly and Ribavirin daily.

115 In addition, Gldani Prison could rely on specialists from the adjoining Prison Hospital, see paragraph 94.

These are positive developments, which are particularly important given the presence of a certain number of inmates with psychiatric or psychological problems in all the prisons visited[116], and the frequency of incidents of self-harm[117] and suicide attempts (see paragraph 96 below).

The importance of appropriate access to psychiatric assistance was well illustrated by the situation of A at Prison No. 7 (see paragraph 58). His case also demonstrates that transferring mentally ill prisoners to appropriate medical facilities can still be difficult, despite the general improvement in this respect (especially as concerns transfers to the psychiatric ward of Gldani Prison Hospital, see paragraph 101).

92. **The CPT recommends 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 at Prison No. 3 in Batumi (shorten the waiting time for consultations);**

- **consider applying the new admission procedure at Gldani Prison (described in paragraph 91) to all other prisons in Georgia;**

- **offer some therapies other than medication and provide some therapeutic activities, with the active involvement of psychologists working in prisons;**

- **ensure that all mentally ill prisoners who require in-patient psychiatric treatment are transferred without delay to appropriate hospital facilities** (see also paragraph 58).

93. At the outset of the visit, the delegation was informed by senior officials of the Ministry of Corrections of the existence of plans to build a new mental health centre for inmates in 2016/17. **The Committee would like to receive more detailed information on these plans, including the planned capacity of the new establishment, its location, staff, referral procedure and the exact time-line for implementation.**

94. At Gldani Prison, the delegation saw (in the new admission unit, see paragraph 66) three so-called "de-escalation rooms", which were supposed to serve for temporary placement of prisoners who had become agitated/aggressive or may attempt to harm themselves. The rooms had been in service for two months but had not yet been actually used. The delegation was told that prisoners could only be placed in them upon recommendation of a medical doctor, and that the stay in them would be limited to a maximum of four days.

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116 For example, the delegation was informed by the head doctor at Prison No. 3 that 45 prisoners were on psychiatric medication, some of them for a long time. In the two months preceding the delegation's visit, six prisoners had been referred for hospitalisation in a psychiatric establishment because of serious mental disorders.

117 Self-harm was resorted to particularly frequently at Prison No. 7 and, to a lesser extent, at Prison No. 3 (e.g. over 20 cases of self-harm in 2013). The delegation itself saw inmates who had recently cut their arms, legs and other parts of their bodies in both prisons, some of them (including four at Prison No. 7 and eight at Prison No. 3) with relatively serious injuries. See also paragraphs 59 and 126.

A multi-disciplinary team would be responsible for supervising and assisting the prisoners placed in the "de-escalation rooms". This would involve constant supervision by custodial staff permanently seated in the corridor in front of the room, with direct visual contact with the inmate (through a window next to the door). The procedure also required regular (daily) visits by a doctor, psychiatrist and/or psychologist, and the keeping of a dedicated register where such visits and any observations made would be recorded.

The CPT has some misgivings about the very purpose of setting up the "de-escalation rooms" and the above-mentioned procedure, especially as regards the role of a doctor. The way it was explained to the delegation, an impression could be created that doctors were supposed to authorise placement in seclusion on security grounds, which would be unacceptable for the Committee. In the CPT's view, the doctor's involvement in such a context should be to get informed by custodial staff immediately after the placement and to see the inmate as soon as possible, in order to check whether there are grounds to transfer the prisoner to a psychiatric establishment. **The Committee would like to receive clarification of this point from the Georgian authorities.**

Furthermore, the current maximum time-limit for placement in a "de-escalation room" (four days) is way too long. It should preferably be limited to a few hours and, in any event, not more than 24 hours. **The CPT recommends that the relevant provisions be amended accordingly.**

95. The conditions in the "de-escalation rooms" could be considered as adequate on the whole (the rooms measured approximately 9 m² each, were well lit and ventilated, equipped with a mattress placed on the floor and a stainless steel toilet and sink, as well as CCTV which did not cover the toilet area). However, the delegation noted the presence of a number of sharp edges in the rooms (window sills, toilets and washbasins), which could be potentially dangerous for the prisoners placed in them. **The Committee recommends that these deficiencies be remedied.**

96. According to the information provided by the Ministry of Corrections, suicide prevention programmes had been launched in five prisons[118] in the beginning of 2014, and it was planned to expand these programmes in the near future to the female prison and to the strict-regime Prison No. 6 in Rustavi. This was deemed important by the Ministry, given that suicides and suicide attempts were considered a serious problem affecting the Georgian prison system.[119]

At Gldani Prison, the delegation was told by the Director that 88 inmates were covered by the programme and that its introduction had had an obvious positive impact as no successful suicide had taken place in his establishment following the programme's launch.[120]

The CPT welcomes the introduction and planned enlargement of the scope of implementation of the suicide prevention programmes in Georgian prisons. **It would like to receive more detailed information on the precise content of these programmes and on whether it is planned to extend these programmes to all penitentiary establishments.**

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118 Prisons Nos. 2 and 3, Gldani Prison, the juvenile establishment in Avchala and the TB establishment in Ksani.

119 Senior officials of the Ministry of Corrections informed the delegation that six inmates had committed suicide in 2013 and seven in 2014 (until 1 December). There had been 242 suicide attempts in Georgian prisons during the period between 1 January and 1 December 2014 (including four at Prison No. 3 in Batumi). See also paragraph 126.

120 There had been one suicide at Gldani Prison in 2013.

vi. drug addiction

97. The Georgian authorities acknowledged from the outset that addiction to illicit drugs and other intoxicating substances (such as alcohol[121]) 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.[122]

The delegation noted that a methadone detoxification programme was proposed to inmates at Gldani Prison (it was followed by 66 prisoners at the time of the visit); however, as far as the delegation could ascertain, nothing of the kind was available in the other prisons visited. 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 no specific psycho-socio-educational assistance.

98. The CPT wishes to stress again that the management of drug-addicted prisoners must be varied – combining detoxification, psychological support, socio-educational programmes, rehabilitation and substitution programmes – and linked to a real prevention policy. This policy should 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 co-operate closely with the other (psycho-socio-educational) staff involved.[123]

In this context, the delegation has noted with interest the information provided at the outset of the visit, according to which an independent expert group (comprising psychiatrists, neurologists, pharmacologists and psychologists), set up in the spring of 2014, was in the process of elaborating new drug treatment and rehabilitation programmes for prisoners. The delegation was also told that a new methadone programme was to be launched in prisons, in co-operation with the Ministry of Health, Labour and Social Affairs, before the end of 2015.

The Committee would like to receive more information on this subject, including the time-line for the implementation of the new programmes. In this context, **the CPT also recommends that the Georgian authorities take duly into account the Committees remarks set out above.**

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121 It is interesting to mention here that the incident of 12 November of 2014 at Gldani Prison (see paragraphs 51 and 17) was reportedly related with the production and consumption of alcohol (the so-called "braga") by prisoners.

122 E.g. the psychiatrist at Prison No. 3 estimated that about 60 to 70% of the inmates accommodated in the establishment were drug addicts.

123 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.

b. Prison Referral Hospital No. 18 (Gldani Prison Hospital)

99. Gldani Prison Hospital, visited by the CPT in 2010 and 2012[124] and located within the secure perimeter of Gldani Prison, had undergone substantial refurbishment completed in mid-2014. With an official capacity of 146 beds, the hospital was accommodating 82 patients (including 19 on remand and three women) at the time of the visit.[125] The three-storey facility was divided into several wards following the pattern already described in the report on the CPT's 2010 visit.[126] The hospital had a nationwide coverage as regards in-patient care, and catered for Tbilisi and Eastern Georgia as regards out-patient care.

The staff comprised 61 doctors, 68 nurses and a number of external specialists (in neurology, haematology, ophthalmology, ENT, etc.) who regularly held surgeries at the hospital. In case of need, inmates could also be transferred to other (civilian) hospitals.

The medical equipment and supply of materials was adequate, and there was no shortage of medication. To sum up, the level of healthcare appeared to be satisfactory.

100. That said, it became apparent that the allocation of patients into different rooms throughout the establishment was left to the discretion of the head of security department, without any input from the medical staff. As a result, in some wards rooms were empty whereas other rooms were filled to capacity. Further, and even more of concern, the delegation came across cases of accommodating in the same room patients recovering from recent surgery with those suffering from infectious diseases; this is a potentially dangerous practice. **The CPT invites the Georgian authorities to ensure that the allocation of patients into rooms at Gldani Prison Hospital takes place in full consultation with the medical staff**.

101. The delegation paid particular attention to the psychiatric ward, which had 24 beds and held 22 patients at the time of the visit. The ward's staff comprised four psychiatrists, one medical psychotherapist, one psychologist, six nurses, four orderlies (including one vacant post) and two social workers.[127] There was no occupational therapist. The delegation was informed that four more post of orderlies would be added as of January 2015 and would soon be filled.

The treatment offered to psychiatric patients was essentially based on pharmacotherapy, and there was also some cognitive behavioural therapy. The supply of medication was adequate and included psychotropic drugs of newer generation. There was no common room nor were there any organised activities. In short, psychiatric patients were confined to their rooms for some 23 hours a day with no other occupation but reading books.

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124 See paragraphs 99 to 104 of CPT/Inf (2010) 27, and paragraph 49 of CPT/Inf (2013) 18.

125 There were also six patients undergoing treatment in civilian hospitals.

126 There were different wards (diagnostic, surgery, psychiatry, internal medicine, chronic/long-term care, and infectious diseases) and several other units (an admission unit, an X-Ray unit, a dental office, a laboratory, rooms for endoscopy and physiotherapy, and a pharmacy).

127 These numbers (as concerns doctors and nurses) are included in the total numbers mentioned in paragraph 99 above.

The CPT reiterates its recommendation that steps be taken on the psychiatric ward of Gldani Prison Hospital to develop a broader range of psycho-social therapeutic activities for patients, in particular for those who remain in the ward for extended periods; occupational therapy should be an integral part of the rehabilitation programme. In this context, consideration should be given to recruiting an occupational therapist.

102. The psychiatric ward had six outdoor exercise yards of an oppressive design, equipped with one or two benches each, surrounded by high walls topped with metal wiring and fitted with a shelter against rain and sun. Armed perimeter guards were posted above the yards and the whole area was covered by the CCTV. That said, none of the patients from the psychiatric ward interviewed by the delegation did confirm having been offered outdoor exercise.

The Committee recommends that steps be taken to ensure that psychiatric patients have daily access to outdoor exercise; efforts should also be made to improve the design of the exercise yards, in the light of the above remarks.

103. The delegation was informed that seclusion was not practiced on the psychiatric ward and that, since the re-opening of the establishment, patients were no more subjected to physical restraint in their rooms. In case of need, they could be restrained in a separate room equipped with a restraint bed (with a mattress to prevent pressure sores), CCTV and a nurse's chair next to the bed. The room had reportedly never been used.[128]

Indeed, none of the patients interviewed by the delegation reported any resort to physical restraint on the ward. That said, **the CPT reiterates its recommendation that a specific register for recording every instance of restraint (both physical and chemical) of a patient be introduced on the psychiatric ward**.

104. Patient's rooms (on all the wards) accommodated one to four patients each and were not overcrowded. Access to natural light and artificial lighting was adequate and so was the ventilation. Rooms were in a good state of repair and cleanliness. All rooms, but those of the psychiatric ward, had recently been equipped with TV sets and radios. The delegation was informed that the psychiatric ward was soon to also benefit from such equipment; **the Committee would like to receive confirmation that this has now happened.**

On the whole, the patients' rooms on the psychiatric ward offered an austere environment, with nothing but the beds and either bedside tables or tables, and sometimes shelves. **The CPT recommends that steps be taken to provide a more congenial and personalised environment on the psychiatric ward of Gldani Prison Hospital.**

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[128] The restraint room had been set up following the refurbishment of the hospital, i.e. after June 2014.

