VISIT REPORT

GEORGIA

November 2024 | January 2025

CPT

EUROPEAN COMMITTEE
FOR THE PREVENTION OF
TORTURE AND INHUMAN OR
DEGRADING TREATMENT
OR PUNISHMENT

PERIODIC VISIT

18 - 29 November 2024
and 21 - 22 January 2025

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COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

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EXECUTIVE SUMMARY

Throughout the visit, until and including 28 November 2024, the overwhelming majority of interviewed detained persons who were or had recently been in **police custody** stated that the police had treated them in a correct manner. By contrast, the delegation was inundated with allegations of ill-treatment when it interviewed numerous persons detained in connection with the demonstrations in Tbilisi on 29 November 2024. Most of the interviewed persons bore visible injuries, some of them severe and having necessitated urgent medical attention.

The persons concerned referred to what appeared to represent a clear pattern of police behaviour during the demonstrations: masked and hooded officers wearing no form of identification had reportedly carried out arrests in groups of several officers, punching and kicking detained persons indiscriminately all over the body, swearing at them and threatening them. The persons reportedly did not resist and were already fully under the control of the police. Further, the beatings were reportedly carried out repeatedly, by several officers at a time, including whilst the detained persons had their hands cuffed behind the back. In almost all of the cases, the ill-treatment was said to have stopped once the hooded and masked police officers handed the detained persons over to patrol (or criminal) police officers who were not masked. That said, the delegation heard some allegations that following such handovers, detained persons had been subjected to questioning (without the presence of a lawyer), aimed at forcing them to confess or provide information.

The CPT reiterates its long-standing recommendation that steps be taken by the Georgian authorities to ensure that, when apprehending persons, the police only use force that is absolutely necessary and proportionate; there can never be any justification for any form of violence in respect of persons who are already in police custody and who have been brought under the control of police officers. Further, the highest priority should be attached to the provision of appropriate training to police officers in crowd control techniques. Steps must also be taken to ensure that all masked and/or hooded law enforcement officials deployed in the course of demonstrations bear visible identification (e.g. a warrant number) on the front side of their helmets or uniforms.

The delegation gained the impression that notification of custody (that is, providing the detained persons' next-of-kin or other persons of their choice with information about the fact of those persons' detention and their whereabouts) was as a rule performed quickly and systematically. Most detained persons also stated that they had been given access to a lawyer, either a private or an *ex officio* lawyer, although this right seemed, as a rule, only to be effective several hours or even up to 2 – 3 days after the actual deprivation of liberty. The Committee reiterates that the right of access to a lawyer must be fully effective for all detained persons from the very moment they are physically obliged to remain with the police.

As regards access to a doctor, *de facto* it did not exist in the very early stages of police custody while persons were held for initial questioning at police stations. However, medical examinations were performed systematically upon arrival at temporary detention isolators (TDIs), either by health-care staff employed by those TDIs or by ambulance doctors, and such examinations comprised also the recording of injuries. The examinations performed by TDI doctors were found to be of an overall good quality (unlike many of those carried out by ambulance doctors), and so was the recording and reporting of the injuries.Information on rights was generally provided to detained persons, although it would seem that at least the written information was as a rule only handed out when the detained persons were brought to a TDI (that is, not from the very outset of police custody). The Georgian authorities should make further efforts to improve the oral information on rights upon apprehension.

The Georgian authorities should also introduce systematic full, unaltered electronic recording of all police interviews (including initial questioning), which should be used for the purpose of properly documenting all of the interviews and safeguarding persons in police custody from being ill-treated. Further, the Georgian authorities should improve the training of police officers in interviewing criminal suspects.

The subject of impunity (and, more precisely, effective investigations into possible ill- treatment by law enforcement and prison officials) was addressed at length in the report on the CPT's 2018 visit to Georgia. In this context, the Committee is very concerned about the steps to abolish the Special Investigation Service (SIS) and transfer its functions back to the Prosecutor's Office. The CPT recalls that the setting up of an independent mechanism to investigate allegations of ill-treatment by law enforcement officials has been a long-standing recommendation by the Committee and other international actors, the reason being the perceived lack of efficiency of investigations into such allegations carried out by the Prosecutor's Office. Abolishing an independent investigation body, rather than strengthening it, appears to be going in the exactly opposite direction to that long advocated by the CPT.

The delegation found the conditions of detention to be good in the refurbished TDIs and even excellent in the new facilities. However, it is regrettable that – despite the Committee's long-standing recommendation – only persons under administrative arrest had access to outdoor exercise and a shower. Further, in the older TDIs there was almost no access to natural light and multiple occupancy cells still had only partially screened sanitary annexes. As regards administrative detainees, the Committee again recommends – for as long as the sanction of administrative arrest continues to be applied – that more efforts be made to offer them some form of activity.

The delegation carried out follow-up visits to **Prison No. 8** and **Prison Hospital** (Penitentiary Establishment No. 18) in Gldani and to **Prison No. 15** in Ksani. Further, a first- time visit was carried out to **Prison No. 1** in Laituri. In addition, the delegation paid a brief visit to **Prison No. 2** in Kutaisi, mainly focused on interviewing newly-arrived remand prisoners.

At the time of the visit, the prison system was no longer overcrowded as such, although localised overcrowding persisted. The Georgian authorities should step up their efforts to ensure that all prisons operate within their official capacities (to be calculated on the basis of the norm of 4 m^2 of living space per prisoner in multi-occupancy cells).

Regarding the prison estate, no progress had been made towards closing any of the existing semi-open prisons (so-called "zonas") which continued to be plagued by negative phenomena, such as overcrowding, absence of prisoner allocation policy, inter-prisoner violence and intimidation, influence of the informal prisoner hierarchy, lack of activities and very low staff complements. The Georgian authorities should take decisive steps towards reaching their own declared goal of closing the three "zonas" and replacing them with smaller prisons, each of them with a layout (smaller modular units) permitting better assessment, allocation and regime diversification, with more organised and individualised activities (with an increased focus on rehabilitation and resocialisation) and with more staff of appropriate categories.

The delegation heard no allegations of physical ill-treatment of inmates by staff of the prisons visited, and only a few allegations of verbal abuse. As regards inter-prisoner violence, incidents were rare in closed-type prisons (that is, Prisons Nos. 1, 2 and 8) where inmates remained locked in their cells and without the possibility to associate between cells for most of the day (if at all). As for Prison No. 15, by contrast, inter-prisoner violence was more common, which was hardly surprising given the open cell regime and the very low staff presence. Further, as previously, there were clear indications of the persistent influence of informal prisoner hierarchy at Prison No. 15. The CPT calls upon the Georgian authorities to step up their efforts to prevent and combat inter-prisoner violence and intimidation, in all prisons but especially in the semi-open prisons ("zonas") including Prison No. 15.

The absence of any real progress in respect of the development of prison regimes in Georgia continues to represent the issue of the CPT's greatest concern. In all of the prisons visited, the overwhelming majority of inmates had no organised out-of-cell activities. Worse still, apart from Prison No. 15 (with its open-door regime during the day), the bulk of the prisoner population continued to be locked inside their cells for up to 23 hours per day. Furthermore, many prisoners were held for months, if not years, in solitary confinement, with no association and very limited human contact, and often under permanent CCTV surveillance. The Georgian authorities must take decisive steps to develop programmes of purposeful activities for both sentenced and remand prisoners. The Georgian authorities must also ensure the full implementation in practice of the provisions of the Penitentiary Code concerning individual risk assessment and individual sentence plans, in respect of all inmates.

As regards health-care services in the prisons visited, the delegation found them to be of a good quality overall. The delegation observed as a positive aspect that there was a systematic and well performed medical screening on arrival, including the screening for infectious diseases and the recording and reporting of injuries. By contrast, the CPT remains concerned by the persistent serious shortcomings in the provision of mental health care to prisoners. There were also numerous prisoners with addiction problems in the prisons visited, the response to which continued to be limited to detoxification to the detriment of the necessary broader approach including MOUD (medication for opioid use disorder) as maintenance therapy.

All the prisons visited were severely understaffed, with a very low custodial staff presence. There were also few social workers. It was clear that such a low staff complement (combined with a low attendance pattern) rendered impossible the development of an adequate regime and activities. Furthermore, at Prison No. 15 the shortage of staff continued to put at risk the security of both staff and prisoners and resulted in the management and staff considering themselves forced to rely to a certain extent on prisoners to assist them in performing custodial tasks. Needless to add that the Committee considers this state of affairs to be totally unacceptable.

As had been the case in the past, the delegation did not observe any excessive recourse to the placements in disciplinary cells in the prisons visited. By contrast, the persistently frequent and sometimes extremely prolonged placements in "de-escalation cells" in most establishments visited remains problematic and appeared sometimes a *de facto* a form of punishment. The "de-escalation cells" should only be used in relation to prisoners who are agitated and/or aggressive, and always for as short a time as possible (preferably just a few hours) and the whole procedure should be under the authority of the doctor, not the custodial staff. Any prisoner who remains agitated after several hours must be clinically assessed and, if necessary, transferred to a mental health establishment.

The Committee further reiterates its long-standing recommendations to ensure that all prisoners, irrespective of category and regime, are offered at least the equivalent of one hour of visiting time per week, and that short-term visiting facilities be modified in all prisons so as to enable prisoners to receive visits, as a rule, under open conditions.

The delegation visited for the first time the Tbilisi Mental Health Centre (**Tbilisi Psychiatric Hospital**) and carried out follow-up visits to the Psychiatric Department at Batumi Medical Centre (**Khelvachauri Psychiatric Hospital**) and the National Centre of Mental Health in Khoni (**Kutiri Psychiatric Hospital**).

No allegations were received of recent physical ill-treatment by staff in the establishments visited. It would also appear that inter-patient violence was not a major problem in any of the hospitals visited and that staff were vigilant in this respect.

Positively, Kutiri Psychiatric Hospital had undergone a comprehensive renovation/reconstruction programme and now offered generally good living conditions. The CPT was also pleased to note that major refurbishment had taken place at Khelvachauri Psychiatric Hospital.

By contrast, conditions were very poor at Tbilisi Psychiatric Hospital. Most patients resided in extremely dilapidated rooms, in conditions which could be described as degrading. Patients' living conditions at the Hospital must be significantly improved.

Similar to the situation found during previous visits, psychiatric treatment was predominantly based on pharmacotherapy. The three establishments largely relied on first- generation antipsychotics, prolonged use of which may cause serious side effects. The Georgian authorities should carry out a review of the practices of prescribing psychotropic medication in all psychiatric establishments, with a view to gradually reducing the prescription of first-generation antipsychotic medication and replacing them, if necessary, by newer-generation antipsychotics.

The possibilities for patients to take part in therapeutic and rehabilitative activities were very limited in the three hospitals visited, *inter alia* due to staff shortages. The provision of psychosocial rehabilitative activities should be developed to prepare patients for a more autonomous life or return to their families. To this end, the staffing levels of psychologists, occupational therapists and other relevant professionals should be increased. The number of nursing and auxiliary staff should also be significantly increased.

It remained the case that patients in psychiatric hospitals were generally required to pay for non-emergency somatic treatment and medication. The CPT stressed once again that this can have a negative impact not only on timely and proper assessment and treatment of somatic diseases, but also on the way accurate assessments of certain psychiatric disorders are carried out (e.g. organic psychiatric disorders).

Further, steps should be taken at Khelvachauri and Tbilisi Psychiatric Hospitals to significantly improve patients' access to the open air, to be combined – weather permitting – with a range of organised activities. The aim should be to ensure that all patients benefit from unrestricted access to outdoor exercise during the day unless treatment activities require them to be present on the ward.

There was no excessive resort to fixation in the hospitals visited, which was generally applied infrequently and for periods ranging from fifteen minutes to two hours. Fixation was usually applied in combination with chemical restraint (intra-muscular injection of sedatives or antipsychotic medication). However, as had been the case in the past, instances of chemical restraint were not recorded in a dedicated register in any of the hospitals visited. The CPT's standards on means of restraint in psychiatric establishments should be effectively implemented at Khelvachauri, Kutiri and Tbilisi Psychiatric Hospitals as well as in all other psychiatric establishments in the country.

Very few of the "civil" patients held at Khelvachauri, Kutiri and Tbilisi Psychiatric Hospitals at the time of the visit had been subjected to an involuntary placement order under Section 18 of the Law on Psychiatric Assistance (LPA). At the same time, the majority of "voluntary" patients were not allowed to leave their (locked) wards or the hospital premises without being accompanied by a member of staff or family member. Moreover, it was not uncommon for such patients to be subjected to means of restraint.

Consequently, many patients who had been classified as "voluntary" were *de facto* deprived of their liberty, without benefiting from the safeguards provided for by law for involuntary patients. The CPT calls upon the Georgian authorities to take urgent steps to ensure that the legal provisions of the LPA on "civil" involuntary hospitalisation are fully implemented in practice.

As concerns the measure of compulsory psychiatric treatment in respect of persons found to be criminally irresponsible, the relevant legal provisions were generally complied with. However, the Georgian authorities should take steps to ensure that, in the context of the review of the forensic psychiatric placement, a psychiatric expert opinion which is independent of the hospital in which the patient is held is always commissioned.

Turning to the issue of consent to treatment, there appeared to be a widespread perception among patients that they had no choice other than to accept any treatment proposed. Thus, it is clear that the consent to treatment given by patients upon admission could not be considered to be genuinely informed consent. The CPT stressed that, as a general principle, all categories of patients with a psychiatric illness (be they voluntary or involuntary, subject to "civil" or forensic placement, with full or restricted legal capacity) should be placed in a position to give their free and informed consent to treatment. The Georgian authorities should ensure that an information brochure on patients' rights is systematically issued to patients (and their families/guardians) upon admission to a psychiatric establishment.

On a positive note, the arrangements for patients' contact with the outside world did not seem to pose any particular problems in practice, especially as regards family visits.

I. INTRODUCTION

A. The visit, the report and follow-up

1. In pursuance of Article 7 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as "the Convention"), a delegation of the CPT carried out a visit to Georgia from 18 to 29 November 2024. The visit formed part of the Committee's programme of periodic visits for 2024, and was the CPT's seventh periodic visit to Georgia.[1]

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

- Therese Rytter, 2nd Vice-President of the CPT, Head of delegation
- Hans Wolff, 1st Vice-President of the CPT
- Lise-Lotte Carlsson
- Nikola Kovačević
- Alexander Minchev
- Ceyhun Qaracayev
- Răzvan-Horaţiu Radu.

They were supported by Borys Wódz (Head of Division), Elvin Aliyev and Aikaterini Lazana of the CPT's Secretariat, and assisted by:

- Jutta Heilmann, consultant forensic psychiatrist, Austria (expert)
- Kira Chokhuri (interpreter)
- Nino Gudushauri (interpreter)
- Tamar Mikadze (interpreter)
- Nelly Pitskhelauri (interpreter).

3. The last scheduled day of the November 2024 periodic visit (that is, Friday 29 November 2024) coincided with the beginning of large-scale demonstrations in Tbilisi.[2] In the light of the circumstances, the delegation decided to postpone presenting its preliminary observations to the Georgian authorities and, instead, spend that day in police establishments throughout the Georgian capital, interviewing persons detained in connection with the said demonstrations.

The visit was completed on 21 and 22 January 2025 when the CPT, represented by Therese Rytter and Alexander Minchev and assisted by Elvin Aliyev and Borys Wódz, returned to Georgia in order to interview persons remanded into custody in relation with the aforementioned demonstrations and present the delegation's preliminary observations to senior Georgian officials.

4. The list of police, penitentiary and psychiatric establishments visited by the CPT's delegation can be found in Appendix I.

5. The report on the visit was adopted by the CPT at its 117th meeting, held from 30 June to 4 July 2025, and transmitted to the Georgian authorities on 11 July 2025. The various recommendations, comments and requests for information made by the CPT are set out in bold type in the present report. The CPT requests the Georgian authorities to provide within six months a response containing a full account of action taken by them to implement the Committee's recommendations and replies to the comments and requests for information formulated in this report.

