



THE GREEK  
OMBUDSMAN  
INDEPENDENT AUTHORITY

# NATIONAL PREVENTIVE MECHANISM AGAINST TORTURE AND ILL-TREATMENT

OPCAT

ANNUAL SPECIAL REPORT

2019



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OMBUDSMAN  
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NATIONAL PREVENTIVE  
MECHANISM  
AGAINST TORTURE  
AND ILL-TREATMENT

ANNUAL SPECIAL REPORT  
**2019**





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In accordance with Article 23 of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment of the General Assembly of the United Nations (OPCAT), ratified by Law 4228/2014

This report presents the Greek Ombudsman's activities in 2019 within its mandate to act as the National Torture Preventive Mechanism, in accordance with article 2 of Law 4228/2014. The material presented herein is based on the National Preventive Mechanism's findings during its visits and on-site inspections in detention facilities. The final editing was supervised by the Deputy Ombudsman responsible for the National Preventive Mechanism, Prof. George Nikolopoulos.

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## FOREWORD BY THE GREEK OMBUDSMAN

Conditions in detention facilities continue to be insufficient as they diverge significantly from the European standards and guidelines set by international organizations. As a result, the fundamental principles and objectives of crime policy cannot be effectively met. The main weaknesses are long-standing, including overcrowding in prisons, police station cells and pre-removal detention centers, understaffing, lack or limited access to necessary services for detainees, namely leisure activities, education, employment and training, unsuitable premises and persistence in protocols that are ill-suited for the treatment of mental patients. Furthermore, any identified improvements are piecemeal and, thus, insufficient to contribute to the overall improvement of detention conditions.

In 2019, a series of key organizational and legislative changes took place in crime policy. We should be able to attempt an initial assessment of the impact of those changes in 2020, namely of the two amendments of the penal code and the code of penal procedure and of transfer of competencies of crime policy from the Ministry of Justice to Ministry of Citizen Protection.

Over the years, the National Preventive Mechanism of the Greek Ombudsman has been set on providing an accurate, complete and well-documented report regarding the detention conditions in Greece and on issuing recommendations aiming at their improvement and their full compliance with the rule-of-law requirements of the 21st century legal civilization.

In order to fulfill its mission, the National Preventive Mechanism utilises all its available resources, including its available tools and provisions of the institutional framework, the expertise of its senior investigators and all available infrastructures. In particular, the NPM is assisted by a significant number of its scientific staff, uses multi-member inspection teams and upgraded methodology and cooperates closely and consistently with its European counterparts and competent international organizations, namely the UN and the CoE.

After the initial mapping of detention facilities in the previous years, the Mechanism's operation has entered a new phase, functioning at multiple levels. In that light, apart from its regular inspections in all detention facilities, the Mechanism has adopted a more targeted and systematic approach in detention monitoring and has focused on those facilities that were associated with the most problematic findings according to the initial inspection and reporting. In this regard, the NPM annual special reports not only provide a snapshot of the detention conditions



Malandrino detention facility, Fokida  
- inspection on 25-26/11/19

during the time of the inspection but already allow for a comparison of the findings of each inspection and an assessment of changes that have taken place over the years, in a short but adequate period of time that may vary from one to several years.

Aiming at upholding the fundamental rights, safety and dignity of all those in a state of detention, the National Preventive Mechanism of the Greek Ombudsman provides a well-documented reporting of relevant developments, highlights shortcomings, malfunctions and distortions and addresses crucial recommendations.

**Andreas I. Pottakis**

**The Greek Ombudsman**



## INTRODUCTION

### By the Deputy Ombudsman responsible for exercising the competence of the National Preventive Mechanism

Running its sixth year of operation, the National Preventive Mechanism has elaborated its mission by introducing improvements on its inspection methodology and reinforcing a deliberative culture with the administrative authorities based on reports and recommendations<sup>1</sup>.

In that light, the Mechanism aimed at establishing an integrated monitoring and inspection system focusing on the protection of human rights of individuals detained or deprived of their freedom on any grounds: criminal, administrative, psychiatric or welfare. Its vision is to introduce a system involving three key steps: 1. Prioritization, involving setting thematic inspection priorities and thus deciding which detention centers to inspect. 2. Main operation, involving on-site inspections in the pre-selected detention areas followed by a report and 3. Communication of the aforementioned report to the administration of the detention facilities and to the state administrative authorities responsible for their oversight and monitoring. Any recommendations included in the report and measures of their implementation shall become the subject of a follow-up inspection. The committed and consistent implementation of the aforementioned steps is a challenge for the successful operation of the Mechanism in the following years focusing at achieving prompt administrative response and promoting institutional as well as practical solutions.

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<sup>1</sup> As stipulated in Article 19 of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment of the General Assembly of the United Nations (OPCAT) "The national preventive mechanisms shall be granted at a minimum the power... (b) To make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty and to prevent torture and other cruel, inhuman or degrading treatment or punishment, taking into consideration the relevant norms of the United Nations; c) To submit proposals and observations concerning existing or draft legislation. Whereas Article 22 provides that " The competent authorities of the State Party concerned shall examine the recommendations of the national preventive mechanism and enter into a dialogue with it on possible implementation measures."



Furthermore, this year was marked by key institutional developments regarding the function of detention facilities, namely the transfer of crime policy to the Ministry of Citizen Protection, the transfer of migration competences from the Ministry of Migration and Asylum<sup>2</sup> to the Ministry of Citizen Protection, changes in the conditions regarding the prerequisites for the administrative detention of third-country nationals (L.4636/2019 entry into force on 1.1.2020) and finally, the amendments introduced with the double criminal reform of the new penal code and subsequently the code of penal procedure<sup>3</sup>. In that context, the Mechanism monitors all recent developments in order to ensure their compatibility with guidelines and priorities set by the international and European legislation. The Mechanism shall continue to monitor all recent developments and assess their actual impact on detention conditions in the light of the detainees' human rights.



Malandrino detention facility, Fokida - inspection on 25-26/11/19

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<sup>2</sup> The Ministry of Immigration and Asylum was abolished after the 2019 parliamentary elections and its competencies were transferred to the Ministry of Citizen Protection (Presidential Decree 81/2019). The Ministry was subsequently re-established with the Presidential Decree 4/2020

<sup>3</sup> The new penal code entered into force on 1.7.2019 with L.4619/2019 and the new code of penal procedure entered into force on 1.7.2019 with L. 4620/2019. Both laws were amended with L.4637/2019, that entered into force on 18.11.2019.



Notwithstanding recent developments, the Mechanism's findings in the field confirm ongoing systemic failures and weaknesses and reaffirm the key red flags underpinned in its annual reports: overcrowding remains a persistent concern as well as understaffing, namely in healthcare and social services with severe impact on detention conditions, thus undermining education, leisure activities, occupation and training opportunities and finally compromising the social rehabilitation process.