105. Finally, the CPT understands that there had been some progress in the implementation of the long-standing plan for the transfer of prison health care to the Ministry of Labour, Health and Social Affairs, although a precise date of this transfer was still unknown. In the light of the observations made by the delegation in the course of this visit, and especially in the context of the incident of 12 November 2014 referred to in paragraphs 51 and 17, the CPT is of the view that such a transfer would certainly help increase the professional independence of prison health-care staff. Therefore, **the Committee strongly encourages the Georgian authorities to proceed with concrete preparations for the transfer of prison health care, comprising precise deadlines.**[129]

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

a. prison staff

106. The staffing situation in the establishments visited varied. While it was quite good at "Matrosov Prison"[130] (having in mind, however, the fact that the establishment was operating at a fraction of its "normal" official capacity), it was much less favourable at Gldani Prison[131] and quite poor at Prisons No. 3[132] and No. 7.[133] It is noteworthy that these figures do not include staff responsible for perimeter security, who were employed by the Ministry of Defence.

Overall, the conclusion reached on previous visits[134] that the staffing levels in prisons are too low (especially if the CPT's recommendations concerning the development of regime and activities were to be implemented), remains valid. Further, such staffing levels diminished the possibility of direct contact with prisoners, impeded the development of positive relations and generated an insecure environment for both staff and prisoners (see also paragraph 108 below).

At the outset of the visit, the Deputy Minister of Corrections told the delegation about the authorities' ongoing efforts to increase prison staffing levels.[135] In the light of the above, **the CPT calls upon the Georgian authorities to step up these efforts.**

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129 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.coe.int/T/DG3/Pompidou/Source/Activities/Prisons/Strasbourg-Conclusions-on-Prisons-and-Health.pdf.

130 The whole staff complement was of 100 persons, including 44 custodial officers. There were 8 vacant posts. It should be stressed that 17 further staff, administratively attached to the prison, were actually deployed in the Penitentiary Establishment No. 12 (located in the nearby Ortachala district of Tbilisi).

131 Despite the fact that Gldani Prison was accommodating slightly more inmates than the last time it had been visited by the CPT (in November 2012), the number of posts had remained virtually unchanged (373) although there were only a few vacancies (as compared with almost 40 in 2012); the Director stressed that 45 of the staff members had been recruited recently.

132 86 staff in total, including 48 custodial officers, and three vacant posts.

133 45 staff in total.

134 See, for example, paragraph 106 of CPT/Inf (2010) 27 and paragraph 50 of CPT/Inf (2013) 18.

135 He said that there had already been a 12% increase in staffing level as compared with 2011.

107. Further, the delegation again noted the absence of female custodial officers in the prisons visited, except in the units for women. Two female custodial officers worked at the female unit of Prison No. 3, with one more post remaining vacant. It is noteworthy that the two female officers complained of heavy workload due to the above-mentioned vacancy.

In view of the potential benefits of mixed-sex staffing for the general atmosphere prevailing within prisons, **the CPT recommends that the Georgian authorities adopt measures to favour the deployment of female staff throughout the Georgian prison system; in particular, mixed-sex staffing should be ensured in units for juveniles.**

Further, **it is crucial that any unit holding female prisoners has female custodial staff in sufficient numbers at all times.** In this context, **urgent steps should be taken to fill in the vacant post at Prison No. 3 in Batumi.**

108. Many directors, management-level staff but also rank-and-file custodial officers in the prisons visited had been recruited relatively recently (in the two years preceding the visit) and were often former police officers, with no previous prison experience.[136] It was clear that this did not make it easier for them to cope with the difficult situation in prisons and tensions between prisoners and staff (see paragraph 54 above).

This situation only underscores further the importance of proper initial and ongoing training, both for the management and the rank-and-file staff, especially in communication skills, risk assessment in a security context, dynamic security and dealing with agitated/aggressive prisoners. In this context, the delegation was told at the outset of the visit that there were plans to increase the financial and human resources of the Penitentiary and Probation Training Centre. It was also planned to carry out comprehensive retraining of all currently serving prison staff (no later than by September 2016). **The CPT would like to receive more detailed and up-to-date information on these plans.** More generally, **the Committee recommends that efforts to improve the initial and ongoing training for prison staff be stepped up, paying particular attention to the above-mentioned aspects** (see also the recommendations in paragraphs 53 and 57 above)**.**

As regards the newly-recruited management-level staff (including prison Directors), the CPT must again stress that the task of managing a prison is a complex one, requiring adequate skills, profile and experience. The importance of leadership provided by prison management is also stressed in the European Prison Rules.[137] The current practice of recruiting former police officers as prison managers does not seem to be in accordance with the above principles. **The Committee invites the Georgian authorities to review the current recruitment policy, in the light of the above remarks.**

109. The Ministry of Corrections has announced plans to draft a special Act on Penitentiary Service Staff. In this context, it was *inter alia* envisaged to draw up precise selection criteria and job descriptions per position. **The CPT would welcome more detailed and updated information on this issue, including the expected dates of adoption and entry into force of the new law.**

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136 According to senior officials from the Ministry of Corrections, all prison Directors and approximately 40% of all prison staff had been replaced since the November 2012 visit. Many (if not most) came from the various agencies of the Ministry of Internal Affairs.

137 Rule 84.1.

b. "special means"

110. Amendments to the Imprisonment Code, in force as from May 2014[138], extended significantly the catalogue of authorised "special means" in prisons. To the previously authorised handcuffs, straitjackets and firearms, the new Section 57[1] of the Code added restraining chairs, restraining beds, truncheons, teargas, pepper spray, non-lethal weapons (tasers), acoustic means, light and sound equipment for psychological impact, water cannons, and dogs. The Public Defender and NGOs expressed concern about this excessively wide catalogue of "special means" (in particular pepper spray, teargas and non-lethal weapons including tasers) and too vague rules on their application.

It should be stressed that, at the time of the visit, the only means reportedly available in the prisons visited were handcuffs.[139] The Director of Prison No. 3 informed the delegation that truncheons had just been delivered to his establishment but not yet issued because staff needed to be trained in their use first.

111. The CPT has serious concerns about many of the "special means" enumerated in Section 57[1] of the Imprisonment Code. Regarding *straitjackets*, the Committee considers that they should never be used in a prison setting, *inter alia* because of their humiliating and stigmatising impact on the prisoners and staff alike. **Straitjackets should be removed from the catalogue of "special means" enumerated in Section 57[1] of the Imprisonment Code.**

Concerning *firearms*, the CPT has repeatedly emphasised that their carrying by staff in direct contact with prisoners is an undesirable and dangerous practice, which could lead to high-risk situations for both prisoners and staff.[140] Further, every discharge of a firearm by a prison officer should not only be recorded but also be the subject of a comprehensive report and, if necessary, a thorough and independent investigation.

Teargas and *pepper spray* are potentially dangerous and should not be used in confined spaces. Further, if exceptionally they need to be used in open spaces, there should be clearly defined safeguards in place. For example, persons exposed to them should be granted immediate access to a medical doctor and should be supplied immediately with means to reverse the effects effectively and rapidly. They should never be deployed against a prisoner who has already been brought under control. Further, they should not form part of the standard equipment of a prison officer.

The use of *tasers* can only be justified as a means of last resort in very extreme circumstances where a real and immediate threat to life has arisen. Moreover, only specially selected and trained prison officers should be allowed to use them, and all necessary precautions should be taken when such equipment is used. There should be no question of tasers being standard issue for staff working in direct contact with prisoners.

The CPT recommends that the rules and regulations concerning the use of firearms, teargas, pepper spray and tasers in a prison setting be amended accordingly.

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138 Implemented by the Minister of Corrections Order No. 145/2014.

139 See, however, the allegations of use of ankle-cuffs and chains at Gldani Prison (paragraphs 51 and 17).

140 Reference should also be made to Rule 69.1 of the European Prison Rules which states that "[e]xcept in an operational emergency, prison staff shall not carry lethal weapons within the prison perimeter".

112. Regarding the other "special means" (allowing physical immobilisation, such as *restraining chairs and beds*), the approach to their use should take into consideration the following principles and minimum standards:

- Regarding its appropriate use, immobilisation should only be used as a last resort to prevent the risk of harm to the individual or others and only when all other reasonable options would fail satisfactorily to contain those risks; it should never be used as a punishment or to compensate for shortages of trained staff; it should not be used in a non-medical setting when hospitalisation would be a more appropriate intervention.

- Any resort to immobilisation should always be immediately brought to the attention of a doctor in order to assess the need for the measure, as opposed to certifying the individual's fitness for it.
- The equipment used should be properly designed to limit harmful effects, discomfort and pain during immobilisation, and staff must be trained in the use of the equipment.

- The duration of immobilisation should be for the shortest possible time (usually minutes rather than hours). The exceptional prolongation of immobilisation should warrant a further review by a doctor. Immobilisation for periods of days at a time cannot have any justification and would amount to ill-treatment.

- As regards supervision, whenever a prisoner is subjected to immobilisation, a trained member of staff should be continuously present in order to provide assistance. Such assistance may include escorting the prisoner to a toilet facility or helping him/her to drink/consume food.

- Prisoners subject to immobilisation should receive full information on the reasons for the intervention.

- The management of any establishment which might use immobilisation should issue formal written guidelines, taking account of the above criteria, to all staff who may be involved.

A special register should be kept to record all cases in which recourse is had to immobilisation; the entry should include the times at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the person who ordered or approved it, and an account of any injuries sustained by the prisoner or staff.

Further, the inmate concerned should be given the opportunity to discuss his/her experience, during and, in any event, as soon as possible after the end of a period of immobilisation. This discussion should always involve a senior member of the health-care staff or another senior member of staff with appropriate training.

The Committee recommends that the relevant provisions on the use of restraining chairs and beds be amended and completed in the light of the above-mentioned principles and standards. More generally, **the CPT wishes to stress that, in principle, restraining chairs and beds should not be used in a non-medical setting.**

113. As for the *acoustic means, light and sound equipment for psychological impact, and water cannons*, these are means that are typically used in crowd-control situations and should not be used in confined spaces, especially inside the cells and accommodation blocks in prisons. Their limited use could be imagined only in open surfaces (outdoors), in case of mass riots. In any event, **there should be proper staff training, recording (including the systematic video-recording) and reporting procedures concerning their use, as in the case of all the other means enumerated in Section 57[1] of the Imprisonment Code.**

Finally, the CPT understands (after receiving explanations by the Deputy Minister of Corrections) that *dogs* would never be used in prisons in any other context than for cell and drug searches, without direct contact with the inmates. **The Committee would like to receive confirmation that this is the correct understanding of the current rules.**

c. contact with the outside world

114. Since the 2012 visit the Imprisonment Code has been amended, extending the prisoners' rights to visits and correspondence[141], introducing long-term visits (lasting up to 24 hours)[142], family visits for female sentenced prisoners (lasting up to 3 hours)[143] and video visits.[144] Naturally, the CPT welcomes these amendments; however, the situation observed on the ground in the prisons visited was quite different and continued to give rise to the Committee's serious concern.