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1. The previous periodic visits took place in May 2001, November 2003/May 2004, March/April 2007, February 2010, December 2014 and September 2018. The CPT has also carried three ad hoc visits to Georgia (in November 2012, May 2021 and March 2023) and a visit to Abkhazia, Georgia in April/May 2009. The Committee's reports on these visits, as well as the responses of the Georgian authorities, have been made public at the request of the Georgian authorities and are available on the Committee's website (https://www.coe.int/en/web/cpt/georgia).

2. The demonstrations followed the announcement of official results of the October 2024 Parliamentary elections and especially the statement, made by Prime Minister Irakli Kobakhidze on 28 November 2024, that the Government would remove from its agenda, until 2028, efforts towards the opening of accession talks with the EU.

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

6. At the outset of the visit, on 18 November 2024, the delegation held consultations with Rati Bregadze, Minister of Justice, Aleksandre Darakhvelidze, Deputy Minister of Internal Affairs, Tamar Gabunia, First Deputy Minister of Internally Displaced Persons from the Occupied Territories, Health, Labour and Social Affairs, Nika Tskhvarashvili, Director General of the Special Penitentiary Service, and Koka Katsitadze, Head of the Special Investigation Service (SIS), as well as with other senior officials from the above-mentioned ministries and agencies.

On 22 January 2025, the CPT's representatives presented the delegation's preliminary observations to senior government officials including two Deputy Ministers of Justice, Beka Dzamashvili and Niko Tatulashvili, Deputy Minister of Internal Affairs Aleksandre Darakhvelidze, and two Deputy Ministers of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, Irina Tsakadze and Tea Giorgadze.

In addition, the delegation had meetings with Levan Ioseliani, the Public Defender (Ombudsperson) and staff of the National Preventive Mechanism Department of his Office, as well as with representatives of international and non-governmental organisations active in areas of concern to the CPT. It is noteworthy that, similar to what had been the case during the Committee's previous periodic visit in 2018, the Georgian authorities decided to invite Elene Ghudushauri, Deputy Public Defender, to attend the final meeting in Tbilisi on 22 January 2025.

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

7. 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, Ketevan Sarajishvili from the Ministry of Justice.

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

The only exception to this excellent co-operation was the situation the delegation encountered on Friday 22 November 2024, when officers from Tserovani Police Station initially refused the delegation's request to interview a detained person in their custody (who was sitting handcuffed in a police vehicle); the refusal was clearly connected with the fact that the officers concerned were unaware of the CPT's visit and the delegation's mandate. The delegation could speak with the detained person only after a considerable delay and after having contacted the Liaison Officer, once the person has been admitted to the Temporary Detention Isolator (TDI) in Mtskheta.

The Committee expects that, on its future visits, all police officers in Georgia (not only those employed in TDIs) will be informed of the fact that a CPT visit is taking place and of the delegation's mandate and powers.

9. As stressed by the Committee many times 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 CPT's recommendations. During the 2025 visit, the Committee noted a number of positive developments, in particular as regards the continuing efforts to improve material conditions of detention in police establishments and prisons.

That said, the CPT is concerned that little or no progress has been made in other areas, such as combating excessive use of force by the police and impunity, tackling inter-prisoner violence and the influence of informal prisoner hierarchies, eliminating prison overcrowding, developing prison regimes and activities, improving prisoners' access to psychiatric and psychological care, and enabling them to maintain

adequate contact with the outside world. Further, despite ongoing efforts by the Georgian authorities, concerns remain in respect of psychiatric establishments, as regards treatments available, access to outdoor exercise and the practical implementation of legal safeguards in the context of involuntary hospitalisation and treatment.

The Committee trusts that the Georgian authorities will address these outstanding issues and inform the CPT of the measures taken in their response to this report. Indeed, a failure to do so could oblige the CPT to consider having recourse to the procedure set out in Article 10, paragraph 2 of the Convention.[3]

10. As already mentioned in paragraph 1 above, the CPT has so far carried out 11 visits to Georgia; all of the 10 reports transmitted to the Georgian authorities to date have been published following the authorities' request. The Committee welcomes this.

Having said that, in recent years, both the Committee of Ministers and the Parliamentary Assembly of the Council of Europe have been encouraging the Organisation's Members States which have not done so to request the automatic publication of future CPT visit reports and related government responses.[4]

The Georgian authorities are invited to consider authorising in advance the publication of all future CPT visit reports concerning Georgia and related Government responses, subject to the possibility of delaying publication in a given case.

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

11. As mentioned in paragraph 6 above, on 22 January 2025 the CPT's representatives met senior Government officials in order to acquaint them with the main facts found during the visit.

On that occasion, the CPT made an immediate observation pursuant to Article 8, paragraph 5, of the Convention, and requested the Georgian authorities to confirm, within 3 months, that all prisoners currently accommodated alone in their cells at Prison No. 1 in Laituri (and, as applicable, in Prisons No. 2 in Kutaisi and No. 8 in Gldani) are offered at least two hours of meaningful human contact each day; this means that they must be able to associate on a daily basis with at least one and preferably more carefully selected fellow inmates (or, if this proves impossible, with suitably trained members of the staff).

12. The Georgian authorities informed the Committee of measures taken in their letter dated 22 March 2025. These measures will be assessed later in the report.

3. Article 10, paragraph 2, of the Convention states as follows: "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."
4. See, in particular, Parliamentary Assembly Resolution 2160 (2017) adopted on 26 April 2017, and Committee of Ministers' reply to Recommendation 2100 (2017), adopted at the 1301st meeting of the Ministers' Deputies of 29 November 2017. See also www.coe.int/en/web/cpt/faqs#automatic- procedure.

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Police establishments

1. Preliminary remarks

13. The legal framework governing police custody of persons detained pursuant to the Code of Criminal Procedure (CCP) has remained largely unchanged since the CPT's 2018 periodic visit. Such persons may be held in the custody of the police for a maximum of 72 hours; in practice, detentions (which take place in temporary detention isolators, TDIs), tend to be shorter.

14. As regards persons detained pursuant to the Code of Administrative Offences, at the time of the 2024 periodic visit the provisions applicable were the same as in 2018, namely the police could hold such persons on their own authority for up to 72 hours, any longer detention requiring a court decision imposing administrative arrest for the maximum of 15 days. However, shortly after the visit (in February 2025) the Code of Administrative Offences was amended and the maximum duration of administrative arrest extended to 60 days.

The CPT has stressed in the past (see e.g. paragraph 17 of the report on the 2018 periodic visit[5]) that there is a general trend observed by the Committee in several States-Parties to the Convention of either shortening the maximum term of administrative detention in police establishments or abolishing that type of sanction altogether. The CPT welcomes this trend given that police establishments are not, as a rule, suitably equipped to hold detained persons for such prolonged periods, especially due to the absence of organized activities.[6] Preferably, persons found guilty of administrative violations should be sentenced to non-custodial sanctions. Unfortunately, the aforementioned recent amendments to the Code of Administrative Offences go in the opposite direction.

The Committee calls upon the Georgian authorities to reconsider their approach to administrative detention in the light of the above remarks.

2. Ill-treatment

15. Throughout the visit, until and including 28 November 2024 (that is, in the context of "routine" law enforcement work and outside the context of policing large-scale demonstrations, see paragraph 17 below), the overwhelming majority of interviewed detained persons who were or had recently been in police custody stated that the police had treated them in a correct manner.

However, the delegation did receive a few allegations of physical ill-treatment (mostly in the form of punches, slaps and kicks) upon apprehension, during transfer in a police vehicle and, in one case, in the course of questioning. Further, a few detained persons alleged having been verbally abused and/or threatened by the police. It is noteworthy though that no such allegations were received in respect of police staff performing custodial tasks in TDIs.

In the light of the aforementioned remarks, the Committee recommends that it be recalled to all police officers that any form of ill-treatment of persons in their custody, be it physical or verbal, is illegal, unacceptable and will result in disciplinary and criminal prosecution.

16. In the aforementioned case involving ill-treatment in the course of police questioning, the delegation directly observed medical evidence consistent with the allegations according to which the person concerned had been slapped, punched and kicked with a knee, reportedly in order to force him to provide information in relation with a criminal offence. The detainee was reportedly also threatened with rape with a baton.

5. Document CPT/Inf (2019) 16, https://rm.coe.int/1680945eca.
6. See also paragraph 31 below.

The detained person, Mr Dimitri Kh, complained about the ill-treatment by officers from Tserovani Police Station (said to have taken place on 22 November 2024) upon his admission, on the same day, to Mtskheta TDI and a report was sent by the TDI doctor to the Special Investigative Service (SIS).[7] At the end of the visit, the CPT requested to be informed of the outcome of the SIS investigation into this case.

In their letter dated 22 March 2025, the Georgian authorities provided information on the various investigative actions taken pursuant to Mr Kh's complaint, including interviewing the complainant, the police officers in question and witnesses, ordering and performing a forensic medical examination of Mr Kh's body, verifying the available CCTV footage and interviewing doctors from the narcological center to which Mr Kh was taken after his interview at Tserovani Police Station. However, the information provided in the aforementioned letter does not refer to any conclusions nor details of any measures taken or envisaged by the SIS in the light of the investigative actions carried out.

The CPT thus reiterates its request to be informed of the outcome of the investigation referred to above.

17. By contrast with what has been stated in paragraph 15 above, the CPT's delegation was inundated with allegations of ill-treatment when it interviewed numerous persons detained in connection with the demonstrations in Tbilisi on 29 November 2024.[8] Most of the interviewed persons bore visible injuries, some of them severe and having necessitated urgent medical attention (as well as, in a few cases, hospitalisation).

The persons concerned, who were interviewed separately and thus unable to coordinate their statements, referred to what appeared to represent a clear pattern of police behaviour during the demonstrations: masked and hooded officers (presumably at least some whom belonged to the Special Tasks Department) wearing no form of identification (some of them in clothes bearing the word "Police", others without any such markings) had reportedly carried out arrests in groups of several (up to 10 or more) officers, punching and kicking detained persons indiscriminately all over the body (including over the face and head), swearing at them and threatening them (including with rape), whilst the persons reportedly did not resist and were fully under control (sometimes lying on the ground).

The beatings were reportedly carried out repeatedly, by several officers at a time (sometimes taking turns), including whilst the detained persons had been handcuffed behind their back. In almost all of the cases, the ill-treatment was said to have stopped once the hooded and masked police officers handed detained persons over to patrol (or criminal) police officers who were not masked. That said, the delegation heard some allegations that following such handover, detained persons had been subjected to questioning (without the presence of a lawyer), aiming at forcing them to confess or provide other information.[9]

It is noteworthy that the injuries, both those directly observed and documented by the delegation and those recorded upon arrival by doctors working in the TDIs,[10] were fully compatible with the allegations made by the detained persons concerned.

18. The CPT is aware of the fact that many more allegations of ill-treatment were recorded by representatives of the Public Defender's Office in the days following the end of the CPT's November 2024 visit, most if not all of them following the aforementioned pattern. The Public Defender has repeatedly[11] publicly condemned the mass recourse to ill-treatment by the police in the context of dispersal of the demonstrations, also as regards the excessive and unprofessional use of water cannons and tear gas. He has called upon the SIS to carry out effective investigations into all of the allegations received.

7. See further comments on the role of the SIS in paragraphs 28 and 29 below.
8. As well as in the days that followed (as referred to by some of the remand prisoners interviewed by the delegation at Prison No. 8 in Gldani on 22 January 2025).
9. See also paragraphs 21 and 27 below.
10. E.g. multiple large and fresh haematomas, abrasions and excoriations on the head, face, shoulders, torso, back and legs, broken teeth and even a fractured skull.
11. Including in his 2024 annual report, see https://www.ombudsman.ge/eng/akhali-ambebi/sakartveloshi--ambebi/sakartveloshi-adamianis-uflebata-da-tavisuflebata-datsvis-mdgomareobis-shesakheb-tsliuri-angarishi-2024

The Committee cannot but join these calls.

The CPT also reiterates its long-standing recommendation that steps be taken by the Georgian authorities to ensure that, when apprehending persons, the police only use force that is absolutely necessary and proportionate; there can never be any justification for any form of violence (including punching, kicking, threatening and verbally abusing) in respect of persons who are already in police custody and who have been brought under the control of police officers.

Further, **the Committee recommends that the highest priority be attached to the provision of appropriate training to police officers (especially those employed at the Special Tasks Department) in crowd control techniques, including in the safe use of water cannons and tear gas.**

19. In this context, it is also noteworthy that in its judgment Tsaava and Others vs. Georgia (Applications Nos. 13186/20 and 4 others), issued on 7 May 2024,[12] the European Court of Human Rights *inter alia* stated that "where the competent national authorities deploy masked police officers to maintain law and order or to make an arrest, those officers should be required to visibly display some distinctive insignia, such as a warrant number. The display of such insignia would ensure their anonymity, while enabling their identification and questioning in the event of challenges to the manner in which the operation was conducted".

It should also be added that during the meeting he held with the delegation on 21 January 2025, Mr Koka Katsitadze, Head of the Special Investigation Service (SIS), acknowledged that the SIS had been unable to identify (never mind propose to charge) a single police officer in the framework of investigations into alleged misconduct by law enforcement agencies during the ongoing large-scale demonstrations as well as in the course of similar previous episodes (e.g. in April 2024[13]), precisely due to the absence of identification of police officers.[14]

The Committee recommends that the Georgian authorities take measures to address this fundamental lacuna of the current law and practice. In particular, steps must be taken to ensure that all masked and/or hooded law enforcement officials deployed in the course of demonstrations bear visible identification (e.g. a warrant number) on the front side of their helmets or uniforms.

3. Safeguards against ill-treatment

20. On the basis of examination of relevant records and files in the TDIs visited, and based on interviews with persons deprived of their liberty, the delegation gained the impression that notification of custody (that is, providing the detained persons' next-of-kin or other persons of their choice with information about the fact of those persons' detention and their whereabouts) was as a rule performed quickly and systematically.

However, many of the persons detained in connection with the demonstrations in Tbilisi, interviewed by the delegation on 29 November 2024 and on 22 January 2025, stated that they had not been enabled to inform a relative or another third person of their detention for several hours, that is until they had been brought to a TDI.[15]

12. The judgment had been referred to the Grand Chamber and was not yet final at the time of drafting this report. However, the Court's position on the issue in question forms part of a long-standing line of jurisprudence set out in numerous judgments in the past.

13. Following the adoption by the Parliament of the Transparency of Foreign Influence Act (so-called "Foreign Agents Act"), criticized inter alia by the Council of Europe's Venice Commission (see https://www.venice.coe.int/webforms/documents/default.aspx?pdffile=CDL-PI(2024)013-e).

14. See also paragraph 28 below.

15. In one case an interviewed detained person alleged having been able to inform his relatives of his arrest only once he had been brought to the court for the remand hearing (and reportedly it was actually his *ex officio* lawyer, with whom he had been allowed to briefly exchange prior to the start of the court hearing, who had informed the family).

The CPT recommends that efforts be made to ensure that notification of custody is never delayed, including when persons are detained in the context of demonstrations.

21. Most detained persons interviewed by the delegation stated that they had been given access to a lawyer, either a private or an *ex officio* lawyer, although this right seemed, as a rule, only to be effective after the person had been brought to the TDI or, in some cases, only during the first court hearing. This could happen several hours or even up to 2 – 3 days after the actual deprivation of liberty, especially in the cases of persons detained in the context of ongoing demonstrations.