A bad situation is made worse when police stations that are already failing to meet minimum standards (in terms of out-of-cell time, safety requirements, guarantees of vital space and sanitation) are used for the administrative detention of third-country nationals (often minors). The Mechanism reaffirms its standard objection regarding the administrative detention of minors in pre-removal detention facilities for third-country nationals, taking also into account its persistent findings in the field regarding severe shortcomings in effective healthcare services and infrastructure maintenance. Moreover, practices implemented in the transfer of individuals admitted for involuntary psychiatric treatment, especially the disproportionate use of mechanical restraint, continue to undermine human dignity. Finally, care institutions for disabled people still face persistent issues regarding their organization and functions, including the lack of recruitment of expert personnel competent to run programs of specialized treatment.

Within its mandate as the National Preventive Mechanism, the Greek Ombudsman shall continue to respond to the new challenges set by recent developments regarding the conditions and functions of detention facilities and reaffirms its solid position regarding the delimitation of repressive measures in the light of respect for the detainees' human rights and in order to ensure that rule of law and transparency are upheld in detention facilities.

**George P. Nikolopoulos**

**Deputy Ombudsman for Human Rights**

1

# THE LEGAL FRAMEWORK OF THE NATIONAL PREVENTIVE MECHANISM IN 2019





Larissa detention facility - inspection 30/9-1/10/19

# 1. THE LEGAL FRAMEWORK OF THE NATIONAL PREVENTIVE MECHANISM IN 2019

## 1.a. Legal framework

The Optional Protocol of the Convention of United Nations against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2019 is an international human rights treaty that was adopted in 2002 by the UN General Assembly and entered into force in 2006. It reflects the States parties' consensus and common belief for the need for a preventive approach against the ill-treatment of persons deprived of their liberty who are thus especially vulnerable.

In that light, States parties have adopted a broad definition of "torture", which includes not only the systematic infliction of pain but also any inhumane and degrading treatment which undermines human dignity. The use of torture offends human dignity and aims at dehumanizing the victim. Apart from constituting a criminal act according to national and international legislation, torture is attacking the very core of human civilization. Detention facilities, such as prisons, detention facilities for migrants, mental hospitals and police stations, to name a few, pose potential threats to human dignity.

Greece ratified the aforementioned Optional Protocol with L.4228/2014, making it an integral part of its domestic law which prevails over any contrary provision of the law (Article 28, par.1 of the Greek Constitution). Article 2 of L.4228/2014 stipulates that the Ombudsman is designated as the National Preventive Mechanism against Torture and Ill-Treatment. Its mission includes the regular monitoring and inspection of the treatment of persons deprived of their freedom and the submission of recommendations and remarks regarding the legislation in force or the proposed legislation.

The National Preventive Mechanism (hereafter NPM) may conduct inspections in public and private detention facilities with or without prior notification of the competent authorities. Such facilities may include prisons, police station cells, psychiatric hospitals, administrative detention facilities for third-country nationals, care institutions, etc. Moreover, in compliance with international practices, those visits may take place in non-working days and even at night time. During the visits, the NPM may collect data using any available means, including inspection of all detention premises, interviews and photographs. Moreover, the Ombudsman has access to any archives, documents, evidence or files (article 103 § 9 of the Greek Constitution and L.3094/2003).





In that context, the NPM proceeds to the planning of its operations embarking from the solid conviction that, constituting the heaviest restriction against freedom, detention must be an exceptional measure and must be imposed only when it cannot be avoided and alternative measures cannot be implemented.

### **1.b. The National Preventive Mechanism in 2019**

In 2019, the Ombudsman ran its 6th year of operation as the National Preventive Mechanism. Having accumulated significant expertise as an independent authority for the monitoring and inspection of the conditions in detention facilities, the Ombudsman aimed at an integrated approach including both institutional and practical interventions regarding the conditions at detention facilities.

It aimed at developing an integrated system for the monitoring and inspection of detainees' rights who face any form of freedom deprivation on penal, administrative, mental or welfare grounds. In that context, it has adopted improvements in its inspection methodology and attempted to enhance its deliberative culture with the administration via regular notification of its reports, findings and recommendations.

In particular, the NPM's list of inspected facilities has been the output of the Mechanism's central planning but also has taken into consideration complaints lodged by detainees regarding detention, their living conditions and rights violations. Furthermore, the NPM has monitored relevant institutional developments and maintained a regular line of communication with the competent Ministries and administrations of the inspected detention facilities aiming at identifying red flag incidents which could either result in interventions of the NPM's own motion or required amendments at a policy level. Finally, the NPM's representatives have attended meetings and participated in networks at a European and peripheral level, thus enhancing the NPM's international cooperations and networking.

2

## PRISONS





Malandrino detention facility, Fokida - inspection on 25-26/11/19

## 2. PRISONS

### 2.a. Policy and legislative developments

#### 2.a.1 Transfer of competencies regarding crime policies

The transfer of competencies regarding crime policies was a landmark policy decision at a symbolic, institutional and functional level. The aforementioned competencies were transferred from the Ministry of Justice to the Ministry of Citizen Protection (Presidential Decree 81/2019) following the change in government after the parliamentary elections in 7.7.2019. Although it is too early to assess the effects of this policy change and namely its impact on the detainees' living conditions and human rights, the NPM is alert in order to ensure its compatibility with guidelines and priorities set by the international and European legislation.

In particular, the transfer of crime policies and of the supervision of prisons to the Ministry of Citizen Protection (also responsible for the Hellenic police) raises severe concerns regarding its compliance with the United Nations Standard Minimum Rules for the Treatment of Prisoners [the «Nelson Mandela Rules»]<sup>4</sup> and the European Prison Rules of the Council of Europe<sup>5</sup>, involving the distinction between

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<sup>4</sup> Regarding the separate roles between the police and correction services, the UN rules stipulate that: "Before the completion of the sentence, it is desirable that the necessary steps be taken to ensure for the prisoner a gradual return to life in society. This aim may be achieved, depending on the case, by a pre-release regime organized in the same institution or in another appropriate institution, or by release on trial under some kind of supervision which must not be entrusted to the police but should be combined with effective social aid" · See Rule 60 (2) in the initial phrasing of years 1955/1957/1977 (Standard Minimum Rules for the Treatment of Prisoners Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955 and approved by the Economic and Social Council by its resolutions 663C [XXIV] of 31.7.1957 and 2076 [LXII] of 13.5.1977) and its amendment in 2015 · identical Rule 87 in the United Nations Standard Minimum Rules for the Treatment of Prisoners [the «Nelson Mandela Rules»], Resolution adopted by the General Assembly on 17.12..2015 (A/RES/70/175)

<sup>5</sup> Rule 71, Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules: "Prisons shall be the responsibility of public authorities separate from military, police or criminal investigation services". In addition, in the respective comment: It is important that there should be a clear organisational separation between the police and the prison administrations. In most European countries the administration of the police comes under the ministry of the interior while the administration of prisons comes under the ministry of justice. The Committee of Ministers of the Council of Europe has



police and correctional services and namely their recommendation to avoid any provision that could entrust the police with competencies regarding detention facilities.

In functional terms, the initial en bloc transfer of the General Secretariat of Crime Policy from the Ministry of Justice to the Ministry of Citizen Protection remained incomplete. Some of its services that were initially transferred to the latter returned to the former<sup>6</sup>, thus reflecting a fragmentation of crime policies.