115. Above all, remand prisoners continued to require prior authorisation by the competent investigating authority or court to receive a visit and, in practice, such authorisation was granted only in very exceptional cases (at least for as long as the prisoner's case was still under investigation). This meant that remand prisoners were deprived of visits for periods that could vary from several months to even years.[145] Further, remand prisoners continued to be banned from making phone calls and sending and receiving letters.

The CPT calls upon the Georgian authorities to amend the Imprisonment Code and to ensure in practice that remand prisoners benefit, as a rule, from the same entitlement to contact with the outside world as sentenced inmates on general regime; any prohibition of visits, phone calls and correspondence for remand prisoners must be specifically substantiated by the needs of the investigation, require the approval of a body unconnected with the case at hand, and be applied for a specified period of time, with reasons stated. Further, **the decision concerning prohibition should be made available to the person concerned and his/her lawyer.**

141 See *inter alia* Sections 14 (1), 16 (1), 62, 63, 65, 66, 70 and 72 of the Code.
142 Section 17[1].
143 Section 17[3].
144 Section 17[2].
145 See paragraph 59 above and paragraph 124 below.

116. As for the sentenced prisoners, despite the Committee's long-standing recommendations, their visiting entitlement continued to depend on their regime and on whether the inmate had been sentenced for the first time or was a repeat offender (e.g. two visits a month for prisoners serving their sentences under a general regime; one visit a month for those subjected to a strict regime).[146] In practice, for most of the inmates the entitlement was *de facto* of one 2-hour visit per month.[147] The visiting arrangements remained totally inadequate; visits 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.

Theoretically, inmates could also receive two long visits per year. However, this was impossible in practice at Prisons No. 7 and No. 9 because of the lack of appropriate visiting facilities.

Access to a telephone for sentenced prisoners[148] varied from one establishment to another: for example, at Prison No. 7 prisoners could make three phone calls per month of up to twenty to thirty minutes, while at Prison No. 3 in Batumi the maximum allowed duration of a call was 15 minutes.[149]

117. The CPT wishes to stress once again that a system under which the extent of a prisoner's contact with the outside world is determined as part of the sentence imposed is fundamentally flawed. In principle, all sentenced prisoners should have the same possibility for contact with the outside world. **The Committee calls upon the Georgian authorities to amend the legislation and change the practice concerning sentenced prisoners' entitlement to visits, in the light of the above remarks and taking into consideration Rule 24.1 of the European Prison Rules. The entitlement of one visit per month is not sufficient to enable a prisoner to maintain good relations with his family and should be substantially increased (preferably to the equivalent of at least one hour every week).**

The CPT also 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.

Further, **the Committee recommends that all prisons be equipped with suitable long-term visiting premises.**

Finally, **the CPT reiterates its recommendation that the Georgian authorities take steps to improve sentenced prisoners' access to a telephone.**

118. As already mentioned in paragraph 59, in some cases restrictions on visits, phone calls and correspondence were combined with *de facto* solitary confinement and a ban on access to media, which resulted in conditions that could be considered as amounting to inhuman and degrading treatment. In this respect, **reference is made to the recommendation in paragraph 59.**

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146 An additional visit could be granted by the prison Director as a reward for the inmate's good behaviour.

147 Many inmates interviewed at Prison No. 7 stated that, in practice, visits usually lasted no more than an hour.

148 Inmates had to buy pre-paid phone cards in the prison shop.

149 An additional phone call could be granted as a reward, and inmates could request the permission to replace a short-term visit with a call.

d. discipline and solitary confinement

119. Amendments, introduced to Section 82 of the Imprisonment Code after the 2012 visit, have added restrictions/bans on visits, phone calls, correspondence and access to media (TV/radio) to the catalogue of disciplinary sanctions. In this context, the CPT 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 above-mentioned amendments are of particular concern because in some cases[150] their application resulted in prisoners being subjected to a regime akin to solitary confinement for prolonged periods.[151] **The Committee recommends that the Imprisonment Code be amended in the light of these remarks.**

At the time of the visit, the provision allowing an additional sanction of disciplinary (administrative) arrest (counted in addition to the sentence) of maximum 60 days at a time[152] was still in force. That said, the delegation was informed of plans to amend the Imprisonment Code so as to limit the application of this sanction only to inmates in closed and high-security prisons.

While such an amendment would no doubt be a step in the right direction, the CPT is of the view that, similar to what is being considered with regard to the sanction of administrative arrest as foreseen in the Code of Administrative Offences (see paragraph 24 above), **the Georgian authorities should reflect upon the possibility of abolishing the above-mentioned sanction altogether.**

The delegation was also informed at the outset of the visit that it was envisaged to reduce the maximum duration of disciplinary solitary confinement from 20 to 14 days. The Committee can only encourage these plans, which would bring the Georgian legislation in this respect into conformity with the CPT's standards. **The Committee would like to receive confirmation, in due course, that the above-mentioned amendment has been adopted and entered into force.**

120. Recourse to formal disciplinary sanctions varied in the prisons visited. It was rare at "Matrosov Prison" (only three cases in 2014)[153] and did not appear excessive at Prison No. 3[154] and at Gldani Prison[155], although the application of disciplinary sanctions was on the rise (as a possible indication of the administration's efforts to regain full control of the prisons).[156]

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150 See paragraphs 59 and 120.

151 E.g. C. had had no visits and phone calls for approximately 2 years, and E. for some 6 months.

152 Maximum 90 days within a given year.

153 There had been 10 cases in 2013, in which restrictions had been imposed on access to the radio/TV, telephone calls and access to the prison shop, but not on visits. The sanction of disciplinary solitary confinement was not applied at "Matrosov Prison" (see also paragraph 122 below).

154 52 placements in disciplinary solitary confinement since May 2014, usually up to a week.

155 As regards the year 2013, there had been 337 placements in disciplinary solitary confinement (out of the total of 664 disciplinary sanctions). The duration of placement was mostly between 5 and 15 days. From 1 January 2014 to 30 March 2014, there had been 189 disciplinary sanctions in total.

156 For example, at Gldani Prison, there had been 80 cases of disciplinary solitary confinement in the period from 1 January to 30 March 2014, whereas during the corresponding period in 2013 there had been only 39 placements. As regards Prison No. 3 in Batumi, there had been only 20 placements in disciplinary solitary confinement during the two-year period between May 2012 and May 2014.

By contrast, the delegation was struck by the excessive recourse to disciplinary sanctions (such as bans on visits, telephone calls, parcels, shopping, radio and TV) at Prison No. 7, with most inmates being subjected to such long-lasting (up to 6 months) and repeated sanctions, including as from the very day of their admission to the establishment. The delegation was also puzzled by what appeared to be relatively minor grounds for such extreme measures (e.g. speaking loudly).

The delegation could not escape the impression that this was being made with the purpose of additionally punishing the prisoners and exerting psychological pressure on them.

In the CPT's view, the current system of disciplinary punishments (especially, but not exclusively, at Prison No. 7) contributes to further escalate certain existent problems and tensions between the administration and prisoners; it is not surprising in this context that some prisoners go on hunger strike or resort to self-harm.

In addition, depriving prisoners who are already subjected to a very restrictive regime of the little that they are entitled to raises issues that could be analysed under Article 3 of the European Convention of Human Rights.[157] **The Committee recommends that the current practice with regard to disciplinary sanctions at Prison No. 7 (and, as applicable, in other penitentiary establishments in Georgia) be reviewed in the light of the above remarks (see also the recommendations in paragraphs 115 and 117 above).**

121. The disciplinary procedure was described in detail in previous reports[158]; it had remained generally satisfactory and so had the relevant documentation in the prisons visited.

However, the overwhelming majority of prisoners interviewed by the delegation (who had been or were being subjected to a disciplinary sanction) complained that the formal procedure had not been respected in practice. In particular, there had allegedly been no oral hearing, the inmates had had no opportunity to explain their version of events, had not been informed of the grounds and duration of the sanction, and had not been told of the right to have legal representation and to appeal the sanction; further not a single prisoner confirmed having been given a copy of the decision in writing.[159] **The CPT recommends that steps be taken to ensure that the formal disciplinary procedure is effectively applied in all prisons.**

122. As already mentioned, there was no "kartzer" (disciplinary cell) at "Matrosov Prison" and the one at Prison No. 7 had not been used for at least two years (according to the prison's Director and the relevant records). Quite rightly, staff at Prison No. 7 commented that it was pointless to use the "kartzer" since the stay in the prison as such was already a punishment.

As for conditions in the disciplinary cells in the two other establishments visited, the cells at Gldani Prison had remained as described in the previous reports[160] and conditions in them were generally acceptable. The same could be said of the "kartzers" at Prison No. 3 (they measured approximately 8 m² each, were well lit and ventilated and equipped with a bed, a table, a bench, a toilet, a washbasin and a call system).

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157 See also paragraphs 59, 118 and 126.

158 See e.g. paragraph 113 of CPT/Inf (2010) 27.

159 It is interesting to note that, in the relevant documentation, the entry concerning the provision of a written copy of the decision contained almost always the following comment by staff: "refused to sign" [to confirm receipt].

160 See e.g. paragraph 117 of CPT/Inf (2010) 27.

123. Concerning the regime for prisoners placed in disciplinary cells, the delegation heard complaints from inmates at Prison No. 3 and Gldani Prison about lack of access to outdoor exercise, shower and reading matter. Further, as in the past, inmates placed in a "kartzer" were automatically deprived of contact with the outside world. **The CPT calls upon the Georgian authorities to take steps to remedy the above failings.**

124. As already mentioned (paragraph 59), a number of prisoners at Prisons No. 3, 7 and 9 were *de facto* subjected to solitary confinement, on the grounds either related with the ongoing investigation or (more frequently) security requirements[161], for prolonged periods (several months and even up to 2 years).

For example, seven inmates were held in solitary confinement on the day of the visit at Prison No. 7 (including all the three lifers). As mentioned in paragraph 59, the decisions and procedures to place those inmates in solitary confinement (especially on security grounds) were lacking clear criteria, grounds and transparency[162], and no appropriate procedural safeguards were applied.

On this issue, the CPT wishes to refer to its well-established body of standards, set out in its 21st General Report[163], and **recommends that the law and practice in Georgia be changed accordingly.**

e. complaints and inspection procedures

125. The Committee will not describe here in detail the possibilities for prisoners to send confidential complaints to outside authorities. Suffice it to say that it was in all respects identical with that already described in paragraph 119 of the report on the 2010 visit, i.e. generally satisfactory albeit with one important reservation: prisoners were reluctant to make use of the available complaints procedures, out of fear of possible reprisals. **The CPT calls upon the Georgian authorities to take immediate steps to ensure that prisoners who make use of the complaints procedures are not punished for having done so; further, the confidential character of such complaints must be respected by the prison administration.**

Similarly, the situation was quite good as regards inspection procedures, penitentiary establishments being visited frequently by staff of the Public Defender's Office and/or members of the NPM team (see paragraph 11).[164]

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161 Mostly due to their attitude/behaviour, but sometimes also reportedly for their own security.

162 For example, decisions taken by the Penitentiary Department were "secret", with the reasons unknown even to the prison Directors.

163 Paragraphs 53 to 64 of CPT/Inf (2011) 28, http://www.cpt.coe.int/en/annual/rep-21.pdf. The relevant paragraphs are reproduced in Appendix II to this report.

164 The delegation met some of the NPM staff when visiting Prison No. 7.

126. However, in the light of the delegation's findings already referred to in paragraphs 54 and 120 above, it is clear that the internal complaints system was not operating well in the Georgian prisons. Most inmates expressed distrust and disillusionment in the formal procedure (as described in the report on the 2010 visit) and felt that they had no other means to have their grievances heard by the administration than by resorting to extreme measures, such as self-harm and hunger strikes.