Hardly any of the detained persons confirmed having had their lawyer present during the initial interview in a police station. Furthermore, in a few cases criminal police inspectors had reportedly attempted to discourage detained persons from requesting to have a lawyer present during questioning, arguing that appointing a lawyer at this early stage of the procedure and having them present at the initial questioning would only complicate and delay the investigation.[16] The delegation also heard a few allegations according to which police officers who had apprehended them had attempted to question the detained persons concerned "informally" (without the presence of a lawyer) in the police vehicle, prior to them being brought to a police establishment.[17]

A systemic problem observed by the delegation was that, in case the apprehending police officer (and/or the investigator in charge of the case) had failed to arrange for the presence of a lawyer before the detained person's arrival at a TDI, the TDI staff were not authorised to have an *ex officio* lawyer appointed and to contact the lawyer themselves, even when expressly requested to do so by the detained person concerned. The only thing the duty officer at a TDI could do was to transfer such a request to the investigator in charge of the case, which could in practice result in further delays in providing access to a lawyer.

The Committee reiterates its recommendation that steps be taken to ensure that the right to have access to a lawyer (including *ex officio* lawyer) is fully effective for all detained persons, as from the very outset of deprivation of liberty (that is, from the moment the person is physically obliged to remain with the police). Detained persons should never be persuaded to waive this right and no attempts should be made to question them on the subject of the criminal offence without them being informed of and allowed to execute their right to have a lawyer present before and during the questioning.
Further, **the current rules should be amended so as to ensure that whenever persons arriving at TDIs have been given no prior opportunity to have an *ex officio* lawyer appointed and to contact a lawyer, this is immediately arranged by the receiving TDI officer (who should systematically ask detained persons whether they have been asked whether they wished to have a lawyer (including an *ex officio* one) and whether they had been able to contact a lawyer and, in the negative, whether they wish this to be done).**

22. Another issue of concern was the observed practice[18] of the police questioning a person officially as a "witness" (thus with weaker procedural safeguards[19]) whilst it was clear to the police that the person in question was at least very likely to become the accused in the same case.

The CPT recommends that measures be taken to ensure that such practices cease.

16. On the other hand, it appeared that, as a rule, whenever detained persons refused to respond to questions without the presence of their lawyer, police officers did not insist and would not continue questioning until the lawyer's arrival.
17. See also paragraph 17 above.

18. E.g. in the case of Mr Kh referred to in paragraph 16 above
19. In particular, the police were not obliged to systematically inform witnesses of their right to be accompanied by a lawyer (although witnesses could insist on having their lawyer present, if they had one) and the general principle was that witnesses could not refuse to testify. It is true that witnesses could decline to provide potentially self-incriminating information, and this should have normally been made clear to them before they were asked to sign a statement (together with the fact that they were allowed to refuse to sign the statement and to insist to have the reason for this refusal expressly mentioned in the interrogation protocol), but detained persons interviewed by the delegation were generally unaware of these procedural rights.

23. As regards access to a doctor, *de facto* it did not exist in the very early stages of police custody while persons were held for initial questioning at police stations. However, medical examinations were performed systematically upon arrival at TDIs, either by health-care staff employed by those TDIs[20] or by ambulance doctors, and such examinations comprised also the recording of injuries. The examinations performed by TDI doctors were found to be of an overall good quality (unlike many of those carried out by ambulance doctors), and so was the recording[21] and reporting of the injuries to the SIS or the MIA General Inspection.

The reporting was done electronically, as a rule without delay. It is noteworthy that in the TDIs which had no on-site health-care staff (e.g. in Ozurgeti), the reporting was performed by the duty officer who copied word by word the certificate issued by an ambulance doctor. Needless to add, such a practice was doubtful from the standpoint of protection of confidentiality of medical data.

In this context, the CPT invites the Georgian authorities to step up efforts to implement their plans to employ doctors and nurses in all TDIs. The Committee also recommends that more efforts be made to ensure the confidential character of medical examinations performed in TDIs; whilst this generally seemed to be the case, some detained persons alleged that non-medical TDI staff had been present inside the room whilst they had been examined by a doctor.

24. Information on rights was generally provided to detained persons, although it would seem that at least the written information was as a rule only handed out when the detained persons were brought to a TDI (that is, not from the very outset of police custody)[22] and, in any event, never prior to the time the arrest protocol was filled in by the apprehending police officer. At the TDIs, written information was provided systematically in a range of languages, and the delegation was able to witness that detained persons were allowed to keep the information sheets with them in their cells. However, some of the detained persons alleged that they had not been able to read the information sheets as their eyeglasses had been taken away from them prior to their placement in the cell.

The Committee recommends that the Georgian authorities make further efforts to improve the oral information on rights upon apprehension. Further, steps should be taken to ensure that persons requiring eyeglasses are not prevented from using them and thus reading the information sheets. More generally, the CPT would like to be informed whether taking away detained persons' eyeglasses is a routine measure or whether it is based on an individual risk assessment.

25. In all the TDIs visited, the delegation observed that the period spent in custody was generally well documented.[23] Further, as had been the case during the 2018 periodic visit, a centralised computer database enabled easy access to custody records of all TDIs in Georgia. This is a positive finding which merits being highlighted here.

26. At the outset of the visit, the delegation was informed by senior officials of the Ministry of Internal Affairs that there was no legal obligation to carry out systematic electronic recording of police interviews.

The CPT has stressed on several occasions that electronic recording of interviews (preferably video and, if not possible, audio) represents an important additional safeguard against the ill-treatment of detainees. Such a facility can provide a complete and authentic record of the interview process, thereby

20. At the outset of the visit, the delegation was informed by senior officials from the Ministry of Internal Affairs that 23 out of the 32 operational TDIs (and, in particular, all the larger ones) had their own health-care staff.
21. The recording was as a rule (upon the detained persons' permission, which was systematically sought) accompanied by good quality photographs of injuries.
22. This seemed to be particularly problematic in the case of persons apprehended in connection with the demonstrations, who often alleged having been provided with information on their rights with a significant delay.
23. There were some understandable initial delays in recording the arrivals to TDIs of persons brought in connection with the demonstrations, given the large numbers of persons arriving in a short period. However, even in those cases it was always possible to find documentary evidence confirming the fact of a person's detention (such as certificates issued by the TDI doctors upon arrival).

greatly facilitating the investigation of any allegations of ill-treatment.[24] This is in the interest both of persons who have been ill-treated and of law enforcement officials confronted with unfounded allegations that they have engaged in physical ill-treatment or psychological pressure. Electronic recording of interviews also reduces the opportunity for defendants to later falsely deny that they have made certain statements.

> In the light of the above**, the CPT recommends that the Georgian authorities introduce systematic full, unaltered electronic recording of all interviews (including initial questioning), which should be used for the purpose of properly documenting all of the interviews and safeguarding persons in police custody from being ill-treated. Recorded statements must be preserved as part of the criminal case files and made available to appropriate persons (including the SIS, the prosecution authorities, the courts, the detained persons and/or their lawyers as well as those responsible for monitoring the police) according to established rules regarding access to police case files. Reference is also made here to paragraph 81 of the CPT's 28th General Report.[25]**

27. From the information provided to the delegation at the outset of the visit,[26] the CPT concludes that there is room for improvement regarding the training provided to police officers in interview techniques. The delegation was told that, as from 1 January 2023, the police again had specialised investigators[27] whose duty was to question detained persons, and the subject of interview techniques was taught to future investigators at the Police Academy (during their initial 2.5 months' training). However, the delegation's interlocutors were not in a position to provide more details of the training curriculum.

As already mentioned in paragraph 17 above, in the course of the visit the delegation received allegations from detained persons according to which they had been exposed to coercive interviews whilst in police custody, the aim of which had reportedly been to force them (in the absence of their lawyers) to confess or provide other information in connection with a criminal offence.

The CPT has stated many times in the past that questioning of criminal suspects is a specialist task which calls for specific training if it is to be performed in a satisfactory manner. First and foremost, the precise aim of such questioning must be made crystal clear: that aim should be to obtain accurate and reliable information in order to discover the truth about matters under investigation, not to obtain a confession from someone already presumed, in the eyes of the interviewing officers, to be guilty. In order to achieve this, provision of training in investigative interview techniques to police officers (both those already in service and those still undergoing initial training) is absolutely indispensable.

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24. The case of Mr Kh (see paragraph 16 above) provides a perfect illustration of this: as his interview at Tserovani Police Station was not recorded (and moreover took place in a room without CCTV coverage), the SIS had reportedly been unable to verify his allegations of having been subjected to ill-treatment in the course of questioning.

25. See document CPT/Inf(2019)9-part (https://rm.coe.int/1680942329). Paragraph 81 of the said General Report states as follows: "The CPT has also stressed the importance of accurate recording of all police interviews (including the start and end times and the names of all persons present during the interview). The electronic recording of police interviews (with audio/video-recording equipment) has also become an effective means of preventing ill-treatment during police interviews whilst presenting significant advantages for the police officers involved. Electronic recordings should be kept securely for a reasonable period, be made available to the detained persons concerned, and/or their lawyers, and be accessible to representatives of international and national monitoring bodies (including NPMs), as well as to any officials responsible for investigating allegations or reports of police ill-treatment."

26. As well as in the light of certain allegations received from detained persons, including Mr Kh.

27. The dichotomy between operative officers and investigators, characterising many post-Soviet law enforcement systems, had been abolished during the police reforms in the mid-2000s and all criminal police inspectors were later supposed to carry out both types of tasks (that is, both the operational and investigative activities).

The Committee recommends that the Georgian authorities improve the training of police officers in interviewing criminal suspects. In this context, reference is made to the 2018 Council of Europe's document "A brief introduction to investigative interviewing. A practitioner's guide"[28] and to the Méndez Principles on Effective Interviewing,[29] as well as paragraphs 73 to 81 of document CPT/Inf(2019)9-part.[30] The CPT would also like to be provided with details of the present Police Academy curriculum concerning police interviews of victims, witnesses and suspects.

28. The subject of impunity (and, more precisely, effective investigations into possible ill- treatment by law enforcement and prison officials) was discussed at length in the report on the CPT's 2018 visit to Georgia.[31]

Both at the outset and at the end of the visit (on 22 January 2025), the delegation met the leadership of the Special Investigation Service,[32] set up in 2020 as a successor of the previous independent investigation mechanism, the State Inspector's Office.

The delegation gained the impression that the SIS generally possessed the necessary human and financial resources for the carrying out of its task. It is also worth mentioning that the law required the SIS to be informed whenever doctors working in TDIs and prisons received allegations of ill-treatment by police (and penitentiary staff)[33] and whenever they observed injuries likely to have resulted from ill-treatment, and as far as the delegation could ascertain this was indeed generally done systematically and expeditiously.[34] Further, at least in most cases, after receipt of such information SIS investigators went to the police (and penitentiary) establishments and interviewed the detained persons concerned (or, sometimes, carried out an online interview).

Nevertheless, the fact remains that the effectiveness of the SIS left something to be desired, as evident in particular on the example of investigations into the alleged ill-treatment of persons detained in connection with the demonstrations in Tbilisi (an issue also highlighted by the Public Defender in his 2024 annual report).

Despite an impressive amount of work done (as presented to the delegation on 22 January 2025),[35] not a single police officer had been charged[36] in connection with any form of misconduct (including excessive use of force/physical ill-treatment) at the time of the drafting of this report.[37] This is *inter alia* linked with the absence of identification of police officers referred to in paragraph 17 above as well as with the lack of systematic electronic recording of police interviews mentioned in paragraph 26 above.

Whatever the root causes of this lack of effectiveness of the SIS, it is beyond doubt that action is necessary to address it.

The Committee recommends that steps be taken accordingly by the Georgian authorities. Reference is also made to the recommendations in paragraphs 19 and 26 above. Further, the CPT requests the Georgian authorities to keep it fully informed of the progress of the above-mentioned investigations.

28. See https://rm.coe.int/guide-to-investigative-interviewing/16808ea8f9.
29. See https://interviewingprinciples.com.
30. "Preventing police torture and other forms of ill-treatment – reflections on good practices and emerging approaches. Extract from the 28th General Report of the CPT, published in 2019", https://www.coe.int/en/web/cpt/preventing-police-torture.
31. See paragraphs 13 to 15 of CPT/Inf (2019) 16.
https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000 016806961f8.
32. See general information on the legal basis, mandate and powers of the SIS on its official website (https://sis.gov.ge).
33. No such obligation existed in case when inter-prisoner (or inter-detainee) violence was suspected, see also paragraph 47 below.
34. See also paragraph 23 above and paragraph 47 below.
35. 430 persons interviewed, 236 forensic medical examinations carried out, 2000 hours of CCTV footage analysed, 84 persons granted a victim status by the Prosecutor's Office, etc.
36. Under the law, charging someone is a prerogative of the Prosecutor's Office but the SIS can formally request the prosecutor to do so based on the collected evidence.
37. See also paragraph 19 above.

29. In this context, the Committee is very concerned about plans[38] to abolish the SIS altogether and transfer its functions back to the Prosecutor's Office.

The CPT wishes to recall that the setting up of an independent mechanism to investigate allegations of ill-treatment by law enforcement officials has been a long-standing recommendation by the Committee and other international actors (including the EU), the reason being the perceived lack of efficiency of investigations into such allegations carried out by the Prosecutor's Office. Abolishing an independent investigation body, rather than strengthening it as recommended above, appears to be going in the exactly opposite direction to that long advocated by the CPT.

The Committee wishes to receive from the Georgian authorities a clarification of the rationale behind the abolishing of the SIS, with a detailed explanation of how, in their view, such a move would increase the effectiveness of investigations into possible ill-treatment by law enforcement (and prison) officials.

30. During its meeting with senior officials of the Ministry of Internal affairs, the delegation was informed that any disciplinary proceedings against police officers (in the context of suspected misconduct vis-à-vis detained persons), carried out by the Ministry's General Inspection (an internal inspection body), would be automatically suspended whenever a criminal investigation was initiated concerning the officer in question;[39] such disciplinary proceedings could only be restarted after the end of the criminal procedure.

Further, there was no mechanism allowing to automatically suspend from duty (or even just transfer to a position without direct contact with the public) a police officer in respect of whom a criminal or disciplinary procedure was ongoing in connection with a suspected misconduct towards persons deprived of their liberty. The SIS could propose such a suspension[40] to the Prosecutor's Office (which in turn could motion the court to authorize it[41]) and the General Inspection could also propose such a suspension to the Minister, but in reality this would only be done once the criminal investigation was completed.

In the CPT's view, the current mechanism is flawed as it fails to effectively prevent and address potential misconduct of police officers vis-à-vis detained persons. Suspending a police officer (or at least removing him/her from a job in direct contact with the public) should be considered a preventive measure. Whilst not necessarily automatic, it should at least be seriously considered given the circumstances of each case.[42]

In the light of the above remarks, **the Committee recommends that the Georgian authorities amend the relevant legal provisions governing disciplinary liability and suspension from duty of police officers during the criminal investigation in the context of their possible involvement in ill-treatment of detained persons.**

4. Conditions of detention

31. At the outset of the visit, senior officials from the Ministry of Internal Affairs informed the delegation that 29 out of the total of 32 operational TDIs had been refurbished in recent years. Indeed, the delegation found the conditions of detention to be good in the refurbished TDIs (e.g. in Kutaisi, Mtskheta[43] and Rustavi) and even excellent in the new facilities such as the TDIs Nos. 1 and 2 in Tbilisi (Zahesi), inaugurated in 2020, where cells had fully partitioned sanitary annexes.

38. Announced on 19 May 2025, see https://civil.ge/archives/682498.
39. In addition, whenever the General Inspectorate, in the context of disciplinary proceedings, collected prima facie evidence of a criminal offence, it had to suspend the disciplinary procedure, inform the SIS and await the outcome of criminal proceedings (or a decision by the SIS to terminate the investigation or by the Prosecutor's Office to refuse to press charges).
40. Or even, in extreme and apparently very rare cases, discharge from duty.
41. The actual administrative decision to suspend an officer would be issued by the Minister.
42. See also the judgment of the European Court of Human Rights issued on 7 April 2015 in case Cestaro v. Italy (Application No. 6884/11), especially paragraph 210.
43. Conditions at Kutaisi and Mtskheta TDIs would have been very good, were it not for the semi- partitioned sanitary annexes in multi-occupancy cells.