### 2.a.2 New Codes

A key development in the domain of criminal policy was undoubtedly the introduction of the new penal code (L.4619/2019, entry into force 1.7.2019) and the new code of penal procedure (L.4620/2019) and their subsequent amendments (L.4637/2019, entry into force 18.11.2019).

The Ombudsman has sent a letter to the Minister of Justice with his general remarks<sup>7</sup> and ad hoc comments regarding specific provisions under amendment and other subsequent legislation regarding crime policy.

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recommended that «there shall be a clear distinction between the role of the police and the prosecution, the judiciary and the correctional system»" (Recommendation Rec [2001] 10, the European Code of Police Ethics). The A. Coyle report that accompanies the rules and the relevant comments underline that: V. Prison administration and staff. a. The responsible ministry. Responsibility for the administration of prisons must lie with a national or regional government department. The Council of Europe strongly recommends that the most appropriate department is the ministry of justice, where it exists, and since the end of the 1980s the Council has required all new accession states to transfer prison administration to this department. This is now the case in all but two jurisdictions: in Spain, but not in Catalonia, it comes under the Ministry of the Interior and in England and Wales, where there is no ministry of justice, prison administration comes under the Home Office. The main reason for this requirement by the Council of Europe is as a means of separating the functions of the police service, which is generally responsible for the investigation of crime and the arrest of suspects, from that of the prison service, which is responsible for the detention of accused and convicted persons as directed by the courts"

<sup>6</sup> Including institutions for the protection of minors, the forensic medical service and the juvenile probation and social assistance services.

<sup>7</sup> The Greek Ombudsman, Annual Report 2019, p.179-181 [https://www.synigoros.gr/resources/ee2019\\_p00-plires-keimeno.pdf](https://www.synigoros.gr/resources/ee2019_p00-plires-keimeno.pdf) (complete version available in Greek and executive summary available in English)



The Ombudsman has remarked that the indefinite suspension of community service (article 98§1, L.4623/2019), undermined the acquis of a measure with a 30- year-old history in Greece, regardless of the specific issues that had arisen during its implementation and would increase pressure in an already overloaded correctional system. He recommended the reinforcement of the existing community service institutions and the establishment of new ones, focusing on human resources and the issuance of the necessary administrative acts that would allow them to function without disruption.

Furthermore, the Ombudsman has focused on the proposed amendment regarding the definition of torture and namely the penal sanctions to civil servants and military personnel who perform such acts. The Ombudsman recommended the abolition of the word "methodical" in the phrasing of article 137A of the Greek penal code ("methodical infliction of physical pain") as it narrowed unjustifiably the subjective elements of the aforementioned crime. The aforementioned abolition has been repeatedly requested by the UN and the Council of Europe so that the definition of torture in the Greek penal law would be aligned with other international provisions (article 1§1 of the UN Convention Against Torture). Finally, article 2 of L.4637/2019 has introduced two significant amendments to article 137A of the penal code:

- ★ First, the addition of paragraph 2 (torture with a motive to discriminate regardless of intention): "Acts of torture performed by those persons and under the circumstances described in the previous paragraph, even if performed without intention, are punishable by the same penalty, if the victim is chosen on grounds of race, colour, national or ethnic origin, religion, disability, sexual orientation, gender identity and gender characteristics. Article 82A PC does not apply in that case."
- ★ Second, in paragraph 6 the word "μεθοδικος"<sup>8</sup> is replaced by the word "εσκεμμένος"<sup>9</sup> to refer to the word 'intentionally' of the English text<sup>10</sup>. According to the explanatory memorandum of the law "... this choice of words is aiming at clarifying that only the infliction of pain, exhaustion etc.

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<sup>8</sup> The word (pronounced "methodikos") means methodical

<sup>9</sup> The word (pronounced as 'eskemenos') is translated as deliberate to show intention but is not commonly used in the greek penal legislation.

<sup>10</sup> It refers to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) adopted by the 39/46 General Assembly Resolution (entry into force in 26.6.1987) and ratified by Greece with Law 1782/1988



without preparation does not fall under the notion of torture; this is also the position of the European Court of Human Rights."



Kos detention facility - inspection 10/9/19

The following remarks are however necessary:

- ★ It would be perhaps better to use the term "από πρόθεση"<sup>11</sup> which is more accurate and established in Greek penal law legislation than the term "εσκεμμένος" which may cause interpretive issues.
- ★ There are issues with the explicit prohibition to apply article 82A of the penal code when article 137A§2.2 is applied. The latter classifies torture as a felony punishable by deprivation of liberty for a period of up to ten years and by the additional penalty (§7) of "ban from holding certain official positions and posts" when a decision becomes irrevocable. This means that article 82A PC<sup>12</sup> does not apply in the case of civil servants and military personnel (paragraph 1, article 137A), and the act is only punishable with the maximum penalty of para.1 of article 137A.

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<sup>11</sup> The word (pronounced "apo prothessi") means "with intention" and is most commonly used in greek penal legislation.

<sup>12</sup> This article increases the minimum of the imposed penalty in case of a hate crime.



## 2.b. Special issues that emerged in 2019

### 2.b.1 The issue of prison overcrowding

The NPM reaffirms that while recent decongestional policies (L. 4322/2015, L.4356/2015, L.4411/2016, L.4489/2017 and L.4571/2018) have gradually led to a smaller number of detainees per available places<sup>13</sup>, three years later numbers have gradually increased and detainees significantly outnumbered the available places, despite the fact that the latter had slightly increased<sup>14</sup>.

It is thus evident that the initial significant prison decongestion trend has gradually receded, mainly due to the high rates of pre-trial detention and the severity of penalties imposed by courts on certain categories of crimes. In particular, detention population data show that on 1.1.2019, 3.317 detainees out of 10.654 (about 31%) were pre-trial detainees whereas the rest 7.337 (about 69%), were convicts. From the latter, 2.732 (about 32%) were convicted for violations regarding narcotics legislation and the rest 4.965 (68%) were convicted on other grounds.

Furthermore, the imposed sentences show significant differences in the percentages of the imposed penalties, namely 6.524 persons (about 89%) have received penalties from 5 to 15 years of imprisonment to life sentences (960 persons, 13%). The remaining 760 detainees (just 11/% of the total detained population) were serving sentences up to five years of imprisonment, including, of course, those who were not able to divert their sentence by fulfilling financial conditions or agreeing to community work.