The CPT recommends that the Georgian authorities review the internal complaints procedures in prisons, in the light of the above remarks. Prisoners should be effectively able to make written complaints at any moment and place them in a locked complaints box located in each accommodation unit.

All written complaints should be registered centrally within a prison before being allocated to a particular service for consideration. In all cases, internal complaints should be processed expeditiously (with any delays duly justified in writing) and prisoners should be informed in writing, within clearly defined time periods, of the action taken to address their concerns or of the reasons for considering the complaint not justified. In addition, statistics on the types of internal complaints made should be kept as an indicator to the management of areas of discontent within the prison.

127. In this context, the Committee notes with interest the plans to improve and streamline internal complaints procedures, as announced by the Deputy Minister of Corrections at the outset of the visit. In particular, it would become easier for the prisoners to complain directly to the Minister, without the need to pass through the prison Director and Head of Penitentiary Department. **The CPT would like to receive more detailed information on these plans and their implementation.**

f. information provided to prisoners

128. The CPT is seriously concerned about the lack of information provided to prisoners on their rights and the procedures applicable to them, in particular in respect of solitary confinement, restrictions on contact with the outside world and access to media, placement in a CCTV cell and transfers to a strict regime.[165] The delegation interviewed many prisoners who stated that they had not been informed of the reasons of their placement under the above-mentioned conditions[166], had not been given a copy of the relevant decision, and were not aware of the possibility to appeal against the decision.

More generally, despite assurances to the contrary given by the Ministry officials and prison staff, it was clear that no written information sheets or brochures on inmates' rights and establishments' daily routine (or house rules) were provided to prisoners at any of the prisons visited.

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165 See paragraphs 59, 118 and 121.

166 Some of them did not even know for how long the decision concerning them would remain valid.

129. **The CPT calls upon the Georgian authorities to address this problem as a matter of high priority. Any prisoner subjected to solitary confinement, restrictions, placement in a CCTV cell and a more strict regime (or whose placement under such conditions is renewed) must be informed in writing of the reasons for that measure (it being understood that the reasons given could exclude information which security requirements reasonably justify withholding from the prisoner) and of the right to call witnesses, to carry out cross-examination, to contest the measure and to use the assistance of a lawyer. Further, the prisoner concerned must be given an opportunity to express his views on the matter. See also the recommendations in paragraphs 59 and 124 above.**

Further, **the Committee recommends that an information brochure be supplied to all prisoners upon their arrival, describing in a straightforward manner the main features of the prison's regime, prisoners' rights and duties, complaints procedures, basic legal information, etc. This brochure should be translated into an appropriate range of foreign languages.**

C. Establishments under the authority of the Ministry of Labour, Health and Social Affairs

1. Preliminary remarks

130. The delegation carried out a follow-up visit to the National Centre of Mental Health named after Academician Bidzina Naneishvili (Kutiri Psychiatric Hospital) and visited, for the first time, Bediani Psychiatric Hospital.

Kutiri Psychiatric Hospital had previously been visited by the CPT in 2007.[167] With an official capacity of 650 beds, the hospital was accommodating 601 patients at the time of the visit including 137 women. Some 12 patients were formally subject to civil involuntary hospitalisation and 273 (including 11 women) were forensic patients under court orders.[168]

Bediani Psychiatric Hospital is located in a village some 85 kilometres from Tbilisi, in an area accessible only by a poor and often unpaved mountain road. It consists of an extensive multi-pavilion complex constructed in the beginning of the 1960s as the national mental health centre and being, back then, the largest psychiatric hospital of the country (it could reportedly accommodate some 1,000 patients at that time). With the construction of Kutiri Psychiatric Hospital in the late 1970s and the economic decline of the surrounding region, most of the hospital's buildings were now empty and derelict. Nevertheless, Bediani Psychiatric Hospital remained the main employer of the remaining inhabitants in the village. With an official capacity of 140 beds, the hospital was accommodating 134 adult patients (of whom 55 were women) at the time of the visit. None of the patients were formally subject to involuntary hospitalisation.

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167 See paragraphs 105 to 141 of CPT/Inf (2007) 42.

168 181 patients were receiving involuntary treatment under Section 22 of the Law on Psychiatric Care (of whom eight were female); 22 were receiving compulsory treatment under Section 22.1; and 70 were convicted transferred prisoners (of whom three were female). The 11 forensic female patients were held in a civil ward and not in the forensic psychiatric unit.

131. The patient population in both hospitals consisted of a mixture of patients diagnosed with mental illnesses and patients suffering from learning disabilities of various degrees. Further, many patients had been in the hospitals for long periods, some for many years. Nearly all the patients – with the exception of those detained under the criminal legislation – were considered as "voluntary" but were held in locked wards. This issue will be discussed later in the report (see paragraphs 154 to 157 below).

132. Since the periodic visit carried out by the CPT in 2010, the psychiatric sector had undergone a series of important changes, including the closing down of Asatiani Psychiatric Institute and opening of small psychiatric structures in Tbilisi and its surroundings, and setting up psychiatric wards at general hospitals.[169]

In addition, the 2007 Law on Psychiatric Care (LPC) had been amended with a view to reflecting the amendments to the Criminal Code and the CCP regarding compulsory psychiatric treatment under criminal legislation (see below paragraph 158). Further, new Governmental orders relating to compulsory psychiatric treatment were adopted in July 2014 and entered into force on 1 October 2014 whereby risk assessment and risk reduction tools were to be applied.

The delegation was provided with the text of the Mental Health Care Concept of December 2013 and the Committee understands that an action plan was in the process of being drawn up. **The CPT would like to be provided with the text of the above-mentioned action plan, as soon as it becomes available**. In this context, the Committee wishes to stress the importance of elaborating and implementing a de-institutionalisation policy, which should be seen in the context of Georgia's obligations stemming from the UN Convention on the Rights of Persons with Disabilities.[170]

2. Ill-treatment

133. The delegation received no allegations of ill-treatment of patients by staff at *Bediani Psychiatric Hospital*, where the general atmosphere appeared relaxed and patients spoke positively about staff.

As regards *Kutiri Psychiatric Hospital*, the delegation received a few isolated allegations of staff slapping patients and displaying rude and verbally abusive behaviour towards them. **The Committee recommends that the management of Kutiri Psychiatric Hospital exercise continuous vigilance and remind the 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.**

134. Inter-patient violence did not appear to be a problem at *Bediani Psychiatric Hospital*. However, on the general psychiatric wards of *Kutiri Psychiatric Hospital*, the delegation witnessed episodes of inter-patient aggression, which was hardly surprising considering the low staffing numbers and the chaotic environment in which the patients lived.

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169 These included *inter alia* psychiatric wards in Tbilisi (at Hospital No. 5 and at the Gudushauri Clinic) and in Rustavi.

170 Ratified by Georgia on 13 March 2014.

The CPT would like to recall 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 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 Psychiatric Hospital to remedy the problem, in the light of the above remarks**.

3. Patients' living conditions

135. Patients at *Kutiri Psychiatric Hospital* were accommodated in 12 wards: seven for men (including four for forensic patients, two for patients suffering from chronic mental diseases, and one for patients suffering from acute mental diseases), two for women (one for chronic mental diseases, and one for acute mental diseases), and one for drug and narcology treatment. In addition, two wards (one for men, and one for women) were reserved for patients suffering from disabilities and requiring special care; these wards were referred to as the "shelter" ("pensionat").[171]

The general psychiatry wards and the "shelter" were located in four two-storey buildings, all of them in varying stages of dilapidation. This part of the hospital had not benefited from any refurbishment and almost none of the shortcomings related to living conditions identified during the 2007 visit had been addressed. The worst conditions were seen in the "shelter" and the male wards, which were dilapidated, unhygienic and malodorous. Dormitories were poorly lit and dirty. Some had broken windows, and in the male chronic ward, there was an open barred door to the outside letting the elements straight in. Most dormitories had either no doors or the doors were broken. The central heating was still not functioning, as had been the case during the last visit of the CPT in 2007, and small grossly insufficient electric radiators had been distributed in the dormitories (where the temperature measured by the delegation during the day was barely from 12 to 15° C). Further, dormitories only contained old and sometimes broken beds with worn out mattresses, and were bleak. Patients had no lockers for storing their personal belongings. Wards were infested with various vermin including rats. The whole environment was chaotic.

The dormitories were not overcrowded and every patient had their own bed.

The conditions were slightly better in the forensic unit, which had benefitted from refurbishment since 2007. The dormitories were bright, well ventilated and clean. That said, conditions were cramped in most of them (e.g. six patients in a dormitory measuring some 15 m², nine patients in a dormitory of approximately 27 m²) and some dormitories already displayed signs of deterioration (damaged wooden floors and walls), especially in wards 9 and 10. All the dormitories were austere and impersonal.

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171 There were 68 patients in the "shelter" at the time of the visit. Placement reportedly took place by a decision of the "Social Agency" (under the authority of the Department of Social Affairs of the Ministry of Labour, Health and Social Affairs).

136. The sanitary facilities in the non-refurbished parts of the hospital were totally dilapidated, unhygienic, filthy, malodorous and unheated, and most had no – or broken – windows (with the temperature, measured during the day, of 5° C). Almost all the showers consisted of nothing but rusted pipes without shower heads. Some facilities only offered one "shower" and a washbasin for over 60 patients.

The general level of hygiene left much to be desired: blankets were dirty, and the personal hygiene of certain patients, such as those who were learning disabled and incontinent, was inadequate.

137. To sum up, the living conditions in the general psychiatry wards and the "shelter" at Kutiri Psychiatric Hospital did not befit a health-care facility and could well be described as inhuman an degrading in some wards. As mentioned in paragraph 8 above, the delegation invoked Article 8, paragraph 5, of the Convention and requested the Georgian authorities to carry out a thorough review of these conditions with the aim of providing a humane, therapeutic and modern clinical environment. The delegation asked the Georgian authorities to provide the CPT, within three months, with a detailed report and action plan setting out how the failings observed would be remedied, within a reasonable timescale, through extensive refurbishment, reconstruction or other means, and outlining the funding which would be provided.

Unfortunately, the information provided by the Georgian authorities in their letters of 6 April and 18 May 2015 fails to address most of the Committee's concerns. Admittedly, the authorities announce their intention to organise a tender (with the budget of 40,000 GEL) for most essential repairs in the hospital's accommodation buildings. That said, it is not clear what would be the exact works to be performed under this tender and what would be the time-line of the implementation of these works.

Further, the responses do not contain any reference to a comprehensive and fully-budgeted reconstruction programme of the establishment, as requested by the delegation at the end of the visit. Moreover, it appears from their responses that the Georgian authorities continue to lack a clear vision of the future of Kutiri Hospital, including as regards its function as a health-care establishment, its legal form and its ownership.

138. In the light of the above, **the CPT calls upon the Georgian authorities to draw up, as a matter of highest priority, a comprehensive and fully budgeted refurbishment or reconstruction programme for Kutiri Psychiatric Hospital, comprising precise timetables. The Committee also recommends that the Georgian authorities take, as a matter of priority, a strategic decision concerning the future of the establishment as a health-care facility, including its possible closure, its legal form and ownership.[172] The CPT would like to be informed of this decision, in due course.**

Further, **the Committee requests to be informed, within one month, of the precise time-line for the implementation of the urgent works referred to in the Georgian authorities' letter of 18 May 2015, and to receive confirmation that these works include:**

- **providing all patients' rooms with a functioning heating system;**

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172 See also paragraph 132.