However, it is regrettable that – despite the Committee's long-standing recommendation – only persons under administrative arrest had access to outdoor exercise and a shower.

The Committee reiterates its recommendation that anyone obliged to stay at a TDI for longer than 24 hours be allowed to use the exercise yard and take a shower.

Further, in the older TDIs (e.g. in TDI No. 3 in Tbilisi and in Ozurgeti TDI) there was almost no access to natural light and multiple occupancy cells still had only partially screened sanitary annexes. It is also to be noted that cells at Rustavi TDI and TDI No. 3 in Tbilisi were not equipped with a call system.

The CPT recommends that efforts be made to address these shortcomings.

As regards administrative detainees, the Committee again recommends – for as long as the sanction of administrative arrest continues to be applied[44] – that more efforts be made to offer them some form of activity (e.g. access to radio/television, books, newspapers, board games). Such offer existed at the TDI No. 2 in Tbilisi but not in the other TDIs visited.

B. Penitentiary establishments

1. Preliminary remarks

32. The delegation carried out follow-up visits to Prison No. 8 and Prison Hospital (Penitentiary Establishment No. 18) in Gldani and to Prison No. 15 in Ksani. Further, a first- time visit was carried out to Prison No. 1 in Laituri. In addition, the delegation paid a brief visit to Prison No. 2 in Kutaisi, mainly focused on interviewing newly-arrived remand prisoners.

The general descriptions of Prisons No. 8, No. 15 and No. 2, and of the Prison Hospital, made in the reports on previous visits,[45] remain valid. At the time of the visit, Prison No. 8 had the official capacity of 2.325 and was accommodating 2.418 inmates[46] including 1.274 adult male remand prisoners, 21 male juveniles[47] and 35 male adult prisoners sentenced to life imprisonment. Prison No. 15 had the official capacity of 1.388 and was accommodating 1.576 male adult sentenced prisoners[48] (including six lifers). As for Prison No. 2, it had the capacity of 1.068 and was accommodating 981 inmates[49] including 364 adult male remand prisoners, four male lifers and 15 male juveniles[50] (six of them sentenced). Regarding the Prison Hospital, see paragraph 51 below.

Prison No. 1 in Laituri was opened recently (in December 2023) after over 20 years of construction. Located in Guria region, near the town of Ozurgeti, it had the official capacity of 670 and was accommodating 300 prisoners[51] including 96 adult men on remand (from Guria and Adjara regions) and 12 adult male lifers, the remainder consisting of adult male prisoners serving fixed-term sentences. Prisoner accommodation was located in the main cross-shaped four-storey detention block comprising four wings (A, B, C and D); at the time of the visit, only two levels of wings A and D and three levels of wings B and C were occupied

44. See paragraph 14 above.
45. See e.g. paragraphs 65 – 67 of the report on the 2014 periodic visit (CPT/Inf (2015) 42) regarding Prison No. 8; paragraphs 99 and 104 of the same report as regards the Prison Hospital; paragraphs 68 – 71 of the report on the 2018 periodic visit (CPT/Inf (2019) 16) regarding Prison No. 15; and paragraphs 32 – 34 of the report on the 2012 ad hoc visit (CPT/Inf (2013) 18) as regards Prison No. 2.
46. I.e. the occupancy of 104% of the official capacity.
47. Not interviewed by the delegation.
48. I.e. the occupancy of 114% of the official capacity.
49. I.e. the occupancy of 92% of the official capacity.
50. Not interviewed by the delegation.
51. I.e. the occupancy of 45% of the official capacity.

33. At the outset of the visit, the Minister of Justice informed the delegation that a recent amendment to the Penitentiary Code had introduced a general legal norm of 4 m^2 of living space for both remand and sentenced prisoners. However, the implementation of this new provision has been postponed until 1 January 2026 so that, at the time of the visit, the norm applicable to remand prisoners was still 3 m^2 per person. Whilst the prison system was no longer overcrowded as such (at the time of the visit, the overall capacity of the prison estate was 12.300 and the total prisoner population 9.397[52]), localised overcrowding persisted, as could be seen by the delegation in Gldani and Ksani (see paragraph 32 above).

Efforts to reduce the prison population included planned streamlining of conditional release procedures and increasing the recourse to electronic monitoring. At the same time, however, legislative amendments introducing harsher punishments for drug offences, including the mandatory and longer-term imprisonment for drug dealing (convicted sellers of even small amounts of drugs being now expected to face prison sentences of 12 to 20 years, or life imprisonment),[53] were likely to contribute to an increase of prisoner population in the near future.[54]

In the light of the above, the CPT calls upon the Georgian authorities to step up their efforts to ensure that all prisons operate within their official capacities (to be calculated on the basis of the norm of 4 m^2 of living space per prisoner in multi- occupancy cells).[55] Further, efforts to manage the prison population should be increased, taking due account of the relevant Recommendations of the Committee of Ministers of the Council of Europe, including Recommendation No. R(99)22 concerning prison overcrowding and prison population inflation, Recommendation Rec(2006)13 on the use of remand in custody, the conditions in which it takes place and the provision of safeguards against abuse, Recommendation Rec(2003)22 on conditional release (parole), Recommendation CM/Rec(2010)1 on the Council of Europe probation rules, Recommendation (2014)4 on electronic monitoring and Recommendation CM/Rec(2017)3 on the European Rules on community sanctions and measures.

The Committee would also like to receive more detailed information on the above-mentioned legislative amendments concerning drug offences and their estimated impact on the prison population.

34. Regarding the prison estate, the Minister of Justice referred to the planned opening of a new smaller-size (capacity 150) prison in Rustavi. However, despite the authorities' commitments vis-à-vis the CPT set out in the response to the report on its 2021 ad hoc visit, no progress had been made towards closing any of the existing semi-open prisons (so- called "zonas"[56]) which (as the delegation could again confirm at Prison No. 15[57]) continued to be plagued by the negative phenomena extensively described in the aforementioned report.[58]

52. Including 1.856 male remand prisoners, 394 women, 75 juveniles (27 of whom on remand) and 86 lifers (three of whom were females). It is noteworthy that, according to the information provided by the Georgian authorities after the visit (in their letter of 22 March 2025), the overall prisoner population had dropped to 8.558 on 1 February 2025 due to a large-scale Presidential pardon in January 2025.
53. Announced by the authorities in March 2025, see e.g. https://civil.ge/archives/668417.
54. It is noteworthy that Georgia remains the country with the second highest imprisonment rate in Europe (254.9/100.000 population). Source: SPACE I 2023 Report (https://wp.unil.ch/space/files/2025/04/space_i_2023_report.pdf). More recent data (available at the World Prison Brief, https://www.prisonstudies.org/country/georgia) suggests a slight decrease of the imprisonment rate (to 232/100.000), which nevertheless remains among the highest on the continent.
55. Sanitary annexe excluded. In single occupancy cells the norm should be at least 6 m^2 of living space.
56. That is, Prison No. 14 in Geguti, Prison No. 15 in Ksani and Prison No. 17 in Rustavi.
57. See paragraphs 36 and 41 below.
58. Such as overcrowding, absence of prisoner allocation policy, inter-prisoner violence and intimidation, influence of prisoner hierarchy, lack of activities, very low staff complement, etc. See, in particular, paragraphs 10 to 13 of the report on the 2021 ad hoc visit (CPT/Inf (2022) 11).

The CPT calls upon the Georgian authorities to take decisive steps towards reaching their own declared goal (as set out in the Strategy and Action Plan on the Development of the Penitentiary and Crime Prevention Systems) of closing the three "zonas" and replacing them with smaller prisons, each of them with a layout (smaller modular units) permitting better assessment, allocation and regime diversification, with more organised and individualised activities (with an increased focus on rehabilitation and resocialisation) and with more staff of appropriate categories. The Committee requests to be provided, in the response to this report, with a detailed update on the steps already taken, those being taken and those still envisaged (with precise deadlines). The CPT would also like to be informed of budget allocations made to secure the implementation of the aforementioned Action Plan.

2. Ill-treatment and inter-prisoner violence

35. The delegation heard no allegations of physical ill-treatment of inmates by staff of the prisons visited, and only a few allegations of verbal abuse. Overall, there was a relaxed atmosphere and good (occasionally even cordial) staff-prisoner relations in the prisons visited.

Nevertheless, the Committee recommends that it be recalled to all prison staff that they should always address prisoners in a respectful and polite manner.

36. As regards inter-prisoner violence, incidents were rare in closed-type prisons (that is, Prisons Nos. 1, 2 and 8)[59] where inmates remained locked in their cells and without the possibility to associate between cells for most of the day (if at all).[60] As for Prison No. 15, by contrast, inter-prisoner violence was more common,[61] which was hardly surprising given the open cell regime and the very low staff presence, with approximately only 40 custodial staff expected to control almost 1.600 inmates circulating freely across the extensive territory of the prison.[62]

Further, as previously, there were clear indications of the persistent influence of informal prisoner hierarchy at Prison No. 15. These indications were of the same nature as those described in detail in the report on the 2021 ad hoc visit,[63] including the conspicuous displaying of typical symbols (in particular, the "Vorovskoy Mir/Thieves World" eight-pointed stars), the visible disparity in conditions between the cells[64] and the striking reluctancy of prisoners to speak with the delegation and their tendency to deny even obvious and confirmed facts (such as documented conflicts and injuries[65]).

59. E.g. four recorded cases at Prison No. 1 since the time of its opening (December 2023) and four cases registered at Prison No. 2 in the period between 1 January and 25 November 2024.
60. See paragraph 41 below.
61. 62 official inter-prisoner violence incidents recorded in the period between 1 January and 21 November 2024.
62. See also paragraph 52 below.
63. See paragraph 12 of that report (document CPT/Inf (2022) 11).
64. Whilst most of the prisoners had to live in cramped and rather dilapidated accommodation, some of the inmates (presumably those occupying higher ranks in prisoner hierarchy) enjoyed relatively comfortable conditions, with more living space, refurbished cells (with parquet or tiled floors) and a lot of non-standard equipment (large TV sets, DVDs, hi-fi towers, air conditioning units, kitchen corners, etc.). See also paragraph 39 below.
65. That is, injuries that had most likely resulted from inter-prisoner violence, e.g. 13 such injuries were found by the delegation's forensic doctor in the medical records at Prison No. 15 (despite their relatively poor quality, see paragraph 47 below). One prisoner with an injury on his forehead sustained on 1 November 2024 had complained of having been assaulted by a cellmate and this had been recorded by the doctor at Prison No. 15; however, when interviewed by the delegation on 22 November 2024, he denied not only the fact of having been assaulted but even having sustained any injury at all.

The delegation also again noted the relatively high number of inmates isolated on their own request (and/or by decision of the administration, for their own safety) and/or transferred to closed prisons (especially Prison No. 8),[66] the very low number of formal disciplinary sanctions[67] and a negligible number of official complaints.[68]

Last but not least, a few prisoners (mostly foreign nationals) did openly acknowledge the existence of informal hierarchy (with "watchers" residing on every floor of every wing) and this was also implicitly acknowledged by the management.[69]

37. In the light of the above remarks, **the CPT calls upon the Georgian authorities to step up their efforts to prevent and combat inter-prisoner violence and intimidation, in all prisons but especially in the semi-open prisons ("zonas") including Prison No.15. 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.**

Reference is also made here to the remarks in paragraph 52 of the report on the 2018 visit, which remain fully relevant:

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

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

38. As stated several times in the past, the Committee is of the view that achieving the aforementioned goal will be very difficult, if not impossible, in the currently existing semi- open prisons, especially given the combination of an open-door regime,[70] the lack of activities[71] and the very low staffing levels.[72] As already mentioned in paragraph 34 above, this is also the stated view of the Georgian authorities and their plan is to

66. There had been 81 such transfers from Prison No. 15 in the period between 1 January and 21 November 2024.
67. It seemed clear that there was a tacit understanding from both the management and members of the prisoner hierarchy that any "misbehaviour" and any internal conflicts between inmates should first of all be dealt with informally, between prisoners (and without formally involving the administration).
68. The very few complaints that were recorded concerned exclusively inmates' criminal cases (and were thus addressed at the criminal justice system – Prosecutor's Office and courts – and not the prison service and the management of Prison No. 15) or, in rare cases, issues such as the refusal of transfer to a different establishment or the refusal to grant early (conditional) release.
69. "There is no prison in the world where such hierarchy does not exist."

70. See paragraph 41 below.
71. As above.
72. See paragraph 52 below.

replace the "zonas" with smaller prisons offering material conditions, regime and staff resources permitting to eliminate the influence of criminal hierarchy and the related phenomena of inter-prisoner violence and intimidation.

Consequently, reference is made to the recommendation in paragraph 34 above.

Further, the CPT refers to the recently published document setting out its views on the phenomenon of informal prisoner hierarchy and on ways to combat its influence (document CPT/Inf (2025) 12), [73] and especially to the remarks in paragraphs 32 to 35 of the said document. The Georgian authorities should draw inspiration from this document in planning their further steps in this area.

3. Conditions of detention

a. Material conditions

39. Unsurprisingly, given the fact that it had been brought into service recently and that it was only operating at less than half of its official capacity at the time of the visit,[74] the best material conditions were observed at Prison No. 1 in Laituri, where the bright, airy and clean standard 15 m^2 cells were accommodating one or two prisoners each and were equipped with fully-partitioned sanitary annexes (comprising also a shower), beds (or bunk beds) with full bedding, tables, stools, lockers, fridges, air conditioners, electric kettles and TV sets.

The remaining prisons visited (that is, Prison No. 8 in Gldani, Prison No. 15 in Ksani and Prison No. 2 in Kutaisi) were at least locally overcrowded[75] and, despite some ongoing refurbishment, parts of prisoner accommodation suffered from visible wear-and-tear.[76] Further, there were problems with cleanliness and vermin infestation, especially at Prisons Nos. 2 and 8.[77]

The CPT recommends that steps be taken to address the aforementioned deficiencies in Prisons Nos. 2, 8 and 15. Regarding overcrowding, reference is made to the recommendation in paragraph 33 above.

40. On the positive side, no noteworthy problems were observed in any of the prisons visited as regards access to a shower (twice per week and every day for the juveniles and the few sentenced prisoners who had a job[78]) and the provision of hygiene items and food.

b. regime and activities

41. The absence of any real progress in respect of the development of prison regimes in Georgia, despite the Committee's long-standing recommendations,[79] represents the issue of the CPT's greatest concern. In all of the prisons visited in the course of the 2024 periodic visit, the overwhelming majority of inmates (including

73. See https://www.coe.int/en/web/cpt/-/the-council-of-europe-anti-torture-committee-cpt-calls-for-action-to-combat-prison-overcrowding-and-informal-hierarchies-in-prisons, and https://rm.coe.int/1680b57a6a.
74. See paragraph 32 above.
75. E.g. six prisoners accommodated in standard 20 m^2 cells (fully screened sanitary annexe included) at Prison No. 8; up to six inmates in standard 16 m^2 cells (including the fully-partitioned sanitary annexe) at Prison No. 2, and up to six in standard 19 m^2 cells (including the fully partitioned sanitary annexe) at Prison No. 15. As already mentioned in paragraph 36 above, some prisoners (presumably those belonging to the higher echelons of informal hierarchy) enjoyed much better conditions at Prison No. 15, with only two inmates sharing the same standard cells.
76. E.g. the ground level of Block 3 at Prison No. 8.
77. In particular in the admission units (so-called "internal classification areas").
78. See paragraph 41 below.
79. See e.g. paragraph 48 of the report on the 2018 periodic visit (CPT/Inf (2019) 16).

the life-sentenced prisoners) had no organised out-of-cell activities.[80] Worse still, apart from Prison No. 15 (with its open-door regime during the day), the bulk of the prisoner population continued to be locked inside their cells for up to 23 hours per day.