Data seem to confirm the findings of the Directorate General of Human Rights and Rule of Law of the Council of Europe that:

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<sup>13</sup> From 11.798 detainees on 1.1.2015 to 9.611 on 1.1.2016 and 9.560 on 1.1.2017 for 9.815 places

<sup>14</sup> 10.011 detainees on 1.1.2018 for 9.935 places, 10.654 on 1.1.2019 for 9.935 places and 10.891 on 1.1.2020, for 10.055 places). Data from Ministry of Justice/ "General Annual Statistics Table of Detainees-Penalties" (2003-2019) <http://www.ministryofjustice.gr/site/el/ΣΩΦΡΟΝΙΣΤΙΚΟΣΥΣΤΗΜΑ/Στατιστικάστοιχείακρατούμενων.aspx> Ministry of Citizen Protection/General Secretariat of Crime Policy/Statistics on Detainees/Statistics Table of Detainees on the 1st and 16th of every month of 2020" [http://www.minocp.gov.gr/index.php?option=ozo\\_content&perform=view&id=7055&Itemid=696&lang=GR](http://www.minocp.gov.gr/index.php?option=ozo_content&perform=view&id=7055&Itemid=696&lang=GR) (available in Greek)





"Greece has the highest percentage of long and very long prison sentences in Europe, while its crime rates are lower or equal to the European median. A more moderate penal policy is possible without affecting the protection of society against crime."<sup>15</sup>

It is noteworthy that, with regard to prison overcrowding, the impact of the new provisions introduced with the new penal code and the new code of penal procedure<sup>16</sup> is yet to be assessed as, until the end of 2019, they have not yet shown their fully-fledged repercussions.

What is more, since their entry into force<sup>17</sup> and up until the end of 2019, they did not seem to affect significantly the initial gradually increasing trend of the detention population in order to allow us an assessment of the introduced legislative changes, e.g the abolition of the option to have one's sentence diverted to pecuniary, or the indefinite suspension of the measure of community service (article 98 § 1 of Law 4623/2019).

In fact, after a short and marginal downwards trend in the 1,5 month<sup>18</sup> that followed the changes, the trend gradually increased<sup>19</sup> and reached its peak on 1.1.2020<sup>20</sup>.

The Ombudsman's remark<sup>21</sup> on prison overcrowding that "overpopulation is a key matter to the core of fundamental rights of prisoners" is thus still relevant. In that light, the Ombudsman's integrated approach proposed an overview "of the overall

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<sup>15</sup> Council of Europe, Report of the Directorate General of Human Rights and Rule of Law, Action against Crime Department, Criminal Law Co-operation Unit, «Reducing Prison Overcrowding in Greece», March 2019, p. 4.

<sup>16</sup> The two codes have entered subsequently into force in mid-2019. See above Chapt.2.a "Policy & Legislative Developments", sect. 2.a.2 "New Codes"

<sup>17</sup> on 1.7.2019 after their initial amendment and on 18.11.2018 after their second amendment

<sup>18</sup> 10.298 detainees on 1.8.2019 compared to 10.216 on mid-September 2019

<sup>19</sup> 10.272 on September 2nd half, 10.330 on 1.10.2019, 10.584 on 1.11.2019, 10.727 on 1.12.2019

<sup>20</sup> 10.891 detainees

<sup>21</sup> Greek Ombudsman, Prevention of torture and ill-treatment – Special report 2014, p.4 [https://www.synigoros.gr/resources/docs/eng\\_web.pdf](https://www.synigoros.gr/resources/docs/eng_web.pdf)

operation of the penal system with its separate aspects, i.e. legislative, judicial and correctional, in the framework of a mid-term penal and correctional policy...».<sup>22</sup>

### 2.b.2 Systemic weaknesses: understaffing, remote premises, access issues

Many issues that came up during NPM inspections, e.g shortcomings in education, leisure, employment and training activities, were aggravated due to severe understaffing. This led to either complete absence of vital services (lack of social services in the detention facility in Kos) or insufficient response to the detainees' needs (the case of the detention facility in Malandrino).

In addition, inspection findings showed that limited mass transportation access to remote detention facilities had a severe negative impact on regular visiting hours. The problem could only be mitigated with video-based visits using Skype or other equivalent equipment.

Lack of flexibility from the prison administration regarding the handling of medical emergencies amplifies problems associated with the remote location of certain detention facilities. For example, in the case of Malandrino detention facility, when the required medical assistance is not available in the Health Center of Lidoriki or the Hospitals of Amphissa or Lamia, detainees are not transferred to the nearest



Malandrino detention facility, Fokida  
- inspection on 25-26/11/19

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<sup>22</sup> Ombudsman, Prevention of torture and ill-treatment – Special report 2015, p.3 [https://www.synigoros.gr/resources/docs/npm\\_2015\\_en.pdf](https://www.synigoros.gr/resources/docs/npm_2015_en.pdf)



detention facility of Agios Stephanos and subsequently in the University Hospital of Patras, just because the latter belongs to a different healthcare district. Instead, detainees are transferred to the detention facility in Larissa and subsequently to the University Hospital of Larissa because it belongs to the same healthcare district as Fokida. The delay may become even greater because of infrequent police transfer itineraries. Loss of precious time may be fatal, as in the case of the detainee who lost his life during his transfer to a dental surgeon in February 2018. The problem had been identified by prison administrations of Malandrino and Larissa, the former because it put its detainees at risk and the latter because it was burdened with transfers that could have been avoided.

## 2.c. Inspections in detention facilities

### 2.c.1 Inspection methodology

Each year, the inspection methodology is complemented and revised based on the in-house assessment of past activities but also on the know-how acquired from training and exchange of expertise at an international level and in compliance with international standards and practices. In 2019, the inspection methodology had no substantial differences from that of the previous year:

- a. NPM inspection teams with at least three senior in-house investigators visited detention facilities without prior notice. Visits took place preferably during working morning hours in order to ensure that all officers were present. Visits lasted at least five hours depending upon the size of the facility and occasionally for two consecutive days. First, the team met with the administration, the head sergeant and the existing scientific personnel (social services, psychologists, physicians, etc) in order to get a first impression of the detention conditions and identify problems, shortcomings, malfunctions but also good practices according to the staff's assessments.
- b. The team then visited the premises – either en bloc or in sub-groups- accompanied by administration representatives and it interviewed detainees preferably individually or in groups. During the time of the interviews prison guards had to remain outside the ward or cell if they were asked to do so. Apart from group interviews with detainees, the team tried to conduct individual interviews in a private room. Furthermore, NPM teams followed activities that took place in prison schools and interacted with teachers and students. The detainees were informed about the competencies of the Ombudsman, the National Preventive Mechanism

for the Investigation of Arbitrary Incidents<sup>23</sup> and were encouraged to file complaints, which were often directly received by members of the inspection team during their visit or were mailed shortly after that.

During their visit in cells and wards, the team distributed questionnaires, with multiple choice close-ended questions and a free text section. The NPM team had decided upon the form and content of the questionnaires following training and in compliance with international standards.

Questions focused on detention conditions, perceptions of safety, violent incidents, access to certain amenities, services or activities and after-release prospects. Questionnaires were anonymously filled with the assistance of the NPM members and were collected on the same or following day. It was the second year that the NPM team had used questionnaires and the response of the detainees continued to be encouraging. The collected material has proved a valuable additional source of information regarding detention conditions, it has contributed to the planning of more targeted interventions and it has provided the Mechanism with the necessary feedback to assess its efficiency and make the necessary adjustments.