- **adapting all patient accommodation areas (and providing the necessary equipment and materials) to the needs of disabled and incontinent patients;**

- **refurbishing the toilet, washing and bathing facilities in the general psychiatry wards and the "shelter", and ensuring that these facilities are adequately heated;**

- **repairing all broken doors to the outside, and replacing doors and windows wherever they are missing;**

- **replacing all broken beds and torn mattresses, and ensuring that all patients have full bedding (mattresses, blankets, sheets and pillows);**

- **improving artificial lighting in the dormitories;**

- **carrying out a full disinfestation of the whole facility.**

139. The living conditions observed at *Bediani Psychiatric Hospital* were comparatively better. The two wards had benefited from regular refurbishment and were generally clean and warm. The female ward was in a stand-alone two storey-building which had been renovated in 2014. The rooms, accommodating from two to six women[173], were well lit and ventilated, and nicely decorated. They were equipped with beds, bedside tables and cupboards.

The male ward had also recently undergone partial refurbishment but offered a less congenial environment. The patients' accommodation was provided in a series of interconnected large rooms with eight to eleven beds (ranging in surface from 32 to 49 m²). The dormitories were well lit, ventilated and clean, but contained essentially only beds, and sometimes also a cupboard.

140. The sanitary facilities were in an acceptable state of repair and cleanliness on the female ward, but dilapidated, unhygienic and malodorous on the male ward.

141. There was no central heating, but the patient accommodation was sufficiently heated by open wood-burning stoves. Having said that, it should be noted that this could be hazardous to patients and also represented an undeniable fire risk.

142. **The CPT recommends that steps be taken at Bediani Psychiatric Hospital to ensure that appropriate fire safety precautions are in place.** Further, **efforts should be made to offer a more congenial and personalised surroundings for patients on the male ward and provide them with lockable space for their personal belongings**. In addition, **the sanitary facilities on the male wards should be repaired and maintained in appropriate state of cleanliness**.

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173 For instance, there were five women in a room measuring some 20 m², six in a room measuring some 28 m² and two in a room measuring some 18 m².

4. Staff and treatment

143. *Kutiri Psychiatric Hospital* had a total staff complement of 453, including ten psychiatrists, six psychiatrists in training, 91 nurses and 124 orderlies (all working full-time). There were also seven full-time general practitioners, 14 consultant specialists (invited in from outside when required), three full-time psychologists, 11 full-time occupational/art therapists and ten full-time social workers. In the general psychiatry wards, the daily shift (from 10 a.m. to 4 p.m.) consisted of one psychiatrist, up to two nurses, two orderlies and one security staff; after 4 p.m. and at night, there was one nurse, one orderly and one security staff, 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; after 4 p.m., 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.

As had been the case in the past, the hospital also employed 65 uniformed security staff who were deployed inside the forensic wards and reportedly acted exclusively upon instructions by health-care staff. However, the presence of security officers on the wards appeared to be perceived by the hospital's management as a *de facto* substitute for the health-care staff. In the Committee's view, this could hardly be seen as contributing to the emergence of a therapeutic environment; it would be far preferable for the role of such staff to be limited to perimeter security. The CPT must stress that no consideration seems to have been given to the recommendations made in this respect in the report on the 2007 visit.

The staff complement at *Bediani Psychiatric Hospital* comprised four psychiatrists, six nurses[174], an art therapist, 18 orderlies and four security staff, all working full time. Six consultant specialists[175] regularly visited the hospital. There were two vacant posts: for a psychologist and a social worker. During the week, the daily shift (from 9.00 a.m. to 3 p.m.) comprised two psychiatrists, three nurses and four orderlies.[176] On weekends, staff worked on 24-hour shifts which comprised one psychiatrist, one nurse and four orderlies.

To sum up, the presence of ward-based staff was grossly insufficient to provide adequate treatment and care for the number of patients accommodated in both hospitals. In addition, the very limited involvement of staff qualified to provide therapeutic activities at both hospitals and the absence of psychologists at Bediani Psychiatric Hospital precluded the emergence of a therapeutic milieu based on a multidisciplinary approach, offering a full range of bio-psycho-social treatments.

144. At both hospitals, treatment was based essentially on pharmacotherapy. Further, as regards the forensic unit at Kutiri Psychiatric Hospital, the emphasis was on security and containment rather than on an active therapeutic environment. In addition, security staff was usually present during medical consultations.

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174 Including one on maternity leave.

175 Including a surgeon, a GP, a lung specialist, a neurologist, a gynaecologist and a laboratory doctor.

176 One of the nurses and all the orderlies worked on a 24-hour shift basis.

There were reportedly no problems with the supply of basic psychotropic medication at both hospitals. Further, according to medical records and information obtained from interviews with patients and staff, there was no evidence of overmedication.

145. Efforts were made at *Bediani Psychiatric Hospital* to offer some occupational therapy in a dedicated large room set up some five years ago. Up to 30 patients a day could engage in painting, drawing and handicraft with a full-time art therapist.

Resort to rehabilitative psycho-social activities, remained very limited at *Kutiri Psychiatric Hospital* due to the shortage of facilities, material and specialised staff. Although the Hospital employed three psychologists, there was little resort to psychotherapy.

146. There were no individual treatment plans at either hospital. As already mentioned in paragraph 136 above, there was no evidence of a multi-disciplinary clinical team approach, either.

147. Recreational activities consisted mainly of watching TV or playing board games. Patients on the general psychiatric wards and in the "shelter" at *Kutiri Psychiatric Hospital* had access to a common area in each ward where there was a TV set; that said, the areas being in the unheated corridors, patients seemed to prefer to stay in their dormitories cowering over the small electric radiators. Patients in the forensic unit of Kutiri Psychiatric Hospital, who were locked in their rooms most of the day, could have TVs, radios and DVD players.

148. Patients at both hospitals were in principle offered access to fresh air most of the day on the territory of the facilities, but only a small number of them were seen outdoors on the general psychiatry wards and in the "shelter" at *Kutiri Psychiatric Hospital*, and none at *Bediani Psychiatric Hospital*. It became apparent that, due to the lack of staff in both establishments and the absence of shelters to protect patients against inclement weather at Bediani, patients rarely ventured outdoors during the winter months.

Forensic patients at Kutiri Psychiatric Hospital were offered access (for 1.5 hour per day) to two large outdoor exercise "cages" of a very oppressive and degrading design, and with no shelter to protect them against inclement weather. Their only association opportunities were during the outdoor exercise and during brief meal times. Staff and patients told the delegation that association had been stopped some 2 years previously, apparently due to security concerns.

To sum up, the vast majority of patients at Kutiri and Bediani psychiatric hospitals, and all forensic patients at Kutiri, were left with very little do all day, for months if not years on end.

149. **The CPT recommends that the Georgian authorities take urgent steps to:**

- **increase the number of ward-based staff at both hospitals;**

- **fill the vacant post of psychologist at Bediani Psychiatric Hospital;**

- **develop, at both hospitals, 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 improving self-image. It is axiomatic that this will require the recruitment of more specialists qualified to provide therapeutic and rehabilitation activities (psychologists, occupational therapists, and social workers) in the two hospitals;**

- **draw up an individual written treatment plan for each patient (taking into account the special needs of acute and long-term patients), including the goals of the treatment, the therapeutic means used and the staff members responsible. Patients should be involved in the drafting of their individual treatment plans and be informed of their progress;**

- **enable all patients at both hospitals to engage in a range of recreational activities**.

As regards the forensic unit at Kutiri Psychiatric Hospital, and with reference to the remarks in paragraph 144 above, the Committee recommends that all medical examinations 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. Further, **the CPT recommends that the management of the hospital ensure that the therapeutic role of staff does not take second place to security considerations.** In addition, **efforts must be made to allow patients to associate on the wards outside their dormitories**.

The Committee also recommends that the Georgian authorities take immediate steps to ensure that all patients at Kutiri and Bediani psychiatric hospitals benefit from unrestricted access to outdoor exercise during the day unless treatment activities require them to be present on the ward. Additional restrictions on access to outdoor exercise for involuntarily admitted patients should only be applied to those patients who represent a danger to themselves or others, and only for as long as that danger persists. Further, **a shelter with means of rest and a protection again inclement weather should be provided to patients at both hospitals. The exercise facilities for forensic patients at Kutiri Psychiatric Hospital should be entirely reconstructed, in the light of the remarks in paragraph 148.**

150. At both hospitals, the delegation observed that mentally-ill patients were accommodated together with learning disabled patients in the same dormitories. **The CPT has serious misgivings about such a practice and recommends that steps be taken, at both hospitals, 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

151. The procedure and safeguards surrounding the resort to means of restraint remained as described in the reports on the visits carried out in 2007 and 2010.[177] In particular, individual seclusion was not practiced at Bediani Psychiatric Hospital and was resorted to only rarely on the forensic wards of Kutiri Psychiatric Hospital.

At both hospitals, the means of mechanical restraint used consisted of fixation to a bed with soft cotton ties or sheets. It was reportedly usually applied for periods ranging from 20 minutes to two hours, i.e. the time necessary to administer a sedative injection and for it to take effect. As far as the delegation could ascertain, patients did not help staff to restrain other patients but security staff could be asked to help in the procedure. Further, patients in both hospitals could be restrained to their beds in full view of other patients (at Kutiri Psychiatric Hospital, often in the corridors).

The delegation received contradictory information regarding the use of straightjackets at both hospitals. Some of the staff members stated that straightjackets were never used, while others said that they could be used occasionally. That said, none of the patients with whom the delegation spoke remembered having been subjected to such means or seeing other patients in straightjackets, and there was no trace of resort to straightjackets in the relevant records. This would indicate that, in any event, straightjackets had not been resorted to recently at either hospital. The CPT welcomes this.

More generally, after the examination of the relevant documentation and interviews with the patients, the delegation gained the impression that means of restraint were not overused in the two establishments visited. Dedicated restraint registers existed in both hospitals and contained entries on the circumstances, the time of beginning and the end of the measures, and a doctor' signature. That said, a few discrepancies had been found at Kutiri Psychiatric Hospital when comparing the above-mentioned register with the patients' individual medical files, especially as concerns the duration of the measures.

None of the two hospitals visited had any written guidelines on the use of restraint (including seclusion), the reason given to the delegation being that the LPC and the Minister's instructions on the procedure for applying means of restraint were sufficient in this respect.

The CPT also wishes to stress that means of restraint should not be applied vis-à-vis formally voluntary patients.[178] **If it is deemed necessary to restrain a voluntary patient, the procedure for re-examination of his/her legal status should be initiated immediately.**

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177 See paragraph 130 of CPT/Inf (2007) 42 and paragraph 138 of CPT/Inf (2010) 27.

178 It should be recalled here that, formally speaking, there were no involuntary patients at Bediani Psychiatric Hospital (and very few at Kutiri Hospital) at the time of the delegation visit; see however paragraph 154.

152. 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 on restraint. 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. Further, if resort is had to sedative chemical restraint, they should be subjected to the same safeguards as mechanical restraints. 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. Such a system of recording information will therefore assist the management and outside bodies to monitor the use of restraints.