Furthermore, many prisoners (including most of the lifers[81]) were held for months, if not years, in solitary confinement, with no association and very limited human contact, and often under permanent CCTV surveillance. On this, the Committee's position is completely clear: when it encounters such restrictive conditions of detention combined with lack of purposeful activities and a very limited contact with the outside world, the CPT considers that it could amount to inhuman and degrading treatment.

42. In this context, the delegation was particularly concerned by its findings from Prison No. 1, which was supposed to be a "new model prison", with an extensive offer of organised activities; instead, it was actually the establishment with the highest number of prisoners in solitary confinement and with close to no organised activities at all.[82]

In the CPT's view, it is not too late to completely rethink the manner in which Prison No. 1 is operated, given that it is so far only filled to 50% of its official capacity.[83] The (yet) unused floors can still be reconstructed so as to provide appropriate association space and ensure meaningful human contact and activities for prisoners. On the same occasion, the totally inadequate, small (measuring approximately 12 m^2), bare and oppressive exercise yards should be enlarged and reconstructed.

The Committee calls upon the Georgian authorities to reconstruct and reorganize Prison No. 1 in accordance with the aforementioned remarks.

43. More generally, the CPT reiterates its long-standing view that the aim should be for all prisoners, irrespective of regime and category (whether on remand and sentenced) to be offered a range of purposeful out-of-cell organised activities (work, vocational training, education, sports, leisure and association) for at least 8 hours per day.[84] Of course, to be able to implement this recommendation, much more staff of all categories (custodial, social workers, psychologists, teachers, work and sports instructors, etc.) must be recruited.

The CPT once again calls upon the Georgian authorities to take decisive steps to develop the programmes of purposeful activities for both sentenced and remand prisoners, taking into account the aforementioned precepts. Regarding prison staff, reference is made to the recommendation in paragraph 52 below.

44. As already mentioned in paragraph 11 above, at the end of the visit the delegation invoked Article 8, paragraph 5, of the Convention, and requested the Georgian authorities to confirm, within 3 months, that all prisoners currently accommodated alone in their cells at Prison No. 1 (and, as applicable, in Prisons No. 2 and 8) are offered at least two hours of meaningful human contact each day; this means that they must be able to associate on a daily basis with at least one and preferably more carefully selected fellow inmates (or, if this proves impossible, with suitably trained members of the staff).

In their letter of 22 March 2025, the Georgian authorities stated that steps had been taken to provide meaningful human contact to all prisoners concerned; however, no details are given as to how exactly this has been achieved.

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80. For example, only some 140 prisoners (out of the total of 2.418) were involved in any form of work or education at Prison No. 8. At Prison No. 15, paid work was only available to 75 inmates and other activities such as arts and crafts to approximately ten prisoners (out of the total of 1.576). At Prison No. 2, only 84 prisoners (out of the total of 981) had a job. As for Prison No. 1, work was available to 33 prisoners (out of the total of 300).

81. On the subject of life-sentenced prisoners, see the substantive chapter of the CPT's 25th General Report (document CPT/Inf(2016)10-part, https://rm.coe.int/16806cc447).

82. Apart from access to a gym three times a week (for sentenced prisoners only) and some occasional arts and crafts for a few prisoners.

83. See paragraph 39 above.

84. Particular attention should be paid to the specific needs of juvenile prisoners.

The Committee requests the Georgian authorities to communicate such details in their response to this report.

45. The CPT also wishes to reiterate its view (previously set out in paragraph 74 of the report on the 2018 periodic visit) that there is an urgent need to completely rethink the philosophy and the approach to medium, higher and high-risk prisoners, to ensure that any restrictions on organised activities, association, privacy and contact with the outside world are only imposed based on a genuine and regularly reviewed individual risk and needs assessment, and with appropriate procedural safeguards (information to inmates on the reasons of placement, systematic oral hearings, possibility to appeal the decision, etc.).

Unfortunately, nothing had changed in this respect: the applicable procedure[85] still lacked transparency, inmates were not granted a hearing and were not informed of the grounds and appeal possibilities. Further, despite this being a legal requirement set out in the Penitentiary Code, individual risk assessments were carried out and individual sentence plans drawn up only in respect of a small minority of inmates, essentially only those defined by the prison authorities as belonging to "vulnerable groups" (such as young prisoners, women, prisoners sentenced for violent crimes including in particular domestic violence and those with drug problems or identified as prone to suicide).[86]

The CPT calls upon the Georgian authorities to fully implement in practice the provisions of the Penitentiary Code concerning individual risk assessment and individual sentence plans, in respect of all inmates. In this context, particular attention should be paid to the procedural safeguards mentioned above and, in the case of individual sentence plans, to involving prisoners in the drafting and reviewing the plans, so as to secure their commitment to the implementation of the plans and to their social reintegration.

4. Health care

46. As regards health-care services in the prisons visited, the delegation found them to be of a good quality overall. There was a 24/7 health-care coverage and a generally quick access to primary health care, with a sufficient number of *doctors*[87] employed in each prison although a somewhat less satisfactory situation with respect to *nurses*.[88]

On the latter aspect, **the Committee recommends that steps be taken to recruit more nurses at Prisons Nos. 2 and 15.** Further, **sustainable measures should be planned to compensate for the loss of doctors and nurses expected to retire in the near future.**[89]

The delegation also found that health-care units were on the whole adequately resourced in terms of *medication*, *equipment* and *premises*, albeit with an important exception of the cramped premises of the health-care service at Prison No. 15.

The CPT recommends that the health-care service at Prison No. 15 be provided with additional space (at least 2 – 3 additional rooms).

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85. Decisions were taken by the Special Penitentiary Service based on proposals by the Directors after consultation with security, regime, medical and psychological staff. They were reviewed every three months.
86. For example, this concerned only approximately 50 prisoners at Prison No. 15 in Ksani (out of the total of 1.576), some 30 sentenced prisoners at Prison No. 2 (out of the total of 981) and approximately 25 at Prison No. 1 (out of the total of 300).
87. Prison No. 8 had 30 FTE (full-time equivalent) doctors (one doctor per 80 inmates), though 15 of the doctors were expected to retire soon; Prison No. 15 had eight FTE doctors (one doctor per 197 inmates), five of whom approaching the retirement age; Prison No. 2 had eight FTE doctors (one doctor per 123 inmates), three of whom were about to retire soon; and Prison No. 1 had seven FTE doctors (one doctor per 42 inmates), one about to retire. It is noteworthy that access to various outside specialists and hospitals did not seem to pose any real problem.
88. Prison No. 8 had 58 FTE nurses (four of whom were planning to retire soon), Prison No. 15 had 22 FTE nurses (of whom 11 were expected to retire in the near future), Prison No. 2 had 19 FTE nurses (seven approaching the retirement age) and Prison No. 1 had 30 FTE nurses (two of them planning to retire soon).
89. At the time of the visit, retiring doctors and nurses were often offered consultant contracts so as to allow them to continue exercising while officially retired; however, for rather obvious reasons this could hardly be considered a long-term solution.

47. The delegation observed as a positive aspect that there was a systematic and well performed *medical screening on arrival*, including the screening for infectious diseases and the *recording and reporting of injuries* (again, with the exception of Prison No. 15 where injuries were poorly recorded[90] and where no attempt was made by doctors to assess the compatibility of the injuries with often completely medically implausible explanations provided by prisoners[91]).

The Committee recommends that steps be taken to remedy this, in particular by providing doctors working at Prison No. 15 with appropriate training.

Another issue of concern (in all the prisons visited) was that the initial screening did not include a proper assessment of mental health aspects, including trauma and suicide risk.

The CPT recommends that the initial screening procedure be modified accordingly.

Further, the aforementioned good recording and reporting procedure (with reports being sent to the SIS accompanied by body charts and photographs[92]) was only applied with respect to allegations of ill-treatment by law enforcement (police or prison) officials or when there were other indications suggesting such ill-treatment, even without any allegations. By contrast, when injuries resulted from inter-prisoner violence (or were likely to have resulted from it), the recording was more superficial (with no photographs taken) and reports were only sent to the General Inspection of the Ministry of Justice.

The CPT recommends that the procedure applicable to injuries resulting (or likely to have resulted) from inter- prisoner violence be aligned with that applied to allegations (or indications) of ill- treatment by police or prison officials.

48. There were individual *medical files* for prisoners in all the establishments visited, and they seemed to be generally well kept. However, as in the past, *medical confidentiality* was not always respected as, firstly, requests for medical consultations had to be made in an open form through custodial staff and, secondly, medical examinations could still occasionally take place in the presence of custodial officers.

The CPT recommends, once again, that steps be taken to ensure that prisoners have confidential access to the health-care service in all the prisons in Georgia. Submitting request forms in sealed envelopes should become a standard procedure; for this purpose, the forms should always be handed over to prisoners together with envelopes. The Committee also calls upon the Georgian authorities to implement its long-standing recommendation that medical examinations/consultations be as a rule conducted out of the sight and hearing of non-medical staff, under conditions fully guaranteeing medical confidentiality.

49. By contrast with the generally positive assessment set out in paragraph 46 above, the CPT remains concerned by the persistent serious shortcomings in the provision of *mental health care* (psychiatric and psychological) to prisoners.[93] In particular, there were still not enough psychiatrists[94] and psychologists.[95] Further, there was in fact almost nothing available for inmates with mental health issues but pharmacotherapy.

90. E.g. no mention of exact location, size and colour of the injuries.
91. E.g. in several cases inmates had sustained facial injuries and explained that those injuries had resulted from a fall, an occupational or sports accident, or falling from an upper bunk bed. The delegation's doctor also found in the relevant medical records a case where a prisoner had had his ligaments sectioned, which was described as having resulted from a fall.
92. The latter with the inmate's consent.
93. See also paragraph 51 below.
94. E.g. there were two psychiatrists at Prison No. 8. Prison No. 2 was visited by a psychiatrist three times per week and Prisons Nos. 15 and 1 once a week.
95. There was only one psychologist at Prison No. 1 and two at Prisons No. 2 and 15. Prison No. 8 was better staffed in this respect, with ten psychologists.

The CPT reiterates its recommendation that the Georgian authorities continue their efforts to reinforce the provision of psychiatric and psychological care to prisoners (based on a professional initial and ongoing screening process, see also paragraph 47 above) and in particular improve access to psychiatrists in all prisons, offer therapies other than medication (e.g. individual and group psychotherapy, art and occupational therapy) and provide therapeutic activities, with the involvement of psychologists working in prisons.

The Committee also reiterates its recommendation that the Georgian authorities reinforce the provision of psychological care in prisons and develop the training and the role of prison psychologists, especially as regards therapeutic clinical work with various categories of inmates. In this context, efforts are needed to recruit, in due course, clinically trained psychologists who should form part of the health-care team and whose work should avoid combining two conflicting roles i.e. risk assessment and therapeutic clinical work.

50. There were also numerous prisoners with *addiction problems* in the prisons visited, the response to which continued to be limited to detoxification[96] (at Prisons Nos. 2[97] and 8[98] and the Prison Hospital[99]) to the detriment of the necessary broader approach including MOUD (medication for opioid use disorder) as maintenance therapy. As previously, there were no harm reduction measures (including needle and syringe exchange programs).

The CPT recommends that further efforts be made to develop the response to the addiction problem in prisons, in the light of the above. Reference is also made to the Committee's remarks in paragraph 90 of the report on the 2018 periodic visit.[100]

In this context, the CPT has learned after the visit about the Georgian authorities' plans to introduce court ordered mandatory treatment as an additional measure for persons convicted of drug-related offences.[101]

The Committee would like to receive detailed information on these plans, including on the envisaged procedure for imposing such mandatory treatment and its planned contents.

51. As already mentioned in paragraph 32 above, the delegation carried out a (brief) follow-up visit to the Prison Hospital (Penitentiary Establishment No. 18), where the overall living conditions were found to be acceptable.[102]

96. Under the supervision of two full-time narcologists (addiction specialists), two other doctors and two full-time specifically trained nurses.
97. 26 prisoners.
98. Approximately 40 prisoners.
99. Three female patients.
100. CPT/Inf (2019) 16). Paragraph 90 of the aforementioned report reads as follows: "The management of prisoners with drug dependence must be varied – eliminating the supply of drugs into prisons, dealing with drug abuse through identifying and engaging drug misusers, providing them with treatment options and ensuring that there is appropriate through care, developing standards, monitoring and research on drug issues, and the provision of staff training and development – and linked to a proper national prevention policy. This policy should also highlight the risks of HIV or hepatitis B/C infection through drug use and address methods of transmission and means of protection. It goes without saying that health-care staff must play a key role in drawing up, implementing and monitoring the programmes concerned and must co-operate closely with the other (psycho-socio-educational) staff involved. 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.
101. See e.g. https://civil.ge/archives/669928.
102. See the description of those conditions made in paragraphs 99 and 104 of the report on the 2014 periodic visit (CPT/Inf (2015) 42), which remains valid. At the time of the 2024 visit, the Prison Hospital had 140 beds (including 60 on the psychiatric ward).

One major difference in comparison with the 2018 periodic visit was that the Prison Hospital was now mostly used for psychiatric patients,[103] inmates requiring somatic treatments being, as a rule, transferred to the VivaMedi Clinic.[104] Whilst the psychiatric ward continued to be sufficiently staffed with doctors and nurses,[105] treatment options had remained limited to pharmacotherapy, with no association and no psycho-social therapeutic activities. Further, the delegation noted cases of extremely prolonged use of "de-escalation cells."[106]

The CPT therefore calls upon the Georgian authorities to develop a broader range of psycho-social therapeutic activities for patients accommodated on the psychiatric ward of the Prison Hospital, in particular for those who remain there for extended periods; occupational therapy should be an integral part of the rehabilitation programme. Regarding the use of "de-escalation cells", reference is made to the comments and recommendation in paragraph 55 below.

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

a. prison staff

52. All the prisons visited were severely understaffed, with a very low custodial staff presence e.g. less than 40 junior custodial staff ("controllers") on any given shift at Prison No. 8,[107] 35 at Prison No. 15[108] and 18 at Prison No. 1.[109] There were also a few social workers (not more than two per establishment) and a small number (up to six) of so-called "case officers" whose task was to be the first point of contact for prisoners in case of any requests or complaints.

It was clear that such a low staff complement (and especially such a low attendance pattern) rendered impossible the development of an adequate regime and activities, as recommended by the CPT on numerous previous occasions.[110] Furthermore, at Prison No. 15 (with its open door regime during the day), the shortage of staff continued to put at risk the security of both staff and prisoners and resulted in the management and staff considering themselves forced to rely to a certain extent on prisoners to assist them in performing custodial tasks. Needless to add that the Committee considers this highly regrettable (and persistent) state of affairs to be totally unacceptable.

In the light of the above, the CPT calls upon the Georgian authorities to step up their efforts to significantly increase prison staff complements at Prisons Nos. 1, 2, 8 and 15 which should concern custodial staff but also social workers, psychologists[111] and other staff qualified to organise activities (teachers, work instructors, arts, crafts and sports instructors, etc.). As regards the situation at Prison No. 15 in particular, reference is made to the recommendation in paragraph 53 of the report on the 2018 periodic visit which remains fully valid:

103. There were 40 of them at the time of the 2024 visit.
104. Visited by the CPT in the course of the 2023 ad hoc visit (CPT/Inf (2024) 02).
105. There were 30 doctors, including three psychiatrists, and 50 nurses. On the psychiatric ward, each shift comprised two psychiatrists, two nurses and an orderly (orderlies were trained on the spot by nurses to work with psychiatric patients).
106. One patient had continuously stayed in a "de-escalation cell" for 24 days, by means of consecutive 72-hour placements. There had been 95 placements in the course of 2023 and 85 during the period between 1 January and 21 November 2024.
107. Population 2.418. This means that there was one "controller" per 60 inmates.
108. Population 1.576, that is, one "controller" per 45 inmates.
109. Population 300, that is, one "controller" per 17 inmates.
110. See e.g. paragraph 48 of the report on the 2018 periodic visit (CPT/Inf (2019 16) and paragraph 43 above.
111. See also paragraph 49 above.