The team had access to all premises of the detention facilities and could take photographs (from cells, wards, solitary confinement areas, first night accommodation



Larissa detention facility - inspection 30/9-1/10/19

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<sup>23</sup> See article 1, L.3938/2011 and article 3 § 4, L.3094/2003, amended with article 188 L.4662/2020



areas, kitchen, leisure spaces, infirmaries, libraries, laboratories, administration offices, etc), examine the prison's records of injuries and, in certain cases, the detainees' medical files, prison board rulings granting or rejecting temporary releases, minutes of disciplinary bodies and could request copies of such documents and information about prison meals.

c. After their visit on the premises and the interviews with the detainees, the team had meetings with the facilities administration in order to investigate problems or complaints that had emerged during its inspection. Furthermore, when possible, the team met with a representative of the correction officers union and the guards union. After the visit, the team members discussed their findings and in the following days the team compiled its report and forwarded it to the administration and the Directorate of the Ministry responsible for the oversight of the detention facility. The report and its recommendations were discussed with the administration and were planned to serve as the basis for a return visit<sup>24</sup>.

## 2.c.2 Remarks on inspected prisons

### 2.c.2.a. Kos detention facility

Kos detention facility is housed in a building constructed by the Italians before 1930 that was initially used as barracks. It has been used as a detention facility since 1950 and is situated within the limits of the urban area. While it has a 56 place capacity it has 100 beds and during our visit the prison population amounted to 106 persons, including 47 convicted detainees and 60 persons in pre-trial detention. It consisted of three wards (with two toilets and one shower in each), which accommodated about 30 persons per ward. Bunk beds were placed in high proximity, hardly allowing any vital space for detainees inside the ward.

All three wards used a common yard area with no cover or shadow. The solitary confinement area was used only under special circumstances for the detainees' protection and consisted of two cells which did not comply to decent living conditions as they lacked lighting and windows. Although the dining hall was spacious enough, the staff failed to accommodate the needs of the prison population.

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<sup>24</sup> According to Article 22 of OPCAT (L.4228/2014): "The competent authorities of the State Party concerned shall examine the recommendations of the national preventive mechanism and enter into a dialogue with it on possible implementation measures."



The infirmary was equipped with the minimum necessary equipment but there was a rural doctor available on a daily basis, apart from the days he was on duty at the Hospital of Kos. Visiting doctors (a dermatologist and a dentist) were also available. However, the local hospital did not have a psychiatrist and the private psychiatrist of the island did not wish to provide his services to the detention facility. Prisoners were thus transferred to the Psychiatric Hospital in Korydallos. As an improvised solution, a military psychiatrist was seeing prisoners on certain days but there was no one to replace him in case he took a leave. Access to medication was adequate with the exception of prescribed psychiatric medication<sup>25</sup> due to the local Citizen Service Center's denial to issue social security numbers<sup>26</sup> to third-country nationals who did not have a passport and tax identification number.

As there were no social and psychological support services, the prison director had personally undertaken the relevant duties. Moreover, the fact that the notice of vacancies issued by the Supreme Council for the Selection of Personnel (ASEP) did not include positions for doctors, social workers, health care workers nor psychologists reinforced our perception of institutional abandonment.

Furthermore, there were no permanent or long-term vocation, training or sports programs; there was no school, despite some efforts to establish one, and the local community was not willing to volunteer. Furthermore, the detainees' needs for personal hygiene products were met with donations and contributions of the local church. Visiting areas seemed adequate but the frequency of visiting hours was disappointing apparently due to the facility's remote location.

As there were no metal detectors in the newcomers' area, if there was a tip or suspicion that someone was smuggling drugs into the facility, detainees went through a very thorough body search<sup>27</sup>. A request for the acquisition of a metal detector arch was still pending as this required a relevant study from the competent region office in order to ensure that the required standards were met.

The majority of temporary release requests were granted. In fact, the prison applied a commendable practice and granted temporary releases to detainees who remained in hotels in Kos and had the opportunity to spend time with their family.

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<sup>25</sup> The aforementioned drugs are indicated with a double red line positioned diagonally on the package label and are containing narcotic substances.

<sup>26</sup> Known as AMKA in Greek

<sup>27</sup> This is also the case with detainees after open visiting hours.



### **2c.2.b. Larissa detention facility**

The Larissa detention facility is housed in a 1968 building; it began its operation as a prison in 1984 and is located in an urban area. On the first day of the inspection, it accommodated 669 detainees. On wards A and B the buildings were obviously old and the detainees complained about bugs. Ward D had problems with humidity and broken sanitation units. In the yard area, there was no covered area or shadow. Solitary confinement areas were not suitable for accommodation and it is imperative to reconstruct them.

There was no permanent physician in the infirmary and the detainees complained that they had no access to the visiting doctors (3 physicians and a psychiatrist). As a result, according to the detainees' allegations, transfers to the city hospitals were very frequent as well as overtreatment with excessive amounts of prescription drugs (antidepressants, antipsychotics and sedatives) sometimes without a medical exam.

The understaffed social service was failing in its main mission because of the overcrowding but also because it was charged with the management of the storage room for clothing and sanitation items.

A model Second Chance School had been operating in the detention facility since 2004. There were Greek language classes available and a high school since 2015. Hellenic Open University students had access to computers. Requests to increase classrooms and numbers of students in the Greek language classes had been declined on security concerns due to the lack of guards.

### **2c.2.c. Malandrino detention facility**

The building was relatively new (it has been operating since 2001) and was in a tolerable condition. It consisted of two independent wards at two levels. Each level included five sub-wards, with seven cells in each one, a kitchen leisure space and yard area. Certain modifications were made in order to increase capacity but problems persisted, namely with insulation, intense humidity and shortcomings in running water, heat and electricity. In particular, the lack of hot water was attributed to the destruction of solar boilers during a past riot and to the rupture of glazing materials due to low temperatures.

The infirmary had a rural doctor from Lidoriki, who visited two to three times a week and a visiting dentist once per week. Healthcare services were the greatest cause of complaints among detainees. In case of an emergency, patients were transferred to the Amphissa Hospital and, in more serious cases, to the Lamia Hospital and



ultimately to Larissa Hospital. Their transfer in Rio Hospital which was the nearest, was not possible due to red-tape issues.<sup>28</sup> Nevertheless, a telemedicine programme was in place.

Social services employed two permanent social workers and one psychologist under a fixed-term contract. It is evident that the available human resources were insufficient for a facility of that capacity, not to mention secluded and isolated from the local community, which accommodated a large number of third-country detainees. Another complain involved the adverse impact of the facility's remote location on visiting hours, which could only be partially replaced by video-based visits using Skype.

A school with five classes had been operating successfully for a fifth year. The school had 50 to 60 students and there was an option for e-participation to high school classes. Enrollment requests had already significantly outnumbered availability. There was also a drama group, a pottery workshop, a model library, leisure spaces, a computer room (donated by the Stavros Niarchos Foundation), video based visiting hours via Skype and a visiting area for children. Available data (relevant decisions) show satisfactory levels of granted temporary releases and adequate justification of declines.

#### **2c.2.d. Kassaveteia special rural detention facility for young offenders**

The facility operates as a rural prison for adults and as a closed prison for young offenders from 18 to 21 years old. The closed sections were recently reconstructed. The old and time-worn houses for working inmates also needed reconstruction, as their roofs were made from asbestos and they were cold during the winter and hot during the summer. The building for young offenders also needed repairs. Although the infrastructure problems in working inmates' houses have been noted in past<sup>29</sup> there was not even the slightest improvement.

