

**Consolidated version of the statements made on 21 September 2018 by
Mr Mykola Gnatovskyy, President of the CPT and Head of delegation,
during the meetings with Georgian Government officials at the end of
the 6th periodic visit to Georgia by the European Committee for the Prevention
of Torture and Inhuman or Degrading Treatment of Punishment (CPT)**

Dear Ministers, Ladies and Gentlemen,

We have now completed the 6th periodic visit of the CPT to Georgia and, in keeping with the Committee's standard practice, I would like to present to you the delegation's preliminary observations. At this stage, I will only focus on issues we wished to bring to your attention today, including those of major concern which should be addressed as a matter of priority. Of course, the full review will be presented in the detailed report after its adoption by the Committee.

A. Co-operation

Let me stress from the outset that the co-operation received from all of the delegation's interlocutors was generally excellent. The delegation had rapid access to all places it wished to visit, including those not notified in advance, and was able to meet in private with those persons with whom it wanted to speak. It was also provided with access to the information and documentation it required. The support provided by the CPT's Liaison Officer, Ms Elene Beradze from the Ministry of Justice, was very much appreciated.

B. Police establishments

The delegation spoke with many persons who were or had recently been in police custody, and I am very glad to say that the positive trend observed during the 2014 visit continues when it comes to the fight against ill-treatment by the police.

Indeed, the delegation has received hardly any allegations of ill-treatment by police officers. Only one formal complaint was received regarding the excessive use of force upon apprehension of a Tunisian citizen by officers from Old Tbilisi Police Station on 20 August 2018. We understand that the case is now under investigation and we are looking forward to receiving, in due course, information about its outcome.

Overall, the delegation received a very positive impression of the results brought by the sustained efforts of the Ministry of Internal Affairs aimed at combating police ill-treatment. Given that utmost vigilance is always required in this field, we are confident that you will continue your efforts to prevent and combat ill-treatment by law enforcement officers in the country.

As you know, our Committee is not an investigation body and it focuses on prevention of ill-treatment. In this context, we pay a considerable attention to the implementation of safeguards for persons deprived of their liberty by law enforcement officers. This includes in particular the

notification of custody, access to a lawyer, access to a doctor and information on the aforementioned rights.

Based on the examination of relevant records and files in the TDIs visited, and on interviews with persons deprived of their liberty, the delegation gained the impression that *notification of custody* was performed quickly and systematically and *access to a lawyer* was generally granted, though some persons in police custody alleged that they had only seen their lawyer after the initial questioning or (in a few cases) only in court. We think this could at least partially be due to some unclarity amongst detained persons as to the exact meaning and extent of their access to a lawyer, especially *ex officio* legal assistance.

As regards *access to a doctor*, medical examinations were performed systematically upon arrival at the Temporary Detention Isolators (TDIs), either by health-care staff employed by the TDIs or by ambulance doctors, and the examinations included the recording of injuries. It is interesting to note that the description of injuries was much more detailed when it was carried out by doctors recruited by TDIs; also the medical records by in-house TDI health-care staff were not kept in administrative files of detained persons, so confidentiality of medical data was better protected. In this context, the delegation notes your plans to employ doctors in all the TDIs.

As concerns *information on rights*, it was generally provided but – in the light of what was said above of some problems with access to a lawyer – there is the need to improve the oral information upon apprehension and to ensure that all persons in police custody receive the information sheet (which exists in 8 languages and copies of which were indeed available in all the TDIs visited – a positive fact) and are allowed to keep it with them in the cell. It was the case in some of the TDIs but not all.

Material conditions of detention in the TDIs visited were on the whole acceptable for the intended purpose and maximum permitted period of police custody. The only issue of concern to be raised at this stage is that criminal suspects held in the TDIs for 24 hours or longer were not offered outdoor exercise (unlike administrative detainees). We understand that a change of legislation is required to remedy this *lacuna* and we think that this should be done as a matter of priority, especially since available infrastructure is already in place in almost all TDIs. We also note your comprehensive plans to further upgrade the existing TDIs and build a new TDI in Tbilisi.

As concerns the conditions of detention at the Temporary Accommodation Centre of the Migration Department of the Ministry of Internal Affairs, they were generally good, although some complaints were heard about the quality of the food (absence of fresh vegetables and fruit) and the impossibility to buy food in a shop. Further, more efforts are needed to offer some organised activities to persons accommodated at the Centre for extended periods (up to several months).

C. Prisons

Let me state from the outset that that we have visited eight penitentiary establishments in different parts of your country, which I believe allows us to have a quite accurate impression of the situation in Georgian prisons.