In this context, guidelines on the use of restraint[179] should include the following points:

- regarding their appropriate use, means of restraint should only be used as a last resort to prevent the risk of harm to the individual or others and only when all other reasonable options would fail to satisfactorily contain that risk; they should never be used as a punishment or to compensate for shortages of trained staff;

- any resort to means of restraint should always be either expressly ordered by a doctor or immediately brought to the attention of a doctor;

- staff must be trained in de-escalating techniques and in the use of restraint. Such training should not only focus on instructing staff as to how to apply means of restraint but, equally importantly, should ensure that they understand the impact the use of restraint may have on a patient and that they know how to care for a restrained patient;

- appropriate devices should be used for the mechanical restraint (fixation) of patients such as purpose-made straps. Old, worn and easily removable devices causing harm to patients should be immediately replaced;

- the duration of the application of means of restraint should be for the shortest possible time. The prolongation of mechanical restraint should be exceptional and warrant a further review by a doctor;

- a patient subject to mechanical restraint should not be exposed to other patients unless the patient explicitly expresses a wish to remain in the company of a certain fellow patient;

- as regards supervision, whenever a patient is subjected to means of mechanical restraint, a trained member of staff should be continuously present in order to maintain the therapeutic alliance and to provide assistance. Such assistance may include escorting the patient to a toilet facility or helping him/her to drink/consume food;

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179 Restraint measures include: mechanical restraint, physical restraint, seclusion and pharmaceutical (chemical) restraint.

- every instance of the use of means of restraint – whether physical/mechanical or chemical – of a patient must be recorded in a specific register established for that purpose, in addition to the individual's file. The entry should include the times 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 the person or staff. This will greatly facilitate both the management of such incidents and oversight into the extent of their occurrence;

- once means of restraint have been removed, a debriefing of the patient should take place. This will provide an opportunity to explain the rationale behind the measure, thus reducing the psychological trauma of the experience as well as restoring the clinician-patient relationship. It also gives the patient an occasion 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.

The CPT recommends that the above-mentioned principles as regards resort to restraint be applied at Kutiri and Bediani psychiatric hospitals as well as in 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**.

6. Safeguards

153. The legal framework governing civil involuntary placement in psychiatric hospitals in Georgia had remained unchanged since the visits carried out in 2007 and 2010[180]; it offers important safeguards to involuntary patients.[181]

154. As mentioned in paragraph 131 above, except for patients detained under the criminal legislation, nearly all patients at Kutiri Psychiatric Hospital and all at Bediani Psychiatric Hospital were formally considered as "voluntary", but were held on locked wards.

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180 See paragraphs 134 and 135 of CPT/Inf (2007) 42.

181 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 LPC). 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 LPC, 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 LPC). 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 LPC). 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 LPC). These decisions can be appealed (Section 18 (14) of the LPC).

After the examination of personal files, interviews with patients and also with staff, it became apparent to the delegation that many patients had been hospitalised upon request from their relatives, or because they had no other place to live, the hospitals thus *de facto* fulfilling social care functions. The majority of patients interviewed at both hospitals stated they wanted to leave them.

155. As regards the formally involuntary patients at Kutiri Psychiatric Hospital, the examination of patients' files revealed that the legal procedure had been followed and there were periodic reviews of hospitalisation. That said, it transpired from interviews with patients that the hearings were perceived as a mere formality.

156. Turning to consent to treatment[182], at Bediani Psychiatric Hospital, consent forms were found in patients' files, but were usually filled in by doctors and did not contain signatures of the patients.

At Kutiri Psychiatric Hospital, all the files reviewed contained a form of "consent to placement and treatment", signed by patients who were voluntary, and not signed by those who were *de iure* involuntary. Interviews with patients demonstrated that some of them had indeed consented to placement/treatment and were informed of their diagnosis and treatment. Having said that, it became clear during the visit that most patients had not understood what they were agreeing to at the time of admission and had not received information about their treatment. It also became clear that consent to treatment was assimilated to consent to placement.

157. The CPT is concerned to note that the management of the two hospitals visited did not seem to realise that the vast majority of patients placed under their responsibility were *de facto* deprived of their liberty without benefiting from the safeguards provided for by law.

The CPT calls upon the Georgian authorities to take steps to ensure that the legal provisions of the Law on Psychiatric Care on civil hospitalisation are fully implemented in practice. The Georgian authorities must also ensure that proper information and training is given, as a matter of priority, to all structures and persons involved (in particular, psychiatrists, hospital management and judges) on the legal provisions pertaining to civil involuntary placement of patients in psychiatric hospitals in Georgia.

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, as regards more specifically Kutiri and Bediani psychiatric hospitals, the CPT recommends that the legal status of all patients currently considered as voluntary be urgently reviewed.

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182 As a reminder, patients' consent to treatment is regulated by Order No. 108/09 of 19 March 2009 by the Ministry of 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.

158. The legal framework governing compulsory medical measures in respect of persons found to be criminally irresponsible had been the subject of recent amendments, which entered into force in October 2014, with a view to developing the provisions of the LPC and reflecting the changes in the Section 191[183] of the CCP in this respect. The amendments have introduced a new procedure in terms of compulsory psychiatric treatment pursuant to which a court can order a measure of compulsory psychiatric treatment, based on forensic psychiatric expertise, for any initial period below four years under the conditions of a new Section 22^1 of the LPC. The treatment should be applied in a psychiatric hospital. This decision can be appealed against by the patient, his/her lawyer or legal representative, and the forced psychiatric treatment can be interrupted (Section 22^1 (3) of the LPC). Annual court reviews of such decisions are performed in the light of recommendations by the psychiatric commission; the treating psychiatrist can recommend any time the interruption of the treatment (Section 22^1 (4) of the LPC) 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 (contrary to what had been required under the old provisions). The patient should also be discharged at the expiration of the measure of compulsory psychiatric treatment (Section 22^1 (6) of the LPC).

Pursuant to Section 22^1 (7) of the LPC, if by the time of expiration of the measure grounds still exist to provide involuntary inpatient care, the hospital's administration shall request the court for involuntary inpatient care under Section 18 of the LPC.

The psychiatric commission now consists 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), whereas in the past the commission was entirely medical and its membership included only the hospital's staff. The psychiatric commission must base its decision on a formal risk assessment and a mandatory psychosocial rehabilitation course established by the Ministry of Labour, Health and Social Affairs.

At the time of the visit, 22 patients at Kutiri Psychiatric Hospital had been the subject of this new procedure, while all other forensic patients were still held under the former system.

From the examination of patients' files and interviews, it transpired that forensic patients did generally attend the meetings of the psychiatric commission (every six months) and were usually present at court hearings (as were their lawyers – mostly *ex officio* ones). That said, patients were not provided with a copy of the court decision and all of them 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.

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183 Pursuant to which, criminally irresponsible persons who have committed criminal offenses are placed in inpatient involuntary treatment by a court's decision for the initial term of six months with possible further extensions for the next six months on the basis of the opinion by a medical (psychiatric) commission convened at the hospital. The person is brought directly to the hospital following the commission of the criminal offense and the psychiatric commission has to decide within 48 hours whether the person should be referred to the court for involuntary treatment.

The CPT welcomes the fact that the psychiatric commissions now include outside experts and that the decisions should, according to the new provisions, be based on a formal risk assessment and a mandatory psychosocial rehabilitation course. **The Committee recommends that the Georgian authorities take steps to ensure that these new safeguards are effectively applied in practice, and that the review procedure offers guarantees of independence and impartiality, as well as objective medical expertise. Further, patients should benefit from the assistance of a legal counsel at all stages of the procedure, including before the psychiatric commission.**

159. Neither of the two psychiatric hospitals visited had any formal complaints system in place, nor provided the patients on admission with any brochure setting out the hospital's routine and patients' rights, including information about complaints bodies and procedures. **The CPT calls upon the Georgian authorities to put in place a formal complaints system and 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**.[184]

160. At both Kutiri and Bediani psychiatric hospitals, the arrangements for contact with the outside world did not seem to pose any particular problems. Patients could receive visits and make phone calls on a daily basis. Some patients at Bediani Psychiatric Hospital even had their mobile phones with them.

That said, at the forensic unit of Kutiri Psychiatric Hospital, a complete ban on postal parcels had been imposed recently after a knife had been found in such a parcel. **The Committee is of the view that such a blanket ban imposes collective responsibility and is disproportionate; it should be reversed.**

161. During the visit to Kutiri Psychiatric Hospital, the delegation came across the case of a female patient, an Iraqi national transferred from a prison for treatment, who could speak Arabic, English and Turkish but had no means of communication with anyone in the hospital; she had not been provided with any reading material in a language she understood and no efforts were being made to help her communicate with the staff. From discussions with the management of the hospital, it also transpired that nothing had been done to inform her relatives of her whereabouts. **The CPT recommends that steps be taken to remedy these deficiencies.**

162. As regards external supervision, both 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 PDO/NPM representatives in private and some had indeed lodged complaints with the Public Defender. The CPT welcomes this.

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

D. Establishments under the authority of the Ministry of Defence

163. The delegation visited the detention facility ("Hauptvakhts") of the 2nd Regional Division of the Military Police Department in Senaki (the Senaki Hauptvakhts), which performed a double function: administrative detention of up to 30 days of soldiers who had violated the military statute, and custody of up to 72 hours of soldiers suspected of having committed criminal offences. The Senaki Hauptvakhts had an official capacity of 36 (calculated on the basis of the norm of 2 m² per detainee) and was empty on the day of the delegation's visit.[185]

164. The Hauptvakhts, opened in 2006, was located in a separate building on the territory of the Senaki army barracks (Headquarters of the 2nd Infantry Brigade). It comprised 9 cells for four detainees each, measuring some 14 m². Apart from the too high intended occupancy, one issue of concern as regards the material conditions in the cells was the extremely restricted access to natural light (because of the small size of the windows and the fact that they were additionally obstructed by dense wire netting); the artificial lighting also left something to be desired. Detained soldiers were supposed to sleep on wooden platforms which were folded up during the day; they were entitled to the same bedding as all other soldiers in the barracks (they brought it themselves upon arrival to the facility).

The delegation was told that detainees would receive the same food (at the same times) as all the soldiers in the barracks. The communal toilets and showers were in a good state of repair and spotlessly clean (as was the whole detention area). That said, detainees were only allowed to take a shower once a week; **the CPT invites the Georgian authorities to increase the frequency of permitted showers to at least twice a week.**

165. As to the regime applied to detained soldiers, it involved at least 8 hours of out-of-cell activities every day (exercise of at least 2 hours taken in a spacious and well equipped yard, sports, maintenance and cleaning work on the territory of the barracks, drill, studying the military statutes, etc.). In short, it did not give rise to any concern for the CPT.

166. As regards health-care, the post of a doctor was vacant but whenever needed, one of the doctors serving in the barracks would be invited to come. This was especially the case with the medical screening, which was carried out systematically both upon the detainees' arrival and before their departure from the Hauptvakhts. Consultation of the relevant documentation confirmed that access to health care was also not a problem during detention.

167. Visits to detained soldiers were only allowed with the permission of the Commander[186], and would take place in the office of the Commander or at the checkpoint at the entrance to the barracks. Phone calls were not allowed (save in exceptional circumstances).

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185 250 administrative detainees and four criminal suspects had been detained at the Senaki Hauptvakhts since the beginning of 2014 (until the beginning of December).

186 Except for visits by lawyers, which were authorised without limitations (and the delegation saw in the relevant documentation that such visits indeed occurred, albeit infrequently).

The Committee recommends that the relevant regulations be amended so as to authorise soldiers detained in a Hauptvakhts to receive visits (preferably once a week). Further, **the CPT recommends that steps be taken to provide administrative detainees with access to a telephone.**

168. Theoretically, soldiers detained at the Hauptvakhts were allowed to make formal complaints to the Commander and then further on to the military prosecutor, but the Commander himself acknowledged that this procedure was never used in practice. The delegation was also surprised to learn that confidential complaints boxes had been removed a few years ago. **The CPT recommends that the current rules and practice be changed so as to allow soldiers detained at a Hauptvakhts to make confidential complaints to an outside authority. Appropriate internal complaints procedures should also be put in place (see recommendation in paragraph 126, which applies *mutatis mutandis*).**

On the other hand, the independent inspections mechanism seemed to work well, with regular (at least every 2 – 3 months) visits by the staff of the PDO and/or NPM and equally frequent visits by NGOs.