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<sup>28</sup> See above Chap.2.b. "Special issues that emerged in 2019" section 2.b.2 "Systemic weaknesses: understaffing, remote location, access"

<sup>29</sup> Greek Ombudsman, Annual Special Report NMP 2018, p.23 <https://www.synigoros.gr/?i=human-rights.en.recentinterventions.614116>





Cleaning services were insufficient due to the detainees' unwillingness to take up the relevant posts. The oil-heating devices performed poorly and requests from the administration regarding the facility's connection with a nearby natural gas fuelling station and for the installation of an archway metal detector were pending.

Young offenders were able to attend a primary prison school. A physician was visiting the facility twice a week. Psychiatric emergencies were transferred to Volos Hospital and a team from the mental health center was visiting the facility every 15 days and held sessions with detainees. A therapy program for dependent individuals (KETHEA) was also available. The facility had three social workers who were transferred every six months in Domokos detention facility; this rotation undoubtedly disrupted the function of the social service.

Over the years, detainees had been complaining that they were forced to remain inside their cells after the prison had shut down for the night (half an hour before sunset and until the following morning) for security reasons.<sup>30</sup>

### 2c.2.e. Corinth detention facility

During the time of the inspection, 18 minors were held in the facility, between 16 and 17 years old. More than half of the population were third-country nationals and the Greeks were in their large majority Roma. Most of them were convicts. Part of the third-country minors came from refugee camps and had participated in riots. Furthermore, 13 minors were held in a separate wing that communicated with the other wings. The minors took up cleaning services, they ran the cafeteria and prepared meals.

The minors were allocated in cells for 2 to 3 people. The dimensions of the cells seemed smaller than the 35m<sup>2</sup> standards set by the correctional code. The space was adequately equipped and its maintenance was tolerable. The toilets were separated with a door from the rest of the cell. The two confinement areas were smaller and lacked windows and natural light. The two classrooms seemed neglected and abandoned despite being properly equipped. The common rooms were in tolerable shape. However, there was no child-friendly space for meetings, common activities and leisure, especially for minors. The same applied for the yard area.

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<sup>30</sup> Wards communicated directly with the yard area without the interference of an in-between roofed space.

Certain minors, especially those who had recently entered the country, were in summer clothes and flip flops (the inspection took place in December) and the children were obviously cold. The social service argued that their needs in clothes and shoes were always met but it was the minors who rejected the clothes or traded them with cigarettes and other commodities. The minors, on their part, persisted that the items that were delivered to them, were not sufficient, and that their requests for clothes were not met.

The infirmary was housed in the same office with the social services and the facility's psychologist. As a result all professionals had difficulties in their work, namely dealing with privacy issues and meeting the detainees' requests. Notwithstanding these setbacks, it is noteworthy that there were psychological support services available as opposed to the past.<sup>31</sup>

We observed increased demand for mental health medicaments from minors. Teenage detainees reported difficulty to sleep, intense anxiety and fear, need for psychiatric monitoring and tendencies of self-harm. This is particularly troubling considering the lack of purposeful activities, including employment, athletic and leisure activities. Another serious problem was the lack of psychosocial support and interpretation.

Primary school students were allocated in five groups depending on their Greek language level. Due to the lack of educators each group of students had lessons once a week. As a result students spent four mornings per week out of school doing nothing. Lessons in high-school differed significantly from those offered in the Ministry curriculum, if they were even followed. There was no option to follow any vocational training programs, certified courses or seminars. A gym instructor was available once a week. Minors could exercise freely during out-of-cell time but weight-lifting was prohibited for security reasons. The gym equipment room remained shut as it could not be used without a gym instructor's supervision for security reasons.

The NPM team found that the lack of purposeful activities had physical, mental and emotional repercussions on minors but it also fueled tensions between inmates and tensions between inmates and guards. On the other hand, the NPM had reported the positive effects of previous practices which had given minors the chance to

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<sup>31</sup> The Greek Ombudsman, National Preventive Mechanism Against Torture and Ill-treatment - Annual Special Report 2016, [https://www.synigoros.gr/resources/docs/opcat\\_2016\\_en.pdf](https://www.synigoros.gr/resources/docs/opcat_2016_en.pdf)



to participate in community activities and attend art or sport events, allowing thus cooperation with schools in combination with in-prison activities.

Inmate communication with their families was a serious problem, especially for third-country minors, as telephone cards were not sufficient and only one out of three telephone devices functioned. Many detainees found the Skype option of little use as their families lacked not only internet access but also the necessary certificates in order to allow that type of communication (namely family status certificates from the country of origin). Legal counseling regarding their rights was also evidently absent.

During the inspection, the NPM team observed that staff-prisoner relationships and inmate relationships were extremely tense. This was evident in the interviews with the staff, the prison director and the detainees but was also depicted in the recent disciplinary records. Some detainees said certain guards were responsible for incidents of physical violence, threats, indecent expressions, hate speech and retaliation. This explained the re-opening of the solitary confinement area that went against the directive of the competent Ministry and the good practice of the administration until recently.

3

## HELLENIC POLICE AND COAST GUARD DETENTION FACILITIES





Aspropyrgos police station cells - inspection on 28/6/19

## 3. HELLENIC POLICE AND COAST GUARD DETENTION FACILITIES

### 3.a. Special issues that emerged in 2019

The 2019 NPM inspection reiterates its solid position that the use of police station cells for other purposes than criminal detention, such as long-term administrative detention, aggravates existing problems namely the absence of out-of-cell time, the lack of security, limited space and insufficient cleaning services.

A new problem that has emerged involved ambiguities and overlapping in competences regarding organizational issues<sup>32</sup> but also issues of detainees' status and protection.<sup>33</sup>

### 3.b. Remarks on inspected police station cells

#### 3.b.1 Omonoia Police Station and Security Department

The police station has four cells with overall capacity for 26 persons. On the day of the inspection 19 men were held, all of whom were third-country nationals under administrative detention. The average maximum time of detention was two months but it usually did not surpass one month. Administrative detainees were not held separately from criminal detainees. After a complete reconstruction that began on December 2017, cells began to operate anew in October 2018. There was a guard available but he remained at the office of the officer on-duty on the top floor. Detainees used hand signs to communicate with the guard via a security camera. A common hallway that allowed detainees to move around was located in front of the cells.

The lighting was insufficient as only two cells had small windows and the available electric lamps did not provide enough light. In the toilet and shower area and in all other spaces, sanitation conditions were fairly poor, because detainees were forced to clean those spaces themselves as there were no cleaning services. The police station had no yard area. Security cameras were placed in the entrance and hallways

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<sup>32</sup> The case with the competence regarding the cleaning services contracts of the Athens Transfers Department

<sup>33</sup> This is the case of the Omonoia Police Station in Athens, where the responsibility for those brought in or arrested belonged to the special squads or operational units that had made the arrest or brought them in.

of the cells, in the waiting room ("temporary detention") and on the back side of the building. All camera material was kept for approximately 15 days and was then automatically erased.