To begin with the issue at the very core of the CPT's mandate, the delegation heard hardly any allegations of ill-treatment of inmates by staff. Overall, there was a relaxed atmosphere and good staff-prisoner relations in the prisons visited. Only a few isolated allegations were heard (and other indications gathered e.g. injuries recorded by prison health-care staff) of excessive force used while prisoners were transferred to so called "de-escalation cells". In our view, prison staff need more training in dealing with such high-risk situations and challenging inmates (of whom there were many in the prisons visited), including in verbal communication, de-escalation techniques and manual control techniques.

As regards inter-prisoner violence, it was not a major issue in closed-type high-security prisons (which is quite normal in establishments where inmates remain locked in their cells for most of the day), except for a few allegations and other indications – such as recorded injuries – at Prison No. 6. However, inter-prisoner violence appeared to be a serious problem at Prison No. 15. This was hardly surprising given the very low staff presence, with slightly over 30 custodial staff attempting to control some 1.800 inmates circulating freely across the extensive territory of the prison.

Another important factor was the influence of informal prisoner hierarchy. Amongst the indications of this influence, one may mention the fact that many prisoners were clearly reluctant and even afraid to speak with the delegation, there was a striking discrepancy in material conditions of different cells (some of the cells being almost luxurious) and the delegation was approached by a few of the self-appointed "prison leaders" who demonstrated their position with their attitude and demeanour. We see this as a troubling sign and we think that efforts are required to ensure that this phenomenon does not spread throughout the prison system.

Further, some injuries sustained by prisoners inside Prison No. 15, and recorded by prison health-care staff, had most likely resulted from inter-prisoner violence, and there was a number of inmates who had requested to be transferred to Prison No. 8 for their own safety. Faced with this situation, the prison's management considered itself forced to share a part of its responsibility for order and security with so-called "strong prisoners", thus exposing weaker inmates to the risk of violence and intimidation. Needless to say, this is totally unacceptable.

Turning to material conditions, the overall picture was to a certain extent positive although some of the prisons visited were overcrowded (especially No. 8 and No. 15). Additional efforts are required to ensure that the national norm of 4 m² of living space per prisoner (sanitary annexe excluded) is indeed respected in all prisons. Other than this, material conditions varied but were generally acceptable (sometimes even good) although cells and communal areas were in clear need of refurbishment and cleaning at Prisons Nos. 6, 8, 15 and to a lesser extent No. 9.

As regards the regime and activities, this is the area of the delegation's greatest concern. In high-risk establishments visited (Nos. 3, 6, 7 and 9) there was basically nothing in terms of organised activities, and a very big proportion of inmates (including the life-sentenced prisoners) were *de facto* held for months if not years in solitary confinement, with no association and very limited human contact, and often under permanent CCTV surveillance. The CPT's position is quite clear: when it encounters such factors and their combination with restrictive provisions on contact with the outside world, the Committee considers that that it could amount to inhuman and degrading treatment.

There is an urgent need to completely rethink the philosophy and the approach to 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 frequently reviewed (at least every 6 months) individual risk assessment, which currently exists only on paper, and with appropriate procedural safeguards (information to inmates on the reasons of placement, systematic oral hearings, possibility to appeal the decision, etc.). The current blanket approach is grossly excessive and perceived by many prisoners as punitive, unfair and arbitrary.

More generally, we must reiterate the CPT's long-standing view that prisoners – irrespective of regime and category – should 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; this applies with equal strength to Prison No. 15. Of course, to be able to implement this recommendation, much more staff of all categories (custodial, social workers, clinical psychologists, etc.) needs to be recruited. We fully understand that it will not be easy for you to achieve.

On a more positive note, we have gained an overall good impression of the regime for juvenile inmates at Prison No. 11, although more efforts could be made to provide organised activities during the school holidays.

The delegation notes a further improvement regarding prisoners' access to health care (both primary and secondary). There was 24-hour health-care coverage in all prisons visited and the number of health care staff was adequate; however, the waiting time for some surgical procedures (e.g. cholecystectomy, operation of hernia, removal of lymphoma) was more than 2 years. Further, medical confidentiality was not always respected.

We note significant improvement in the prevention and treatment of infectious diseases such as TB, HIV and hepatitis but regrettably nothing has been done in area of rehabilitation for drug users, including the lack of opioid substitution therapy. We are also very concerned by the persistent serious shortcomings in the provision of mental health care. There was a lack of psychiatrists (especially at Prisons Nos. 3 and 6 which accommodated numerous mentally disordered inmates) and clinical psychologists, there was nothing available for mentally disordered inmates but pharmacotherapy, and “de-escalation rooms” were overused for those prisoners.