169. The custody registers and other relevant documentation were well kept, and information on rights was posted on the walls in the detention area. This is to be commended.

170. At the end of the visit, the Commander of the Senaki Hauptvakhts told the delegation that there were plans to reconstruct his facility, which would *inter alia* involve fitting the cells with large windows, fully screened sanitary annexes (with toilets and washbasins) and proper beds. In the light of the observations in paragraph 164 above, **the CPT cannot but encourage the Georgian authorities to implement these plans. The Committee also recommends that steps be taken to ensure in practice that every detainee has at least 4 m² of living space.**

APPENDIX I

LIST OF THE NATIONAL AUTHORITIES AND ORGANISATIONS MET BY THE CPT'S DELEGATION

A. National authorities

Ministry of Corrections

Mr Giorgi MGHEBRISHVILI	Minister
Mr Archil TALAKVADZE	Deputy Minister
Mr Gogi GAKHARIA	Head of Penitentiary Department
Mr Joni JOKHARIDZE	Head of General Inspection Department
Mr Davit NATRIASHVILI	Head of Investigative Department
Ms Ana GUTSAEVI	Head of International Relations Department
Mr Kakha KHANDOLISHVILI	Deputy Head of International Relations Department
Ms Nino OSADZE	Head of Analyses, Strategic Planning and Co-ordination Division of the Administrative Department

Ministry of Internal Affairs

Mr Aleksandre TCHIKAIDZE	Minister
Mr Levan IZORIA	Deputy Minister
Ms Ekaterine MACHAVARIANI	Deputy Head of International Relations Department

Ministry of Labour, Health and Social Affairs

Mr Zaza SOPROMADZE	Deputy Minister
Ms Marina DARAKHVELIDZE	Head of Health Care Department
Ms Sophio MORGOSHIA	Senior Specialist, Health Care Department

Ministry of Justice

Mr Gocha LORDKIPANIDZE	Deputy Minister
Mr Levan DZNELADZE	Head of Department on Procedural Administration of Investigation in the Ministry of Defence and the Ministry of Corrections of the Office of the Chief Prosecutor of Georgia
Mr Levan MESHKORADZE	Head of Department of the State Representation to the International Courts of Human Rights
Mr Beka DZAMASHVILI	Deputy Head of the Public International Law Department
Mr Zurab SANIKIDZE	Deputy Head of Analytical Department

Office of the Chief Prosecutor of Georgia

Ms Maia KVIRIKASHVILI	Head of the Human Rights Protection Unit

Office of the Public Defender (Ombudsman)

Mr Ucha NANUASHVILI	Public Defender
Mr Paata BELTADZE	First Deputy Public Defender
Ms Natia KATSITADZE	Deputy Public Defender
Mr Nika KVARATSKHELIA	Head of Department of Prevention and Monitoring

B. Non-Governmental organisations

Georgian Young Lawyers' Association (GYLA)

APPENDIX II

EXTRACT FROM THE 21ST GENERAL REPORT ON THE CPT'S ACTIVITIES [CPT/INF (2011) 28]

Solitary Confinement of Prisoners

Introduction

53. Solitary confinement of prisoners is found, in some shape or form, in every prison system. The CPT has always paid particular attention to prisoners undergoing solitary confinement, because it can have an extremely damaging effect on the mental, somatic and social health of those concerned.[187]

This damaging effect can be immediate and increases the longer the measure lasts and the more indeterminate it is. The most significant indicator of the damage which solitary confinement can inflict is the considerably higher rate of suicide among prisoners subjected to it than that among the general prison population. Clearly, therefore, solitary confinement on its own potentially raises issues in relation to the prohibition of torture and inhuman or degrading treatment or punishment. In addition, it can create an opportunity for deliberate ill-treatment of prisoners, away from the attention of other prisoners and staff. Accordingly, it is central to the concerns of the CPT and, on each visit, delegations make a point of interviewing prisoners in solitary confinement in order to examine their conditions of detention and treatment and to check the procedures for deciding on such placements and reviewing them. In this section of its General Report, the CPT sets out the criteria it uses when assessing solitary confinement. The Committee believes that if these criteria are followed, it should be possible to reduce resort to solitary confinement to an absolute minimum, to ensure that when it is used it is for the shortest necessary period of time, to make each of the solitary confinement regimes as positive as possible, and to guarantee that procedures are in place to render the use of this measure fully accountable.

54. The CPT understands the term "solitary confinement" as meaning whenever a prisoner is ordered to be held separately from other prisoners, for example, as a result of a court decision, as a disciplinary sanction imposed within the prison system, as a preventative administrative measure or for the protection of the prisoner concerned. A prisoner subject to such a measure will usually be held on his/her own; however, in some States he/she may be accommodated together with one or two other prisoners, and this section applies equally to such situations.

As regards more specifically the solitary confinement of juveniles, a practice concerning which the CPT has particularly strong reservations, reference should also be made to the comments made by the Committee in its 18th General Report.[188]

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187 The research evidence for this is well summarised in Sharon Shalev's "A Sourcebook on Solitary Confinement" (Mannheim Centre for Criminology, London, 2008), available electronically at www.solitaryconfinement.org

188 See CPT/Inf (2008) 25, paragraph 26.

This section does not apply to the isolation of prisoners for medical reasons, as the grounds for such a measure are of a fundamentally different nature.

The principles involved

55. Solitary confinement further restricts the already highly limited rights of people deprived of their liberty. The extra restrictions involved are not inherent in the fact of imprisonment and thus have to be separately justified. In order to test whether any particular imposition of the measure is justified, it is appropriate to apply the traditional tests enshrined in the provisions of the European Convention on Human Rights and developed by the case-law of the European Court of Human Rights. The simple mnemonic PLANN summarises these tests.

(a) Proportionate: any further restriction of a prisoner's rights must be linked to the actual or potential harm the prisoner has caused or will cause by his or her actions (or the potential harm to which he/she is exposed) in the prison setting. Given that solitary confinement is a serious restriction of a prisoner's rights which involves inherent risks to the prisoner, the level of actual or potential harm must be at least equally serious and uniquely capable of being addressed by this means. This is reflected, for example, in most countries having solitary confinement as a sanction only for the most serious disciplinary offences, but the principle must be respected in all uses of the measure. The longer the measure is continued, the stronger must be the reason for it and the more must be done to ensure that it achieves its purpose.

(b) Lawful: provision must be made in domestic law for each kind of solitary confinement which is permitted in a country, and this provision must be reasonable. It must be communicated in a comprehensible form to everyone who may be subject to it. The law should specify the precise circumstances in which each form of solitary confinement can be imposed, the persons who may impose it, the procedures to be followed by those persons, the right of the prisoner affected to make representations as part of the procedure, the requirement to give the prisoner the fullest possible reasons for the decision (it being understood that there might in certain cases be reasonable justification for withholding specific details on security-related grounds or in order to protect the interests of third parties), the frequency and procedure of reviews of the decision and the procedures for appealing against the decision. The regime for each type of solitary confinement should be established by law, with each of the regimes clearly differentiated from each other.

(c) Accountable: full records should be maintained of all decisions to impose solitary confinement and of all reviews of the decisions. These records should evidence all the factors which have been taken into account and the information on which they were based. There should also be a record of the prisoner's input or refusal to contribute to the decision-making process. Further, full records should be kept of all interactions with staff while the prisoner is in solitary confinement, including attempts by staff to engage with the prisoner and the prisoner's response.

(d) Necessary: the rule that only restrictions necessary for the safe and orderly confinement of the prisoner and the requirements of justice are permitted applies equally to prisoners undergoing solitary confinement. Accordingly, during solitary confinement there should, for example, be no automatic withdrawal of rights to visits, telephone calls and correspondence or of access to resources normally available to prisoners (such as reading materials). Equally, the regime should be flexible enough to permit relaxation of any restriction which is not necessary in individual cases.

(e) Non-discriminatory: not only must all relevant matters be taken into account in deciding to impose solitary confinement, but care must also be taken to ensure that irrelevant matters are not taken into account. Authorities should monitor the use of all forms of solitary confinement to ensure that they are not used disproportionately, without an objective and reasonable justification, against a particular prisoner or particular groups of prisoners.

Types of solitary confinement and their legitimacy

56. There are four main situations in which solitary confinement is used. Each has its own rationale and each should be viewed differently:

(a) *Solitary confinement as the result of a court decision*

In most countries, courts have the power to order that a person remanded in custody (i.e. placed in pre-trial detention) be held for a certain period in solitary confinement, in the interests of the criminal investigation. Further, in a few countries, a period of solitary confinement is an automatic part of some sentences established by legislation or can be ordered by a court as part of a sentence.

In relation to solitary confinement ordered by a court as part of remand conditions, it is axiomatic that there may be justification, in an individual case and based on sufficient evidence, for keeping a given remand prisoner apart from other particular prisoners or, in even more exceptional circumstances, prisoners in general, and in restricting his/her contact with the outside world. This should only be done to guard against a real risk to the administration of justice and must be subject to the safeguards outlined in paragraph 57 below.

The CPT considers that solitary confinement should never be imposed – or be imposable at the discretion of the court concerned – as part of a sentence. The generally accepted principle that offenders are sent to prison as a punishment, not to receive punishment, should be recalled in this context. Imprisonment is a punishment in its own right and potentially dangerous aggravations of a prison sentence as part of the punishment are not acceptable. It may be necessary for a sentenced prisoner to be subject, for a certain period of time, to a solitary confinement regime; however, the imposition of such a regime should lie with the prison authorities and not be made part of the catalogue of criminal sanctions.

(b) *Solitary confinement as a disciplinary sanction*

Withdrawal of a prisoner from contact with other prisoners may be imposed under the normal disciplinary procedures specified by the law, as the most severe disciplinary punishment. Recognising the inherent dangers of this sanction, countries specify a maximum period for which it may be imposed. This can vary from as little as a few days to as much as a month or more. Some countries allow prison directors to impose a given maximum period, with the possibility for a judicial body to impose a longer period. Most countries – but not all – prohibit sequential sentences of solitary confinement.

Given the potentially very damaging effects of solitary confinement, the CPT considers that the principle of proportionality requires that it be used as a disciplinary punishment only in exceptional cases and as a last resort, and for the shortest possible period of time. The trend in many member States of the Council of Europe is towards lowering the maximum possible period of solitary confinement as a punishment. The CPT considers that the maximum period should be no higher than 14 days for a given offence, and preferably lower.[189] Further, there should be a prohibition of sequential disciplinary sentences resulting in an uninterrupted period of solitary confinement in excess of the maximum period. Any offences committed by a prisoner which it is felt call for more severe sanctions should be dealt with through the criminal justice system.

(c) *Administrative solitary confinement for preventative purposes*

The law in most European countries allows for an administrative decision to place into solitary confinement prisoners who have caused, or are judged likely to cause, serious harm to others or who present a very serious risk to the safety or security of the prison. This may be for as short as a few hours, in the case of an isolated incident, or for as long as a period of years in cases involving prisoners who are considered as particularly dangerous and to continue to pose an imminent threat.