Police officers argued that the active force of the station (107 people) was not sufficient as some officers were responsible for guarding public or other buildings and were entrusted with public order duties. As many special units and squads<sup>34</sup> operated around the police station, its premises were used for police identification checks for the people brought in. We were informed that those brought in for checks were the responsibility of the units that had brought them in and not of the station. Those people remained on the 2<sup>nd</sup> floor of the police station in open view. The premises were not suitable for such use, as the waiting period could last for hours without direct access to the toilet and no suitable seats were available. Moreover, people brought in for identity checks were exposed to the visitors and could pose a danger to others if they tried to escape.

The cells of the security department with a capacity of seven persons were recently reconstructed. At night, however, the number of detainees could amount to 25. On the day of the inspection, four persons were held all of whom on criminal grounds; according to their allegations they were held for two to three days. The walls were filthy and the floor gave the impression that it had not been cleaned for days. There was enough natural light but the windows had no shutters. The cells had three stone



Omonoia police station cells - inspection on 15/2/19

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<sup>34</sup> DIAS motor cycle squad, border control units are responsible for preventing irregular migration



built-in beds, foam mattresses and blankets while the rest of the detainees slept on the floor. The odors from the toilet were intense. Incidents regarding detainees with withdrawal symptoms were frequently reported and there was lack of consistent cooperation with the nearby Organization against Drugs Unit (OKANA). Surveillance (not recording) cameras were placed in the waiting room and the cells and there was always a guard present in the office of the on-duty officer.

### 3.b.2 Attica Transfers Directorate

The NPM inspected the cells of the Transfers Directorate following a series of complaints regarding detention conditions and especially cleaning regimes. Detention areas consisted of four wings with single and five-bed cells. All beds were made of cement and had mattresses. There was no out-of-cell time. There was one wing for women and three for men. Furthermore, in the men's wing, minors were detained in a locked cell in order to be kept separate from the adults. During the inspection day, 36 men and 2 women were held in the police station cells. The detainees, who were in pre-trial detention or convicted, remained in the cells for two to four days in average, until they were transferred or returned to a detention facility. The usual reason for transfer and detention in the cells of the Transfers Directorate was the transfer to court, hospital or to another detention facility, etc. In certain cases, the detention period would be even longer (postponement or continuance of a trial, orders for medical examination, identification checks).

Wings and common areas were not clean and we observed dilapidated sanitation units, damaged walls that needed re-painting and windows in bad shape. If things don't change or if they get worse, sanitary issues may emerge. Moreover, detainees and visitors with disabilities did not have access to the detention and visiting areas because the only elevator was out of order and there was no other alternative. Finally, the Directorate had no doctor available.

The NPM team was informed that the Attica Directorate of third country nationals<sup>35</sup> was competent for issuing a call for tenders for cleaning services and signing the relevant contract. It was also reported that the Directorate of Transfers had no separate budget and consequently had significant difficulties covering even general functional expenses due to budget cuts. Understaffing was also an issue, as from the 469 positions in the Directorate's organization chart only 213 people were present.

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<sup>35</sup> The Directorate of Transfers is housed in the building of the Directorate of third-country nationals.





### 3.b.3 Aspropyrgos Police Station

The station is housed in a privately rented building. The cells were situated in the basement. People who were brought in for identification checks by station patrol units or special Hellenic Police squads and those who were arrested on the act were kept temporarily in a waiting area on the ground floor. The cells were used only by adult detainees. On the first floor, there were newly constructed cells for the Police Directorate of West Attica but they were not in use as they hadn't still been approved from the Police Directorate of West Attica. On the day of the inspection, seven people were held in the basement cells, all administrative detainees apart from one who was a criminal offender. They had been detained for 20 days in average. We were informed that all female detainees were transferred directly to another police station and thus there were no female detainees in the station.

The basement cells had limited lighting and ventilation. They comprised of three cells, two with two beds and one with four beds. All beds were made of stone and had mattresses. The location was supervised by three security cameras that were sending visual material to the office of the on-duty officer but since the Head of the police station was absent we were not able to find out if and for how long the material was kept. Only one squat toilet and one sink were available for all cells. Stagnant waters, intense odor and constant humidity were evident in the perimeter of the cells.

Detainees were forced to clean their own cells and the last disinfection had taken place on June 2017. There was no yard area.

Detainees who wished to use the telephone were taken to the only available telephone on the ground floor. Meetings with lawyers and visiting hours also took place on the ground floor. The cells did not have a doctor and all incidents were taken to the emergency room. Finally, there was no cells guard duty described in the station's internal services.

When other units or squads (DIAS, OPKE<sup>36</sup>, emergency responders etc) had operations in the station's area of competency, the premises of the station were used for identification checks for those brought in. Those people were under the jurisdiction and responsibility of the Department from the moment they were brought in and the relevant entry was made in the police records.

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<sup>36</sup> Crime Prevention and Suppression Squads



### 3.b.4 Volos Police Station and pre-trial detention facility of the judicial mansion of Volos (Transfers)

The cells operate in the premises of the Police Directorate of Magnisia after the merging between the police stations of Volos and N.Ionia. They have a 28-person capacity including men, women and minors. Administrative and criminal detainees were held separately. On the day of the inspection, there were six detainees in the cells: one third-country minor in protective custody, one administrative detainee, two third-country criminal detainees and two Greeks who were to be transferred to court. The minor was held in a separate ward from the others as there was no space available and in order to avoid using the cells for protective custody. In case of involuntary psychiatric treatment, until their transfer, patients were held in a separate ward used for minors and in case of emergency they were transferred directly to a psychiatric clinic by the National Emergency Center (NEC).

The wards had a dual aspect with natural light and ventilation, built-in beds, blankets and sheets. There were pay-phones in each ward, a visiting area, air-conditioning and separate toilets for minors and adults. There was also one custody suite guard. There was a yard area, which is rare to find in a custody suite. Its use, however, depended on staff availability. Disinfection took place almost once every two months.

The transfer area for detainees was situated in the judicial mansion of Volos in the hallway of the ground floor that led to the prosecutor's office and was guarded by a police officer who performed guard duties for the prosecution office. The space had no windows or skylight and it was about 6m<sup>2</sup>. It had electricity and a bench. In the other end, there was a separate space for the toilet, without a door or running water and, thus, particularly filthy; there was also a destroyed drain pipe and waters were running on the floor. The place was dirty, with cigarette butts thrown on the floor. According to the guard, the detainees communicated with their lawyer on the hallway. This room, with no windows that had the dimensions of a storage room, without any openings, natural light or ventilation, was evidently not suitable to be used as a detention area, even for a few hours. The situation would get even worse if detainees were more than one.

### 3.b.5 Larissa Security Department

The cells were housed in the basement of the Larissa police directorate in a building that had been used since 2010. There were cells with four and twelve beds and a capacity of 39 places in total. A three-bed cell was used for the detention of women.

The premises were freshly painted and disinfection took place once a month. Cleaning services were provided by a private company. The cell areas were in good shape and there was a hallway with windows ensuring sufficient natural light. However, toilets and showers were filthy and poorly maintained. The yard area was spacious enough and there were sports facilities available. Every day, detainees had five hours out-of-cell time.