"An end must be put at Prison No. 15 (as well as, as applicable, in other prisons) to the practice of delegating authority to informal prisoner leaders and using them to maintain order and security among the inmate population. All informal prisoner leaders and their close circle must be deprived of privileges which other prisoners do not enjoy, including as regards material conditions; consideration might be given in this context to segregating the informal leaders and their close circle from the rest of the prison population, on the basis of a proper individual risk and needs assessment."[112]

53. As during previous visits, the delegation observed that most of the custodial staff in the establishments visited worked on 24-hour shifts followed by three days off. The CPT can only reiterate its opinion that such a shift pattern has an inevitable negative effect on professional performance; no-one can perform in a satisfactory manner the difficult tasks expected of a prison officer for such a length of time.

The Committee calls upon the Georgian authorities to discontinue this practice.

b. disciplinary and "de-escalation" cells

54. As had been the case in the past, the delegation did not observe any excessive recourse to the placements in disciplinary cells in the prisons visited,[113] and at Prison No. 15 the number of such placements was (again) strikingly low.[114] Further, as previously, the CPT has no major concerns regarding the material conditions in disciplinary cells[115] nor the placement procedure which generally contained the necessary safeguards. [116]

55. By contrast, the persistently frequent[117] and sometimes extremely prolonged placements in "de-escalation cells"[118] in most establishments visited (including the Prison Hospital but with the exception of Prison No. 15[119]) are an issue of serious concern to the Committee. Although in principle such placements were for a maximum of 72 hours, in practice they could be imposed consecutively reaching, on some occasions, as many as 24 days without interruption. As had been the case during the 2018 periodic visit,[120] the delegation could not escape the impression that placement in "de-escalation cells" was sometimes *de facto* a form of punishment (and indeed many prisoners perceived it as such).

112. See also paragraph 37 above.
113. For example, the average was 4 – 5 placements per month (of 3 – 5 days mostly) at Prison No. 8 (population 2.418, half of them on remand). At Prison No. 1 (population 300), since the establishment had been brought into service (in December 2023), there had been 17 placements in a disciplinary cell, usually for between 3 and 7 days. See, however, paragraph 55 below.
114. E.g. 16 placements (usually 2 to 10 days) in the whole year 2023 and 5 between 1 January and 21 November 2024, in an establishment accommodating 1.576 inmates at the time of the visit. This was, of course, in principle a positive thing; see, however, the remarks in paragraph 36 above.
115. They were overall well-lit and ventilated and usually measured approximately 10 to 15 m^2 and contained a sleeping platform, a mattress, a blanket and a pillow, a table and a stool fixed to the floor, a partially screened sanitary annexe (comprising a break-proof stainless-steel toilet and a washbasin), a call bell and (sometimes) CCTV. They were all found to be in a decent state of repair and cleanliness.
116. Prisoners had the right to be informed of the charges, to have an oral hearing, to be represented by a lawyer (although this almost never happened in practice), to be given a copy of the disciplinary decision and to appeal the sanction to the court within 10 working days (the appeal having no suspensive effect).
117. E.g. approximately 800 placements at Prison No. 8 in 2023, and some 380 between 1 January and 19 November 2024. At Prison No. 2, there had been over 500 placements in the same period. There had been less placement at Prison No. 1 (52 in the period between 1 January and 26 November 2024).
118. Which were bare except for a secure floor-level toilet, with a rip-proof mattress and blanket given while inmates were placed in them. Most of the "de-escalation cells" seen by the delegation were adequately lit and ventilated, clean and in a good state of repair. All were fitted with CCTV and some also had a sort of anti-chamber with a table and stools, where inmates might be allowed to take their meals (in the presence of staff) provided they had calmed down sufficiently.
119. Which did not possess "de-escalation cells".
120. See paragraph 101 of the report on the 2018 periodic visit (CPT/Inf (2019) 16).

The CPT must reiterate its view that "de-escalation cells" should only be used in relation to prisoners who are agitated and/or aggressive, and always for as short a time as possible (preferably just a few hours) and the whole procedure should be under the authority of the doctor, not the custodial staff.[121] Any prisoner who remains agitated after several hours must be clinically assessed and, if necessary, transferred to a mental health establishment.

The Committee calls upon the Georgian authorities to amend the rules and change the practice with respect to the use of "de-escalation cells", in the light of the above remarks.

56. At Prisons Nos. 1 and 8, the delegation came across cases when prisoners had been placed handcuffed (for periods of one to three hours) whilst in a "de-escalation cell", reportedly with the aim of preventing self-injury. The CPT finds this unacceptable. The very purpose of "de-escalation cells" is to have safe premises for agitated prisoners, where they cannot harm themselves. If there is a risk of self-harm, prisoners should never be handcuffed but instead placed under permanent, personal and direct supervision by staff.[122] Needless to add, such placements can only be carried out under medical supervision.

The Committee recommends that steps be taken to modify the current practice accordingly.

c. contact with the outside world

57. At the outset of the visit, the Minister of Justice informed the delegation that the Penitentiary Code had recently been amended so as to allow long-term visits also for remand prisoners. This is a welcome development which, however, was clearly not yet in force in the prisons visited. In general, the visiting entitlement had remained the same as during the 2018 visit,[123] which meant that it was insufficient.

The Committee must therefore reiterate its long-standing view that the existing legislation should be amended so as to ensure that all prisoners, irrespective of category and regime, are offered at least the equivalent of one hour of visiting time per week.

The CPT calls upon the Georgian authorities to amend the Penitentiary Code accordingly.

58. The Committee is also concerned by the fact that, as a rule, short-term visits still took place in small booths with a plexi-glass or glass partition, preventing any possibility for prisoners to have physical contact with their relatives, including young children.[124]

The CPT reiterates its recommendation that short-term visiting facilities be modified in all prisons so as to enable prisoners to receive visits, as a rule, under 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.

59. As for access to a telephone, it varied between unlimited at Prison No. 15 to three times per month at Prison No. 8. At Prisons Nos. 1 and 2 there were no restrictions as to the number and frequency of calls but instead a limit on the total duration per month (60 to 90 minutes, according to the risk category).

In this respect, **the Committee reiterates its recommendation that the Georgian authorities take steps to improve access to a telephone for all categories of prisoners.[125]**

121. Currently the opinion of a doctor and a psychologist is sought, but the placement is a decision by the duty guard (on a provisional basis, 24 hours maximum) to be confirmed as soon as possible by the Director.
122. At the time of the visit, checks on prisoners placed in "de-escalation cells" were performed irregularly (generally up to four times per day) and reliance was essentially had on CCTV monitoring instead of personal direct supervision.
123. One to three short-term (one hour) visits per month and two to three long-term (23 hours) visits per year, depending on the risk category.
124. By contrast, long-term visit premises were found to be fully adequate in all the prisons visited.
125. See also Rules 24.1 and 99 of the European Prison Rules.

60. The delegation was pleased to note that the possibility of video calls (every 10 days), introduced as a temporary measure to compensate for the absence of long-term visits during the Covid-19 pandemic,[126] had been rendered permanent. That said, due to the persistent requirement for inmates' relatives to use computers located in regional Probation Service offices, access to video calls was still de facto impossible for foreign prisoners and Georgian prisoners whose relatives lived abroad.

The CPT recommends that the Georgian authorities seek ways to cease this discriminatory practice.

126. See paragraph 30 of the report on the 2021 ad hoc visit (CPT/Inf (2022) 11).

C. Psychiatric establishments

1. Preliminary remarks

61. The CPT delegation visited for the first time the Tbilisi Mental Health Centre (hereafter: Tbilisi Psychiatric Hospital) and carried out follow-up visits to the Psychiatric Department at Batumi Medical Centre (hereafter: Khelvachauri Psychiatric Hospital) and the National Centre of Mental Health in Khoni (hereafter: Kutiri Psychiatric Hospital).

Tbilisi Psychiatric Hospital, opened in 2006, is located on the northern outskirts of the city and occupies a five-storey building (formerly used as a police training centre). With an official capacity of 210 beds distributed among two wards for men and one ward for women, it was accommodating 129 male and 78 female patients at the time of the visit, all of whom were adults and had been formally admitted to the hospital on a voluntary basis (see, however, paragraph 62). The main diagnosis among the patients was schizophrenia in its various forms, followed by affective and personality disorders. The number of admissions/discharges ranged between 900 and 1.200 persons per year, the average length of hospitalisation being two to three weeks.[127]

That said, at the time of the visit, there were about 30 persons (mainly patients with intellectual disabilities) who had been staying in the hospital already for several months, and some of them for more than a year. The delegation was told that those patients no longer needed to be held in the hospital but had to remain there due to a lack of adequate care/accommodation in the community. As stressed by the CPT in the past, for persons to remain deprived of their liberty as a result of the absence of appropriate external facilities is a highly questionable state of affairs (see, in this regard, paragraph 63).

Khelvachauri Psychiatric Hospital was first visited by the CPT in 2018.[128] It continued to function within a private multifunctional healthcare facility near Batumi and had the same official capacity as in 2018 (i.e. 150 beds). At the time of the 2024 visit, the hospital was accommodating 153 adult patients (including 52 women),[129] of whom seven had been subjected to involuntary hospitalisation of a civil nature under Section 18 of the Law on Psychiatric Assistance (LPA). The delegation was informed that the hospital admitted approximately one hundred persons every month and that the average length of hospitalisation was 20 days.

Kutiri Psychiatric Hospital had been visited by the CPT several times in the past, most recently in 2018.[130] With an official capacity of 660 beds spread over several buildings, it was accommodating 612 patients (including 48 women and four children) at the time of the visit.[131]

Among them, 57 were "civil" patients (including three involuntary placements) and 397 were subject to a court-ordered measure of compulsory in-patient psychiatric treatment under Section 191 (2) of the Code of Criminal Procedure (CCP). There were also 118 remand and sentenced prisoners who had been transferred to the hospital to receive treatment and a further 40 persons undergoing involuntary psychiatric treatment pursuant to Section 22^1 (7) of the LPA.[132] In addition, the hospital continued to have on its premises a social care facility ("shelter") which provided separate accommodation to some one hundred women and men with different diagnostic categories of mental disorders.

127. The hospital also provided out-patient services to some 5 000 persons per year.
128. See paragraph 105 of CPT/Inf (2019) 16.
129. Some of the patients' rooms had been equipped with an additional bed to manage similar situations of overpopulation.
130. See paragraph 105 of CPT/Inf (2019) 16.
131. The hospital had 10 forensic psychiatry wards, two general psychiatry wards, one child psychiatry ward and one ward for patients with substance addiction.
132. Having initially been subjected to forensic psychiatric placement under Section 191 (2) of the CCP for compulsory treatment of up to four years, such patients were subsequently committed to the hospital under the civil placement procedure (as they were thought to still require in-patient psychiatric care) but continued to be held on forensic wards.

62. As indicated above, with some exceptions, all "civil" patients accommodated in the three psychiatric hospitals visited (that is, over 400 persons) had been formally admitted on a voluntary basis. However, most of them had been subsequently placed in locked hospital wards and, as became apparent from interviews with patients and staff, were prevented from leaving the hospital on their own. Thus, they appeared to be *de facto* deprived of their liberty, without benefiting from the legal safeguards accompanying the involuntary placement in psychiatric establishments. This issue will be dealt with in the relevant section of this report (see paragraphs 98 and 99).

63. During the visit, representatives of the national health authorities informed the delegation about ongoing reforms in the field of mental health which focused on the de-institutionalisation of long-term patients and the promotion of community-based care. Particular reference was made to efforts to develop a network of out-patient community centres and mobile outreach teams with a view to supporting people who have spent long periods of time in psychiatric institutions. It was also indicated that there had been a steady increase in recent years in budget allocations for the development of community psychiatric care. However, serious challenges remained, mainly linked to human resources (i.e. lack of psychiatrists, psychologists, social workers, nurses, etc.) and training.

The CPT would like to be updated on the progress made by the Georgian authorities in the implementation of their de-institutionalisation policy.

2. Ill-treatment

64. The delegation received no allegations of recent physical ill-treatment by staff in the establishments visited. On the contrary, patients generally spoke favourably of their relations with staff.

However, at Khelvachauri and Tbilisi Psychiatric Hospitals, allegations were received of nursing assistants (orderlies) shouting at patients and using disrespectful language. On one occasion, the delegation witnessed for itself such behaviour by a nursing assistant at Tbilisi Psychiatric Hospital.

The CPT recommends that the management of these two hospitals regularly instruct nursing assistants that patients must be treated with dignity and respect and that any form of ill-treatment of patients, including verbal abuse, is unacceptable and will be punished accordingly.

65. It is also essential that, given the challenging nature of their job, nursing assistants be carefully selected and given appropriate training before taking up their duties as well as ongoing training. Particular attention should be given to training in the prevention and management of aggressive behaviour in patients, including verbal de-escalation skills. Further, while carrying out their duties, nursing assistants should be closely supervised by healthcare staff.

The Committee recommends that the procedures for the selection, training and supervision of nursing assistants in psychiatric hospitals be developed in light of these remarks.

66. It would appear from the information gathered during the visit that inter-patient violence was not a major problem in any of the hospitals visited and that staff were vigilant in this respect. That said, occasional physical altercations between patients did take place, which was hardly surprising considering the generally low numbers of ward-based staff (which made the supervision of patients and interaction with them difficult) and the lack of organised activities for patients (which resulted in somewhat chaotic environment on some wards) in each of the establishments visited. Reference is made in this regard to the recommendations in paragraphs 81 and 84 below.

3. Living conditions

67. Material conditions at Kutiri Psychiatric Hospital had been the subject of severe criticism by the CPT in its previous visit reports, the conditions in certain parts of the establishment being qualified as "unfit for a healthcare institution", or even "inhuman and degrading".[133]

Consequently, the Committee was very pleased to note during the current visit that the hospital had undergone a comprehensive renovation/reconstruction programme and had transformed into a facility which offered its patients and social care residents living conditions of a generally good standard.

68. Patients' accommodation rooms throughout the establishment were in a good state of repair, clean, well lit, and sufficiently heated and ventilated. They were furnished with beds with full bedding, bedside cupboards, shelves and a TV set and possessed a sanitary annexe (toilet and shower). Further, individual lockers were available in the corridor of every ward, in which patients could keep their personal belongings. The hospital also had new kitchen and laundry facilities.

69. Most of the patients' rooms on the hospital's forensic wards contained four beds. The delegation noted however that many of these rooms measured only between 14 and 15 m^2 (excluding the sanitary annexe) while being fully occupied, thus providing cramped living space.

In this regard, the delegation was informed by the hospital management that, with the planned commissioning in early 2025 of a new facility for social care residents with mental disorders, the hospital would gain some extra bed capacity, leading to reduced occupancy levels on its forensic wards.[134]

The CPT would like to receive confirmation that these plans have materialised.

70. The Committee was also pleased to note that major refurbishment had taken place at Khelvachauri Psychiatric Hospital since its previous visit to the establishment in 2018, which has led to improved living conditions for patients, notably in terms of general state of repair and of beds and bedding. The accommodation areas were also adequately heated and ventilated and well lit.

71. However, the delegation observed that most of the patients' rooms on the two wards for men – particularly the so-called "acute" ward – already displayed signs of deterioration (e.g. dirty and sometimes damaged walls). Further, the sanitary facilities on these wards (whether in-room or communal) were often unhygienic.

Although material conditions were generally better on the two women's wards (including as regards hygiene), the delegation noted that some of the patients' rooms on the "acute" ward were affected by damp and one such room had severely damaged walls.