At Prison Hospital (Establishment No. 18), living conditions were acceptable but psychiatric treatment was rather limited and the number of psychiatric patients was considerably increasing, with no association and no psycho-social therapeutic activities. Moreover, transferring prisoners to the forensic psychiatric unit in Kutiri continued to face long delays, and the legal *lacuna* preventing involuntary psychiatric treatment of prisoners had not been eliminated.

There is an urgent need to develop adequate mental health care provision including psychological assistance in prisons; at present, mentally ill prisoners and those with personality disorders (of whom there are many, especially in Prisons No. 3 and 6) are held in an environment in which their condition may only deteriorate.

In the delegation's view, time has come to take concrete steps towards the transfer of responsibility for prison health-care to the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs. This is in particular needed to improve the quality of healthcare through its better integration with the public health system, and also to strengthen the professional independence of health-care staff working in prisons.

As already mentioned, all prisons were understaffed to varying extents, the most so Prison No. 6 and Prison No. 15. Serious efforts must continue to recruit more prison staff, which will not be possible without increasing salaries to make them more competitive, and to improve staff training in preventing and dealing with high-risk and conflict situations.

Another area which is very much related and should be viewed together with above-mentioned issues concerns the disciplinary and isolation measures. With the striking exception of Prison No. 3, formal disciplinary sanctions (including placement in "kartzer" cells) were resorted to (very) rarely, which in principle is a good thing. However, we observe a clear tendency to make frequent use of "de-escalation cells" as *de facto* punishment (and indeed many prisoners perceived it as such). "De-escalation cells" should only be used to place, for as short a time as possible (preferably just a few hours), prisoners who are agitated and/or aggressive, and the whole procedure should be under the authority of the doctor, not the security staff. Any prisoner who remains agitated after several hours must be clinically assessed and, if necessary, transferred to a mental health establishment. The current procedure is a hybrid between security and medical elements and, considering the absence of procedural safeguards, it is all too tempting for prison Directors to apply it as a means of ensuring order and discipline in the establishment.

Clearly, prisoners who are not mentally disturbed and who violate internal regulations should be dealt with using disciplinary provisions; those who repeatedly violate order and discipline may be subjected to administrative segregation (not isolation) including transfer to a higher-security prison, but also this procedure should contain all the safeguards, which is not the case at present. More generally, there is a lack of a national strategy of dealing with challenging prisoners, which poses serious difficulties for the prison administration in general and for prison Directors. The current system is only based on punishment ("de-escalation cells" used as *de facto* punishment, bans on visits, calls, parcels, correspondence). We believe that you should allow for rewards to provide some incentive to such prisoners and thus make the management of those inmates more effective. There are well-documented studies available in scientific publications which show that such an approach leads to positive results.

When it comes to contact with the outside world, the delegation must reiterate the CPT's long-standing recommendation that the existing legislation 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. Further, the current provisions concerning visiting arrangements must be changed: open-type visits must become the rule and visits through glass a duly justified and temporary exception, based on an individual risk assessment. Finally, temporary bans on visits and phone calls should only be allowed if the disciplinary violation is related to a visit or a phone call.

As a final note, I would like to emphasise that significant progress has been achieved and positive trends are visible but there are still some issues which need to be addressed urgently. As you know, the Council of Europe (the CPT but also other entities in charge of co-operation activities) stands ready to support you in your efforts.

D. Psychiatric establishments

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

Although at Surami Psychiatric Hospital we received no allegations of recent physical ill-treatment of patients, the delegation noted that there had been serious physical ill-treatment (including beating of patients with sticks) in the recent past, the staff directly involved no longer being employed at the establishment. The position of the current management of Surami Psychiatric Hospital is very clearly positive in this respect. At Kutiri, in the shelter ("pensionat"), the delegation received one allegation of physical ill-treatment of a patient and, at Khevalchauri, a number of allegations of physical ill-treatment of male acute patients (slapping, punching by orderlies), in addition to some complaints that orderlies displayed rude and verbally abusive behaviour there; this was probably linked with the very low staff complement and the poor level of training of the orderlies. All staff of the three hospitals visited must be regularly reminded that any form of ill-treatment of patients is totally unacceptable, will not be tolerated and will be the subject of severe sanctions by appropriate authorities.

On the general psychiatric wards in Kutiri and Khevalchauri Psychiatric Hospitals, the delegation heard a number of complaints regarding, and indeed witnessed, episodes of inter-patient conflicts and violence (patients punching each other violently), which was again hardly surprising considering the low staffing numbers and the chaotic environment in which the patients lived.