This is potentially the longest lasting type of solitary confinement and often the one with the fewest procedural safeguards. It is therefore crucial that there be rules to ensure that it is not used too readily (e.g. as an immediate response to every disciplinary infraction pending adjudication), too extensively or for too lengthy periods. Accordingly, the safeguards described in paragraph 57 below must be rigorously followed.

(d) *Solitary confinement for protection purposes*

Every prison system has prisoners who may require protection from other prisoners. This may be because of the nature of their offence, their co-operation with the criminal justice authorities, inter-gang rivalry, debts outside or inside the prison or the general vulnerability of the person. While many prisoners can be managed in the general prison population in these circumstances, the risk to some is such that the prison can only discharge its duty of care to the individuals by keeping them apart from all other prisoners. This may be done at the prisoner's own request or at the instigation of management when it is deemed necessary. Whatever the process, the fact is that it can be very difficult for a prisoner to come off protection for the rest of the sentence – and maybe even for subsequent sentences.

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189 The maximum period should certainly be lower in respect of juveniles.

States have an obligation to provide a safe environment for those confined to prison and should attempt to fulfil this obligation by allowing as much social interaction as possible among prisoners, consistent with the maintenance of good order. Resort should be had to solitary confinement for protection purposes only when there is absolutely no other way of ensuring the safety of the prisoner concerned.

The decision of placement in solitary confinement: procedures and safeguards

57. In order to ensure that solitary confinement is only imposed in exceptional circumstances and for the shortest time necessary, each type of solitary confinement should have its own distinct process for applying and reviewing it. The CPT outlines here what it considers to be the appropriate processes:

(a) *Solitary confinement as part of remand conditions*

As already indicated, solitary confinement of persons remanded in custody should only be used sparingly and where there is direct evidence in an individual case that there is a serious risk to the administration of justice if the prisoner concerned associates with particular inmates or others in general. Such decisions should be made in open court, with as fully reasoned a judgment as possible, and be separately appealable. They should also be reviewed by the competent court on a frequent basis to ensure that there is a continuing need for solitary confinement.

(b) *Solitary confinement as a disciplinary sanction*

The reason for the imposition of solitary confinement as a punishment, and the length of time for which it is imposed, should be fully documented in the record of the disciplinary hearing. Such records should be available to senior managers and oversight bodies. There should also be an effective appeal process which can re-examine the finding of guilt and/or the sentence in time to make a difference to them in practice. A necessary concomitant of this is the ready availability of legal advice for prisoners in this situation.

Prisoners undergoing this punishment should be visited on a daily basis by the prison director or another member of senior management, and the order given to terminate solitary confinement when this step is called for on account of the prisoner's condition or behaviour. Records should be kept of such visits and of related decisions.

(c) *Administrative solitary confinement for preventative purposes*

This can result in very long-term placements under solitary confinement and the administrative decisions involved are often indeterminate; both these elements aggravate the negative effects of the measure. Consequently, there is a need for stringent controls.

The CPT considers that placement in administrative solitary confinement should only be authorised by the most senior member of staff in the prison; any imposition of this measure as an emergency should be reported to the most senior member of staff on duty immediately and brought to the attention of the prison director as soon as possible. A full written report should be drawn up before the member of staff who makes the decision goes off-duty. This should record the reasons for the decision and the precise time the measure was adopted as well as the views of the prisoner as far as these can be ascertained.

There should be constant, logged, monitoring of all cases for the first few hours and the person should be released from solitary confinement as soon as the reason for the imposition of the measure has been resolved. In all cases where the measure continues for longer than 24 hours, there should be a full review of all aspects of the case with a view to withdrawing the measure at the earliest possible time.

If it becomes clear that solitary confinement is likely to be required for a longer period of time, a body external to the prison holding the prisoner, for example, a senior member of headquarters staff, should become involved. A right of appeal to an independent authority should also be in place. When an order is confirmed, a full interdisciplinary case conference should be convened and the prisoner invited to make representations to this body. A major task for the review team is to establish a plan for the prisoner with a view to addressing the issues which require the prisoner to be kept in solitary confinement. Among other things, the review should also look at whether some of the restrictions imposed on the prisoner are strictly necessary – thus it may be possible to allow some limited association with selected other prisoners. The prisoner should receive a written, reasoned decision from the review body and an indication of how the decision may be appealed.

After an initial decision, there should be a further review at least after the first month and thereafter at least every three months, at which progress against the agreed plan can be assessed and if appropriate a new plan developed. The longer a person remains in this situation, the more thorough the review should be and the more resources, including resources external to the prison, made available to attempt to (re)integrate the prisoner into the main prison community. The prisoner should be entitled to require a review at any time and to obtain independent reports for such a review. The prison director or senior members of staff should make a point of visiting such prisoners daily and familiarise themselves with the individual plans. Medical staff should also pay particular attention to prisoners held under these conditions.

(d) *Solitary confinement for protection purposes*

"Own request" protection cases raise fewer questions than those ordered to go on protection by staff, but they still need some consideration. The CPT considers that all the alternatives, including transferring to another prison either the individual prisoner in need of protection or the prisoners causing the problem, mediation and assertiveness training, should be tried first and the full consequences of a decision to go on protection explained to the prisoner. Of course, a request from any prisoner on voluntary protection to return to the mainstream should be considered and granted if this can be safely done.

Those who are placed on protection against their will should have the right to play a full part in the discussion of the decision and to proffer alternative solutions. They should be given a full explanation of the decision and the opportunity to challenge it at a higher level. The decision should be reviewed on a regular basis so that solitary confinement can be ended as soon as it is no longer necessary.

Material conditions in solitary confinement

58. The cells used for solitary confinement should meet the same minimum standards as those applicable to other prisoner accommodation. Thus, they should be of an adequate size, enjoy access to natural light and be equipped with artificial lighting (in both cases sufficient to read by), and have adequate heating and ventilation. They should also be equipped with a means of communication with prison staff. Proper arrangements should be made for the prisoners to meet the needs of nature in a decent fashion at all times and to shower at least as often as prisoners in normal regime. Prisoners held in solitary confinement should be allowed to wear normal prison clothing and the food provided to them should be the normal prison diet, including special diets when required. As for the exercise area used by such prisoners, it should be sufficiently large to enable them genuinely to exert themselves and should have some means of protection from the elements.

59. All too often, CPT delegations find that one or more of these basic requirements are not met, in particular in respect of prisoners undergoing solitary confinement as a disciplinary sanction. For example, the cells designed for this type of solitary confinement are sometimes located in basement areas, with inadequate access to natural light and ventilation and prone to dampness. And it is not unusual for the cells to be too small, sometimes measuring as little as 3 to 4 m²; in this connection, the CPT wishes to stress that any cell measuring less than 6 m² should be withdrawn from service as prisoner accommodation. The exercise areas used by the prisoners concerned are also frequently inadequate.

60. It is common practice for cells accommodating prisoners undergoing solitary confinement as a punishment to have a limited amount of furniture, which is often secured to the floor. Nevertheless, such cells should be equipped, as a minimum, with a table, adequate seating for the daytime (i.e. a chair or bench), and a proper bed and bedding at night.

As regards the cells used to accommodate prisoners undergoing other types of solitary confinement, the CPT considers that they should be furnished in the same manner as cells used by prisoners on normal location.

Regimes in solitary confinement

61. As with all other regimes applied to prisoners, the principle that prisoners placed in solitary confinement should be subject to no more restrictions than are necessary for their safe and orderly confinement must be followed. Further, special efforts should be made to enhance the regime of those kept in long-term solitary confinement, who need particular attention to minimise the damage that this measure can do to them.

It is not necessary to have an "all or nothing" approach to the question. Each particular restriction should only be applied as appropriate to the assessed risk of the individual prisoner. Equally, as already indicated, there should be a clear differentiation between the regimes applied to persons subject to solitary confinement, having regard to the type of solitary confinement involved.

(a) *Prisoners placed in solitary confinement as part of remand conditions ordered by a court* should be treated as far as possible like other remand prisoners, with extra restrictions applied only as strictly required for the administration of justice.

(b) *Prisoners undergoing solitary confinement as a disciplinary sanction* should never be totally deprived of contacts with their families and any restrictions on such contacts should be imposed only where the offence relates to such contacts. And there should be no restriction on their right of access to a lawyer. They should be entitled to at least one hour's outdoor exercise per day, from the very first day of placement in solitary confinement, and be encouraged to take outdoor exercise. They should also be permitted access to a reasonable range of reading material (which, for example, should not be restricted to religious texts). It is crucially important that they have some stimulation to assist in maintaining their mental wellbeing.

(c) *Prisoners placed in administrative solitary confinement for preventative purposes* should have an individual regime plan, geared to addressing the reasons for the measure. This plan should attempt to maximise contact with others – staff initially, but as soon as practicable with appropriate other prisoners – and provide as full a range of activities as is possible to fill the days. There should be strong encouragement from staff to partake in activities and contact with the outside world should be facilitated. Throughout the period of administrative solitary confinement, the overall objective should be to persuade the prisoner to re-engage with the normal regime.

(d) *As regards prisoners placed in solitary confinement for protection purposes*, there is a balance to be struck between on the one hand the need to avoid making this kind of solitary confinement too attractive to prisoners and on the other hand minimising the restrictions put on persons to whom the measure is applied. Certainly, at the outset of such a period of solitary confinement, steps should be taken to reintegrate the person as soon as possible; if it becomes clear that there is a need for long-term protection, and no other response is possible, regime enhancement should be pursued. Special efforts should be made to identify other prisoners with whom the prisoner concerned could safely associate and situations where it would be possible to bring the person out of cell.

The role of health-care staff in solitary confinement

62. Medical practitioners in prisons act as the personal doctors of prisoners and ensuring that there is a positive doctor-patient relationship between them is a major factor in safeguarding the health and well-being of prisoners. The practice of prison doctors certifying whether a prisoner is fit to undergo solitary confinement as a punishment (or any other type of solitary confinement imposed against the prisoner's wishes) is scarcely likely to promote that relationship.

This point was recognised in the Committee of Ministers' Recommendation Rec (2006) 2 on the Revised Prison Rules; indeed, the rule in the previous version of the Rules obliging prison doctors to certify that prisoners are fit to undergo punishment has now been removed. The CPT considers that medical personnel should never participate in any part of the decision-making process resulting in any type of solitary confinement, except where the measure is applied for medical reasons.

63. On the other hand, health-care staff should be very attentive to the situation of all prisoners placed under solitary confinement. The health-care staff should be informed of every such placement and should visit the prisoner immediately after placement and thereafter, on a regular basis, at least once per day, and provide them with prompt medical assistance and treatment as required. They should report to the prison director whenever a prisoner's health is being put seriously at risk by being held in solitary confinement.

Conclusion

64. The aim of the CPT in setting out these standards is to minimise the use of solitary confinement in prisons, not only because of the mental, somatic and social damage it can do to prisoners but also given the opportunity it can provide for the deliberate infliction of ill-treatment. The CPT considers that solitary confinement should only be imposed in exceptional circumstances, as a last resort and for the shortest possible time.

Prisoners undergoing solitary confinement should be accommodated in decent conditions. Further, the measure should involve the minimum restrictions on prisoners consistent with its objective and the prisoner's behaviour, and should always be accompanied by strenuous efforts on the part of staff to resolve the underlying issues. More specifically, regimes in solitary confinement should be as positive as possible and directed at addressing the factors which have made the measure necessary. In addition, legal and practical safeguards need to be built into decision-making processes in relation to the imposition and review of solitary confinement.

Ensuring that solitary confinement is always a proportionate response to difficult situations in prisons will promote positive staff-prisoner interaction and limit the damage done to the very persons who are often already among the most disturbed members of the inmate population.