72. The majority of patients were accommodated in rooms with up to five beds. While these rooms could be regarded as providing acceptable living space,[135] the conditions in the larger rooms which had up to nine beds were cramped, with some beds touching. It was clear that the hospital's official capacity of 150 beds was far too high considering the overall living space available to patients. In this regard, it is regrettable that the authorities' long-standing plans to reduce the establishment's capacity to 100 beds have still not been implemented.[136]

133. See, most recently, paragraph 110 of CPT/Inf (2019) 16.
134. The delegation was told that the construction of a new "shelter" facility in the vicinity of Kutiri Psychiatric Hospital was nearing completion, to which the social care residents currently accommodated in the hospital would subsequently be transferred.
135. For example, a room with five beds measured some 20 m^2 and a room with four beds some 17 m^2 (excluding the sanitary annexe).
136. See paragraph 114 of CPT/Inf (2019) 16.

73. **The CPT recommends that steps be taken at Khelvachauri Psychiatric Hospital to keep patients' accommodation areas (including sanitary facilities) in an adequate state of repair and cleanliness, in light of the above remarks.**

The Committee also recommends that occupancy levels at Khelvachauri Psychiatric Hospital be reduced. In this context, it should also be recalled that large- capacity rooms are not compatible with current standards of psychiatric in-patient accommodation; such rooms may have a counter-therapeutic and depersonalising effect on patients and compromise their privacy. In CPT's view, patients' rooms in psychiatric establishments should not, as a rule, accommodate more than four persons.

74. Turning to Tbilisi Psychiatric Hospital, the Committee is particularly concerned about the very poor living conditions in this establishment, which had reportedly not benefited from major refurbishment since its opening in 2006. As a result, most patients resided in extremely dilapidated rooms, in conditions which could be described as degrading.

75. Although of a reasonable size,[137] well lit and sufficiently heated, many of the patients' rooms (as well as common areas) on the men's wards and in the "chronic" section of the women's ward[138] displayed significant shortcomings in terms of the state of repair, such as very dirty and crumbling walls and broken floor tiles. Further, the already limited room furniture was often old and/or broken, and patients had no lockable space in which to keep personal belongings. Moreover, the windows in most of the patients' rooms lacked window shades or curtains, which were particularly necessary in summer when the rooms got very hot from the sunlight. In addition, complaints were heard from patients about infestation with bedbugs.

On a more positive note, the delegation noted that the decrepit metal beds and the thin foam mattresses were being gradually replaced with new beds and bedding.

76. The CPT considers that given the deficiencies described above, Tbilisi Psychiatric Hospital cannot be regarded as providing a humane environment, let alone a suitable therapeutic environment. The Committee is aware that the construction of a new hospital in the Tbilisi area is planned. However, as acknowledged by the Georgian authorities themselves, the full realisation of this project will take some years.

The CPT therefore recommends that the Georgian authorities take urgent steps to significantly improve patients' living conditions at Tbilisi Psychiatric Hospital, in particular with a view to ensuring that:
- **all patient accommodation areas are kept in an adequate state of repair and hygiene and are suitably equipped, including with personal lockable space for patients;**
- **patients' rooms are fitted with window shades or curtains;**
- **patient accommodation areas are disinfested on a regular and frequent basis.**

Further, the Committee would like to receive confirmation that all patients' rooms at Tbilisi Psychiatric Hospital are now equipped with new beds and bedding

77. In the three hospitals visited, patients' rooms and communal areas were generally austere and impersonal and lacked any decoration. Patient's rooms were particularly bleak at Khelvachauri and Tbilisi Psychiatric Hospitals where beds and bedside cupboards (or cabinets) were usually the only equipment available.[139] As the Committee has stressed in the past, such conditions are not conducive to the creation of a therapeutic environment for patients with mental disorder

137. For example, rooms for three and four patients measuring 15 and 18 m2 respectively.
138. The women's ward was divided into the "acute" and "chronic" sections. Conditions were somewhat better in the former.
139. In some of the patients' rooms at Khelvachauri Psychiatric Hospital beds were the only piece of furniture.

The CPT recommends that steps be taken at Khelvachauri, Kutiri and Tbilisi Psychiatric Hospitals to ensure that patient accommodation areas have less austere and more therapeutic environment; patients themselves should be encouraged and supported to personalise and decorate their rooms and areas of common use.

4. Staff and treatment

78. At the time of the visit, *Khelvachauri Psychiatric Hospital*[140] employed seven full-time psychiatrists; another two psychiatrists' posts were vacant. The nursing and auxiliary staff consisted, respectively, of 38 nurses and 36 nursing assistants, all working on a full-time basis.

As regards staff presence on the hospital' wards, the delegation was told that, in addition to one psychiatrist who was present during the day on working days,[141] each ward (including the ones for patients with acute symptoms) had only two nurses and three auxiliary staff at any given time for approximately 40 patients.

79. The staff complement at *Kutiri Psychiatric Hospital*[142] comprised 19 psychiatrists (and several additional vacant posts), 69 nurses and 118 nursing assistants (all full-time). Further, the hospital had 15 interns undergoing a specialisation in psychiatry, and visits by various specialists (such as a general practitioner, an epidemiologist, a TB specialist and a dentist) were arranged on a regular basis. In addition, the establishment's forensic wards were staffed with security personnel who reportedly acted strictly upon the instructions of healthcare staff.[143]

Each forensic ward (accommodating between 50 and 70 patients) was staffed with two psychiatrists and a chief nurse during working hours from Monday to Friday, assisted by only one nurse and two nursing assistants who were present around the clock. There was also a permanent presence of security staff on each ward.

80. *Tbilisi Psychiatric Hospital*[144] employed eight full-time psychiatrists, a further three posts being vacant at the time of the visit. They were supported by three medical interns and 28 full-time nurses. The auxiliary staff comprised 78 nursing assistants. Further, as at Kutiri, specialist consultations were regularly provided by outside physicians.

At any given time, each ward (between 60 and 70 patients) reportedly had only one or occasionally two nurses and four nursing assistants (as well as one psychiatrist during the day on weekdays).

81. The CPT considers that the staffing levels of nurses and nursing assistants and their presence on the wards continue to be insufficient;[145] this was also acknowledged by the management and staff in the hospitals visited.

Moreover, the delegation was informed that hardly any professional training was organised for nursing assistants as regards understanding the needs of persons with mental disorders or intellectual disabilities, including in supported decision-making, communication and de-escalation techniques.

140. Accommodating 153 patients at the time of the visit.
141. At night and on weekends, there was one psychiatrist on duty for the whole hospital.
142. 612 patients at the time of the visit.
143. It should be noted that, unlike during previous visits, members of security staff did not wear uniforms (nor were they equipped with any special means).

144. 207 patients at the time of the visit.
145. See paragraph 122 of CPT/Inf (2019) 16.

The CPT recommends that the Georgian authorities take steps to significantly increase the number of nursing and auxiliary staff at Khelvachauri, Kutiri and Tbilisi Psychiatric Hospitals. Refence is also made in this context to the recommendation in paragraph 65 concerning the selection and training of nursing assistants. Further, steps should be taken to fill the vacant psychiatrists' posts in these hospitals.

82. Similar to the situation found during previous visits, psychiatric treatment was predominantly based on pharmacotherapy in the hospitals visited. Although there appeared to be no major problems with the supply of psychoactive medication, the delegation noted that the three establishments largely relied on first-generation antipsychotics, prolonged use of which may cause serious side effects. Further, it would appear that, when mood stabilisers such as lithium were administered to patients, regular blood tests were not always carried out.

The CPT recommends that a review be carried out of the practices of prescribing psychotropic medication in all psychiatric establishments in Georgia, with a view to gradually reducing the prescription of first-generation antipsychotic medication and replacing them, if necessary, by newer-generation antipsychotics. Steps should also be taken to ensure that all patients under prescribed treatment of mood stabilisers are subject to regular blood tests.

83. In each of the establishments visited, efforts were being made by a small psychosocial team (consisting only of a few psychotherapists or occupational/art therapists, two to three psychologists and up to three social workers) to supplement pharmacotherapy by a range of therapeutic, rehabilitative and recreational activities.

At Khelvachauri Psychiatric Hospital, diverse activities, such as painting, handicrafts and sport, were organised for patients at the establishment's occupational therapy facility. These activities took place several times per week, in different groups, and reportedly involved about one-third of the patients. At Tbilisi Psychiatric Hospital, some psychosocial activities, such as art therapy, ergotherapy and cognitive stimulation, were organised at the time of the visit for approximately 20 patients (in two one-hourly sessions per week). The psychosocial team of Kutiri Psychiatric Hospital organised weekly group activities for "forensic" patients on various topics (for example, conflict management, increased self- esteem, life skills, anger management, etc.) and occasional art activities, reportedly engaging some 70 patients.

84. To sum up, it became clear from the information gathered that the possibilities for patients to take part in therapeutic and rehabilitative activities were very limited in the three hospitals visited, *inter alia* due to staff shortages. Indeed, many patients met by the delegation complained of a complete lack of activities apart from watching television in the ward corridors and socialising with other patients, especially during the early stages of hospitalisation.

The CPT recommends that steps be taken at Khelvachauri, Kutiri and Tbilisi Psychiatric Hospitals to further develop the provision of psychosocial rehabilitative activities, preparing patients for a more autonomous life or return to their families; occupational therapy should be an important part of a patient's treatment programme, providing for motivation, development of learning and relational skills, acquisition of specific competences and an improved self-image. To this end, the staffing levels of psychologists, occupational therapists and other professionals qualified to provide therapeutic and rehabilitative activities should be increased accordingly.

85. The delegation noted that efforts were being made in the establishments visited to draw up individual treatment plans for newly admitted patients. However, the examination of patients' files revealed that such plans were not systematically drawn up, and most of the treatment plans seen by the delegation were poorly kept (e.g. notes and observations being scant and usually repetitive). Moreover, many patients seemed to be unaware of the contents of their treatment plans.

The Committee recommends that an individual treatment plan be drawn up for every patient shortly after admission (taking into account the special needs of acute, long-term and "forensic" patients including, with respect to the latter, the need to reduce any risk they may pose), comprising the goals of the treatment, the therapeutic means used and the staff members responsible. The treatment plan should also contain the outcome of a regular review of the patient's mental health condition and a review of the patient's medication. Patients should effectively be involved in the drafting of their individual treatment plans and their subsequent modifications, and informed of their therapeutic progress.

86. In the three hospitals visited, individual medical files were generally well-kept and comprehensive, providing a good overview of the patients' ongoing treatment and medical history.

However, the delegation noted that patients' screening and test results were often missing from their personal files. More specifically, although the required blood tests for patients receiving clozapine were generally carried out on a regular basis in all the establishments visited, their results were not included in the patients' medical files.

The CPT recommends that steps be taken in the three hospitals visited to remedy this shortcoming.

87. The delegation noted that at Khelvachauri and Tbilisi Psychiatric Hospitals patients with intellectual disabilities were accommodated on the same wards with patients whose primary diagnosis was a mental illness.

The CPT considers that these two categories of patient should be accommodated separately, to enable both categories to benefit from better targeted and specific treatment regimes.

88. It is also a matter of concern that, despite a specific recommendation made by the Committee in the report on the 2018 visit,[146] it remained the case that patients in psychiatric hospitals were generally required by the existing regulations to pay for non-emergency somatic treatment and medication (only very basic medicines being provided free-of-charge).

The CPT must stress once again that the aforementioned regulations can have a negative impact not only on timely and proper assessment and treatment of somatic diseases, but also on the way accurate assessments of certain psychiatric disorders are carried out (e.g. organic psychiatric disorders). The fact that indigent psychiatric in-patients are expected to fund their own somatic healthcare is totally unacceptable.

The CPT reiterates its recommendation that the Georgian authorities take urgent action to remedy this state of affairs.

89. It is noteworthy that the forensic wards at Kutiri Psychiatric Hospital were now equipped with spacious outdoor exercise yards (containing a mini-football pitch and some sports equipment) to which patients had access every day for five to six hours. Patients could also associate on the wards, mainly during mealtimes.

As regards Khelvachauri and Tbilisi Psychiatric Hospitals, the delegation noted that patients' rooms were generally not locked, and all patients were in principle free to move within their wards (including in the common area which was equipped with a television set and chairs/sofas) and associate with each other. However, it appeared from the information gathered that in each of these hospitals a considerable number of patients had not had access to outdoor exercise for days on end (and some apparently even for weeks), as it was reportedly often denied by staff. This situation was closely linked to the very low staff presence on the wards.

146. See paragraph 128.

The CPT recommends that steps be taken at Khelvachauri and Tbilisi Psychiatric Hospitals to significantly improve patients' access to the open air, to be combined – weather permitting – with a range of organised activities. The aim should be to ensure that all patients benefit from unrestricted access to outdoor exercise during the day unless treatment activities require them to be present on the ward.

5. Means of restraint

90. The legal provisions governing the use of means of restraint in psychiatric establishments remain essentially unchanged since the CPT's 2018 visit.[147] It should be recalled that Georgian legislation regulates the use of mechanical restraint and seclusion but not chemical restraint (see, in this regard, paragraph 94).

91. Mechanical restraint, that is, fixation to a bed with cloth straps, was used in the three hospitals visited. On the other hand, the delegation was told that individual seclusion was not practised in any of them.

From the information gathered by the delegation during the visit, it would appear that there was no excessive resort to fixation in any of the hospitals visited, which was generally applied infrequently and usually for periods ranging from fifteen minutes to two hours. Indeed, the vast majority of patients interviewed by the delegation stated that they had never been fixated.

92. In all the establishments visited, fixation was applied by healthcare staff in observation rooms or single-occupancy accommodation rooms, usually ensuring adequate privacy for the restrained patient. However, at Khelvachauri and Tbilisi Psychiatric Hospitals, a few allegations were received from patients that they had been fixated in an observation room in the presence of another restrained patient. It also transpired from the information gathered that no staff member was designated to stay with and observe the fixated patient in any of the hospitals visited. In practice, such patients were monitored through a window, record being kept of the patient's condition every 15 minutes by the supervising nurse. As the CPT has stressed in the past, such a practice cannot be considered as a substitute for a continuous staff presence.

93. Specific registers for the use of mechanical restraint were kept in each of the hospitals visited. Such registers contained entries indicating, *inter alia* the circumstances of the case, the time of application and the duration of the restraint measure, the patient's vital parameters, and the signatures of the doctor who ordered the measure and of the nurse in charge.

However, from the examination of relevant records and interviews with staff and patients at Khelvachauri and Tbilisi Psychiatric Hospitals, the delegation gained the impression that instances of fixation were not always recorded in the registers. Further, there was no indication in the registers of whether a debriefing had taken place with a member of the healthcare staff after the end of the restraint measure.

94. In the three hospitals visited, fixation was usually applied in combination with chemical restraint (intra-muscular injection of sedatives or antipsychotic medication), which was administered to calm down the patient at the outset of the restraint episode. However, as was the case in the past, instances of chemical restraint were not recorded in a dedicated register in any of the hospitals visited.

147. The use of means of restraint is regulated by Section 16 of the LPA and the Instruction on the rules and procedures for use of physical restraint against patients with mental disorders (approved by Order No. 92/N of 20 March 2007 by the Minister of Labour, Health and Social Affairs). The Instruction sets out the conditions under which seclusion of a patient and mechanical restraint (fixation) are permissible, the purpose of the restraint, as well as the modalities regarding the decision to restrain patients. In particular, it stipulates that a decision on the use of mechanical restraint is made by a medical doctor (or a duty physician) who records the reasons of mechanical restraint in the patient's medical documentation indicating the exact time of the start of restraint. A responsible person determined by the internal regulations of an institution shall supervise the patient to whom mechanical restraint is applied. That person shall monitor the condition of the patient every 15 minutes to provide assistance to them if necessary. The permission to mechanically restrain a patient is valid for four hours. If, after four hours, the patient's condition still requires the use of mechanical restraint, the psychiatrist makes new entries in the registry and the monitoring is continued under the same conditions.