Regarding the living conditions, the delegation positively noted that all three hospitals were in a state of transition with major renovation and reconstruction and, at Kutiri, the construction of brand-new patient accommodation. However, prior to the completion of this, patients in many parts of the three hospitals continued to reside in woefully dilapidated and sometimes overcrowded dormitories, in deprived and degrading conditions lacking privacy and not ensuring patients' dignity.

Until the reconstructions occurring in the three hospitals have been completed, the clinical environments offered in the three hospitals do not befit those of health care institutions. In Kutiri, the delegation was especially concerned about the terrible state of patients' beds on the general psychiatric and female forensic wards, and the "pensionat".

Although a series of recommendations covering the relevant aspects of patients' living conditions will be provided in the full report on this visit, in the light of the serious concerns regarding living conditions in Surami and Kutiri Psychiatric Hospitals and the general psychiatric wards in Khevalchauri, the delegation requests the Georgian authorities to provide the CPT with **regular and detailed update reports**, on a quarterly basis, regarding the progress in completing the renovation and building works in all three hospitals, thus ensuring that patients are provided with a humane, therapeutic and modern clinical environment. The first such report should be sent to the CPT **within three months**.

Further, the delegation makes an **immediate observation** under Article 8, paragraph 5, of the Convention and requests the Georgian authorities to replace all patients' beds on the general psychiatric and female forensic wards, and in the "pensionat" at Kutiri Psychiatric Hospital. The Georgian authorities are requested to confirm to the CPT that this has indeed been done **within three months**.

Regarding staffing, the number of psychiatrists in Kutiri Psychiatric Hospital was grossly inadequate and there were low numbers of multi-disciplinary clinical staff in all three hospitals, and the number of ward-based staff was totally insufficient to provide proper care or even supervision for patients (for example, on some wards of the hospitals visited, two nurses and two orderlies working 24-hour shifts were caring for over 60 highly-needy and vulnerable patients). A significant increase in staffing numbers must accompany the aforementioned improvements to living conditions if a full range of modern psychiatric treatments is to be offered to patients therein.

Turning to treatment, in the three hospitals it was based extensively on pharmacotherapy, predominantly using first-generation antipsychotic medication. Although opportunities for psycho-social treatment and rehabilitation, including the provision of meaningful activities for patients existed, they were rudimentary and scantily provided. Of further concern, the delegation notes that, under current regulations, patients in the psychiatric wards of the hospitals visited are not entitled to free somatic assessments and treatments. The fact that impoverished mentally disordered in-patients are expected to fund their own somatic health care is unacceptable and action is required to remedy this.

As found during the CPT's previous visit, on the forensic psychiatric unit at Kutiri Psychiatric Hospital, nearly all patients continued to remain locked in their rather overcrowded and dilapidated dormitories for over 20 hours a day, often for years, except for access to a large outdoor cage and during brief meal times. Indeed, access to outdoor exercise for some patients on the general psychiatric wards at both hospitals (Kutiri and Khevalchauri) and in the "pensionat" at Kutiri was very limited. Some had not had access to outdoor exercise for weeks, months and sometimes, at Kutiri, years.

The delegation invokes Article 8, paragraph 5, of the Convention and makes another **immediate observation**, requesting the Georgian authorities to ensure daily access to outdoor exercise to all patients of Kutiri and Khevalchauri Psychiatric Hospitals. The Georgian authorities are requested to inform the CPT of the steps taken **within three months**.

Regarding means of restraint, soft ties and restraint jackets were used at Kutiri Psychiatric Hospital. There and in Khevalchauri, there were also rooms for individual seclusion of patients. These restraint measures were not overused; however, the delegation gained the impression that European standards regarding these interventions and the use of chemical restraint were not followed. For example, they were not always systematically and accurately recorded in a dedicated register and patients were restrained in front of other patients and not subject to continuous personal supervision.

Concerning legal safeguards in the context of involuntary hospitalisation, it was remarkable that of some 330 patients accommodated on various general psychiatric wards in the three hospitals visited, only four were *de jure* involuntarily detained. However, many patients were clearly not consenting to their continuing hospitalisation and treatment and had therefore lost the protection offered by formal legal safeguards. This, unfortunately, was very much the same situation as observed during the 2014 visit. In the delegation's view, the Georgian authorities must attach far greater importance to the effective implementation in practice of the safeguards surrounding involuntary hospitalisation.

Finally, let me stress that the delegation supports the Georgian authorities' efforts to continue to further develop de-institutionalisation and psychiatric care in the community.

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This concludes the delegation's preliminary remarks, which as always are made in a constructive spirit. The visit report, which you will most likely receive towards the end of March next year, will go into greater detail and also cover certain issues not addressed today. Any comments and information provided by the Georgian authorities in response to the delegation's observations will be taken into account when that report is drawn up.