95. **In light of the above, the CPT reiterates its recommendation that the Georgian authorities take the necessary steps – including by issuing instructions and providing training to relevant staff – to ensure that the CPT's standards on means of restraint in psychiatric establishments are effectively implemented at Khelvachauri, Kutiri and Tbilisi Psychiatric Hospitals as well as in all other psychiatric establishments in the country. In particular, steps should be taken to ensure that:**

- **whenever a patient is subjected to mechanical restraint, they always benefit from continuous, direct and personal supervision by a qualified member of staff who maintains the therapeutic alliance with the patient and may provide prompt assistance;**

- **patients are not subjected to mechanical restraint in view of other patients (unless the patient explicitly expresses a wish to remain in the company of a certain fellow patient);**

- **once means of restraint have been removed, a debriefing of the patient takes place; this will provide an opportunity for healthcare staff to explain the reasons for the restraint, reduce the psychological trauma of the experience and restore the doctor-patient relationship. For the patient, such debriefing should provide an occasion to explain their emotions prior to the restraint, which may improve both the patient's own and the staff's understanding of their behaviour;**

- **a dedicated register is established – and properly maintained – to record all instances of recourse to means of restraint, including chemical restraint. The entries in the register should include the time at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, the time at which the patient had a debriefing, and an account of any injuries sustained by patients or staff. The keeping of such a register will allow hospital management to monitor the extent of recourse to means of restraint and enable measures to be taken, where appropriate, to reduce their incidence.**

The Committee also recommends that the use of chemical restraint in psychiatric establishments be regulated by law.

96. The CPT has noted that Section 16 of the LPA was amended in July 2020 and now requires that, when applying restraint to a voluntary patient, the patient's legal status be reviewed. However, the delegation noted that, as was the case in the past, formally voluntary patients accommodated in the hospitals visited were occasionally restrained against their will and no attempts were made to have their status reviewed.

The CPT reiterates its recommendation that, if the application of means of restraint to a voluntary patient is deemed necessary and the patient disagrees, the procedure for re-examination of their legal status be initiated immediately, as required by law.

6. Legal safeguards

97. The legal framework governing involuntary placement of a civil nature in a psychiatric establishment as set out in the Law on Psychiatric Assistance has remained unchanged since the CPT's 2018 visit.

It is recalled that, as regards the initial placement procedure,[148] the law provides for the examination of a person by a commission of psychiatrists within 48 hours of the moment of involuntary hospitalisation (Section 18 (5)). If the commission concludes that there are grounds for continued hospitalisation (based on the criteria specified in Section 18 (1)), the hospital administration should apply within 48 hours to the competent court which, within the next 24 hours, should decide whether or not the person is to be subjected

148. The initial placement decision is taken by the hospital's admission/duty doctor.

to involuntary in-patient care. Involuntary hospitalisation may be ordered initially for a period of up to six months; this period can be renewed repeatedly.[149] The necessity of continued hospitalisation must be subject to a review by the psychiatric commission on a monthly basis (Section 18 (10)).[150] The law also provides for the mandatory presence of the person concerned and their legal representative or lawyer[151] at the court hearing and the possibility of appealing against the court's decision on involuntary hospitalisation.

98. As already indicated in paragraph 62, very few of the "civil" patients held at Khelvachauri, Kutiri and Tbilisi Psychiatric Hospitals at the time of the visit had been subjected to an involuntary placement order under Section 18 of the LPA. The rest were formally classified as voluntary patients.

At the same time, most of them were accommodated on locked wards and the majority of "voluntary" patients were not allowed to leave their wards or the hospital premises without being accompanied by a member of staff or family member. Moreover, as already indicated above, it was not uncommon for such patients to be subjected to means of restraint.

Several patients interviewed at Khelvachauri and Kutiri Psychiatric Hospitals[152] claimed that they had been persuaded by staff and/or family to agree to their placement and to sign the relevant consent form upon admission.[153] In this connection, many of the patients met did not seem to be aware of the fact that consent to hospitalisation entailed the possibility to be discharged at their own request. Some of them affirmed to the delegation that they wished to leave the hospital.

Consequently, many patients who had been classified as voluntary were *de facto* deprived of their liberty, without benefiting from the safeguards provided for by law for involuntary patients.

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

Further, **persons admitted to psychiatric establishments should be provided with full, clear and accurate information (in a language and format they understand) including on their right to consent or not to consent to hospitalisation, and on the possibility to withdraw their consent subsequently.**

The Committee also recommends that the legal status of all formally "voluntary" patients currently accommodated at Khelvachauri, Kutiri and Tbilisi Psychiatric Hospitals (and, where appropriate, in other psychiatric establishments in Georgia) be reviewed, in light of the remarks made in paragraph 98. Immediate steps should be taken to notify to the competent court (with the view to initiating, if required, an involuntary procedure) all patients who have been voluntarily admitted and who express a wish to leave the hospital, but still require in-patient treatment.

100. As regards the formally involuntary "civil" patients held at the time of the visit at Khelvachauri and Kutiri Psychiatric Hospitals, the examination of relevant documentation revealed that the legal procedure set out in Section 18 of the LPA had, as a rule, been followed.

149. If the psychiatric commission considers it necessary to extend the period of involuntary psychiatric treatment, the hospital management should apply to the court 72 hours prior to the expiry of the court's decision for placement (Section 18 (12)).
150. 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 immediately notified (Section 18 (13)).
151. If the person is unable to hire one, a lawyer should be appointed by the court (Section 18 (8)).
152. During its visit to Kutiri Psychiatric Hospital the delegation focused on forensic psychiatry wards and conducted only a few interviews on the general psychiatry ward.
153. Some of them were under the impression that they would be hospitalised for a longer time should the court decide on their involuntary placement, so they chose to consent to their placement.

Court hearings generally took place online (a practice introduced during the Covid- 19 pandemic), with the participation of the patient together with a (usually state-appointed) lawyer. The decisions on involuntary placement mentioned, *inter alia* that the patient had the right to appeal within 48 hours, starting from the notification of the decision. However, as it transpired from the files examined, patients rarely appealed. Further, in the absence of corresponding documents in the patients' files relating to a mandatory monthly review by a commission of psychiatrists of the continuation of involuntary in-patient psychiatric care, the delegation could not establish whether such reviews were actually carried out in practice.

The CPT recommends that the Georgian authorities take steps at Khelvachauri and Kutiri Psychiatric Hospitals (and, as appropriate, in other psychiatric establishments) to ensure that patients subject to civil involuntary hospitalisation receive the necessary information and support for effectively introducing an appeal against the decision on involuntary placement, should they so wish. Steps should also be taken to ensure that the monthly reviews foreseen in Section 18 (10) of the LPA are carried out and the relevant documentation included in the patients' files.

101. As concerns the measure of compulsory psychiatric treatment in respect of persons found to be criminally irresponsible,[154] the examination of several individual files of such patients at Kutiri Psychiatric Hospital[155] revealed that the relevant legal provisions were generally complied with.

However, it appeared that, despite a specific recommendation made by the Committee in the report on its 2018 visit,[156] it remained the case that an external specialist was in practice never part of the hospital's psychiatric commission when carrying out an annual review of the forensic psychiatric placement. In this regard, the hospital's management informed the delegation that there was no funding available for experts to travel to Kutiri, which created an obstacle to their participation.

The CPT reiterates its recommendation that the Georgian authorities take steps to ensure that, in the context of the review of the forensic psychiatric placement, a psychiatric expert opinion which is independent of the hospital in which the patient is held is always commissioned. This is of all the more relevance in respect of patients who have already spent lengthy periods of time in hospital.

102. Turning to the issue of consent to treatment, the delegation noted that "civil" patients in the hospitals visited were asked upon admission to sign a form entitled 'Informed consent to the provision of medical services' (Form No. IV-300-12/a), thereby attesting that they had received from the doctor essential information about the proposed treatment and its expected results, the related risks and possible side effects, and any alternative treatment options. The form also specified that it was possible for the patient to withdraw their initial consent to treatment at any stage.

103. By consenting to their treatment at the very outset of hospitalisation – before the clinical indications for a particular form of treatment could possibly be established – patients gave a blanket consent to undergo any treatment regarded as necessary by the treating doctor. Moreover, most of the patients with whom the delegation spoke said that they had signed the above-mentioned form without having discussed their

154. Compulsory in-patient psychiatric treatment may be ordered by a court based on forensic psychiatric expertise, for an initial period of up to four years (Section 191, paragraphs 2 and 2[1], of the Code of Criminal Procedure). The court decision can be appealed against by the patient, his/her lawyer or legal representative. Annual court reviews of such decisions are performed in light of recommendations by the psychiatric commission consisting of the Head doctor, the patient's treating psychiatrist, a social worker, the head of the treatment department and an external specialist (i.e. a psychiatrist or a psychologist). The treating psychiatrist can recommend any time the interruption of the treatment (Section 22[1] (4) of the LPA) and the patient can be discharged by the hospital based on the commission's recommendation, without the need to have this decision confirmed by court (Section 22[1] (5) of the LPA). The patient should also be discharged at the expiration of the measure of compulsory psychiatric treatment (Section 22[1] (6) of the LPA). Should involuntary treatment be considered necessary after the expiration of the measure, the hospital's administration should initiate the "civil" involuntary placement procedure pursuant to Section 18 of the LPA (Section 221 (7) of the LPA).

155. Kutiri Psychiatric Hospital is the only establishment in Georgia for this category of patients.

156. See paragraph 141.

condition with the doctor and it was generally felt that the signing of the form upon admission was a mere formality. Indeed, there appeared to be a widespread perception among patients that they had no choice other than to accept any treatment proposed by the doctor. Thus, it is clear that the consent to treatment given by patients upon admission could not be considered to be genuine informed consent.

104. The CPT wishes to stress that, as a general principle, all categories of patients with a psychiatric illness (be they voluntary or involuntary, subject to civil or forensic placement, with full or restricted legal capacity) should be placed in a position to give their free and informed consent to treatment,[157] with appropriate assistance and help whenever needed. Consent to treatment can only be qualified as free and informed if it is based on full, accurate and comprehensible information about the patient's condition, the treatment which is proposed and its possible side effects, as well as about the possibility to withdraw the consent, and if the patient concerned has the capacity to give valid consent at the moment when it is sought. Further, it is essential that all patients who have given their consent to treatment are continuously informed about their condition and the treatment applied to them and that they are placed in a position to withdraw their consent at any time.

Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances and should be accompanied by appropriate safeguards. In particular, the relevant legislation should require a second psychiatric opinion (from a psychiatrist not involved in the treatment of the patient concerned) in any case where a patient does not agree with the treatment proposed by the treating doctor; further, patients should be able to challenge an involuntary treatment decision before an independent outside authority and must be informed in writing of this right.

The CPT calls upon the Georgian authorities to take the necessary steps to bring the relevant legislation and practice in line with the above-mentioned precepts.

105. Newly admitted patients in the hospitals visited generally received some verbal information on patients' rights and on the hospital's internal rules. However, as far as the delegation could ascertain, newly arrived patients still did not receive a brochure or information sheet about their rights.

Further, although patients could, in principle, lodge complaints with various outside bodies, including the Public Defender's Office which also carried out monitoring visits,[158] most of the patients met by the delegation were actually unaware of any outside avenues of complaint.

The CPT once again calls upon the Georgian authorities to ensure that an information brochure on patients' rights – including the right to lodge complaints on a confidential basis with clearly designated outside bodies as well as the modalities for doing so – is systematically issued to patients (and their families/guardians) upon admission to a psychiatric establishment. This brochure should be available in an appropriate range of languages and patients who are unable to understand it should be provided with the necessary assistance.

106. In the three hospitals visited, the arrangements for patients' contact with the outside world did not seem to pose any particular problems in practice, especially as regards family visits. Relatives of patients were seen by the delegation visiting patients, bringing food and spending time with them. That said, **patients' access to a telephone at Khelvachauri Psychiatric Hospital could be improved by allowing them to make phone calls every day** (as opposed to two to three times per wee

157. That is to say, the admission of a person to a psychiatric establishment on an involuntary basis, be it in the context of civil or criminal proceedings, should not preclude seeking informed consent to treatment.
158. The hospitals also received visits by NGOs.

APPENDIX I – Establishments visited

The delegation visited the following places of detention:

Police establishments

- Temporary Detention Isolator (TDI) in Batumi
- TDI in Kobuleti
- TDI in Kutaisi
- TDI in Mtskheta
- TDI in Ozurgeti
- TDI in Rustavi
- TDIs Nos. 1, 2 and 3 in Tbilisi
- Tserovani Police Station

Penitentiary establishments

- Penitentiary Establishment No. 1, Laituri
- Penitentiary Establishment No. 2, Kutaisi
- Penitentiary Establishment No. 8, Gldani
- Penitentiary Establishment No. 15, Ksani
- Penitentiary Establishment No. 18 (Prison Hospital), Gldani

Psychiatric establishments

- Psychiatry Department of Batumi Medical Center (Khelvachauri Psychiatric Hospital)
- National Centre for Mental Health in Khoni (Kutiri Psychiatric Hospital)
- Tbilisi Mental Health Centre (Tbilisi Psychiatric Hospital)

APPENDIX II – List of the Authorities met during the visit

National authorities

Ministry of Internal Affairs

- Mr Aleksandre Darakhvelidze, Deputy Minister
- Ms Sophio Imerlishvili, Head of the International Relations Department

Ministry of Justice

- Mr Rati Bregadze, Minister
- Mr Beka Dzamashvili, Deputy Minister
- Mr Niko Tatulashvili, Deputy Minister
- Ms Ketevan Sarajishvili, Head of the International Relations and Legal Cooperation
- Mr Nika Tskhvarashvili, Director General of the Special Penitentiary Service
- Mr Malkhaz Urtkmelidze, Head of the Medical Department, Special Penitentiary Service

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

- Mr Mikheil Sarjveladze, Minister
- Ms Tamar Gabunia, First Deputy Minister
- Ms Tea Giorgadze, Deputy Minister
- Ms Irina Tsakadze, Deputy Minister
- Ms Ketevan Goginashvili, Head of the Healthcare Policy Unit

Other bodies

Special Investigation Service

- Mr Koka Katsitadze, Head
- Ms Natia Songulashvili, Deputy Head
- Mr Levan Verulashvili, Deputy Head of the Investigation Department
- Mr Shota Kakulia, Deputy Head of the International Relations and Strategic Development Department

Public Defender / National Preventive Mechanism

- Mr Levan Ioseliani, Public Defender
- Ms Elene Ghudushauri, Deputy Public Defender
- Mr Nika Kvaratskhelia, Head of the National Prevention Mechanism (NPM)
- Mr Giorgi Dzadzua, Representative of the NPM
- Ms Khatia Kheladze, Representative of the NPM
- Ms Tamar Khokhobashvili, Representative of the NPM
- Ms Mery Samsonia, Representative of the NPM

International organisation

- Council of Europe Office in Georgia
- EU Delegation to Georgia

Non-governmental organisation

- Empathy
- Georgian Young Lawyers' Association (GYLA)

"NO ONE SHALL BE SUBJECTED TO TORTURE OR TO INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT"

Article 3 of the European Convention on Human Rights

Established in 1989 by the Council of Europe Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the CPT's aim is to strengthen the protection of persons deprived of their liberty through the organisation of regular visits to places of detention.

The Committee is an independent, non-judicial preventive mechanism, complementing the work of the European Court of Human Rights. It monitors the treatment of persons deprived of their liberty by visiting places such as prisons, juvenile detention centres, police stations, immigration detention facilities, psychiatric hospitals and social care homes. CPT delegations have unrestricted access to places of detention, and the right to interview, in private, persons deprived of their liberty. They may access all the information necessary to carry out their work, including any administrative and medical documents.

The CPT plays an essential role in promoting decency in detention, through the development of minimum standards and good practice for states parties, as well as through coordination with other international bodies. The implementation of its recommendations has a significant impact on the development of human rights in Council of Europe member states and influences the policies, legislation and practices of national authorities regarding detention.

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