On the day of the inspection, 31 third-country administrative detainees were held, including three minors under protective custody whereas the only criminal detainee had been just released. Administrative detainees remained in custody from three days up to two months.



Larissa Security Department cells - inspection on 1/10/19

### **3.b.6 Thessaloniki Migration Management Departments**

In the Thessaloniki Migration Management Department, cells were housed in the premises of a factory for the maintenance and repair of Hellenic Police vehicles, 1 km northeast of New Raideostos. There was one cell with capacity for five persons and one cell for seven persons; a hallway connected all spaces (cells and offices). Each cell had its own toilet and shower. There was enough light but no yard area. A television set and pay-phone were available outside the cells. There was hot water and air-conditioning. The radiator functioned when petroleum were available.



On the day of the inspection, five persons, who were treated for infectious diseases, were held in the five-person cell whereas the rest of the third-country nationals were crowded in the second cell. During our inspection, almost everyone was lying on mattresses on the floor and there was no space left. The officers argued that almost always the number of the detained third-country nationals surpassed the department's twelve-person capacity. When cells did not suffice, detainees were usually forced to sleep on the hallway and officers were forced to walk around them in order to reach their office.

In conclusion, despite piecemeal improvements and the determination of the local police officers to find solutions, systemic and important issues persisted. Infrastructure was completely unfit for long-term detention and there was lack of key services such as interpretation, provision of bedding, preventive medical check-ups upon the detainees' arrival.

On the day of the inspection in the Kordelio department, we found nine adult detainees, including seven men and two women. The department was used as a short-time detention facility. Detainees were usually not held more than one day until a decision was issued that either ordered the continuance or lift of their detention. The detainees remained locked in the detention facility, where there was a toilet and shower available but no yard area. Detainees were sleeping on mattresses on the floor; they were given blankets but were forced to buy their own personal hygiene products. There was no medical staff present and in case of medical emergencies detainees were transferred to the local community health center.

The Agios Athanasios department had two cells of five-person capacity and one hallway. Each cell had a toilet and a shower. There was no yard area. The space that was initially used as the deputy chief's office had been reconstructed for the temporary accommodation of mothers and children. On the day of the inspection, 17 male detainees were held. We identified the usual problems despite improvements and good intentions on the part of the personnel.



4

## PRE-REMOVAL DETENTION CENTERS





Amygdaleza Pre-removal Detention Center (Attica) - inspection on 18/7/19

## 4. PRE-REMOVAL DETENTION CENTERS

### 4.a. Policy and legislative developments in 2019

This year was marked by key institutional developments, including the transfer of migration competences from the Ministry of Migration and Asylum<sup>37</sup> to the Ministry of Citizen Protection and changes regarding the prerequisites for the administrative detention of third-country nationals (L.4636/2019 entry into force on 1.1.2020). Although, it is too early to assess this change of policy and namely its impact on the detainees' living conditions and human rights that would allow a well-documented overall assessment, the NPM is alert in order to ensure its compatibility with the guidelines and priorities set by international and European legislation regarding migration policies and conditions of freedom deprivation. In his intervention before the competent parliamentary committee, the Ombudsman made extensive remarks regarding the provisions of the introduced bill (voted as Law 4636/2019) and namely the vague notion of the closed reception and identification centers that "shall be organized according to the standards of pre-removal detention centers".

Among other, the Ombudsman commented on the prolongation of detention time regarding minors, which also falls within the Mechanism's focus area. In particular, there are issues with the expansion and prolongation of the administrative detention of asylum seekers and namely with three policy choices: a) the provision introducing general administration detention instead of the continuation of detention only for asylum applicants b) the establishment of closed reception and identification centers and c) the dissociation of the administrative detention time from the administration time for returns. In that manner, the maximum time limits set in the Directive 2008/115/EC "on common standards and procedures for returning illegally staying third-country nationals" do not apply. It must be noted that the 18 month-time limitation set by the Directive 2008/115/EC (para.5-6 of article 15, ECJ Katzoev C-457/09 and Bashir Mohammed Ali Mahdi C-146/14) may under no circumstances be violated. The proposed provision allowed for an 18 plus 18 detention period, which was unacceptable for a rule-of-law state. The Mechanism has reiterated its solid objection regarding the administrative detention of minors

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<sup>37</sup> The Ministry of Immigration and Asylum was abolished after the 2019 parliamentary elections and its competencies were transferred to the Ministry of Citizen Protection (Presidential Decree 81/2019). The Ministry was subsequently re-established with Presidential Decree 4/2020





considering it a practice that opposed the child's best interest and was not justified even as an ultimate measure under article 37 of the UN Convention on the Rights of the Child. Furthermore, in his general remarks, the Ombudsman stressed the risk of normalizing an exceptional measure, namely the detention of asylum applicants in accordance with Directive 2013/33/EU, thus testing the limits of the application of the proportionality principle in the limitations of personal freedom (article 5 of the Greek constitution, article 5 ECHR).

#### **4.b. Special issues that emerged in 2019**

The Mechanism's main findings<sup>38</sup> include persistent problems with effective medical services (the pre-removal center of Moria being the worst case) and poor maintenance of infrastructure (the pre-removal center of Xanthi being the worst case). These issues reaffirm the relevance the Ombudsman's past recommendation<sup>39</sup> about the key importance of an uninterrupted funding process regarding pre-removal detention centers.

#### **4.c. Remarks on inspected pre-removal centers**

##### **4.c.1. Moria Pre-removal Detention Center**

The detention center had a capacity of 210 people (112 in Wing A and 98 in wing B). In wing A there were eight containers (Isobox type) that were used as detention areas and seven additional in wing B, placed in a row on both sides of a small pathway. The space between them was used as a yard area. Out-of-cell time was 1,5 hour in the morning and 1,5 hour in the evening. Detainees spent a disproportionately long part of their day (21 hours) locked in the containers. There seemed no obvious reason for such a restriction given the available police force (40 police officers) and the lack of individual risk assessment files and records with a history of violence.

Each container had 14 bunk beds, two toilets and two showers, air conditioning system and hot water. Each wing had a leisure area and a praying area. Due to the small number of detainees, there was an extra space in each wing for visiting hours.

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<sup>38</sup> Those findings are confirmed by other Ombudsman inspection teams in its competence as the external monitoring mechanism for forced returns (L. 3907/2011)

<sup>39</sup> Greek Ombudsman, Migration flows and refugee protection – administrative challenges and human rights - Special Report 2017, p.87-91



Amygdaleza Pre-removal  
Detention Center (Attica)  
- inspection on 18/7/19

All spaces were guarded with a high barbed wire fence. The condition of the premises was adequate. In fact, some improvements were even made, perhaps due to the small number of detainees. Further improvements are, however, required, namely in cleaning services, purposeful activities and meal distribution. Cleaning services were satisfactory and the cleaning crew was available on a daily basis. Furthermore, funds allowed for the regular washing of beddings and blankets.

Detainees had access to a psychologist, a social worker and an interpreter but the center had no doctor or nurse. There were issues with medical emergencies and other healthcare issues but also with practical issues, namely drug administration. There was only one psychologist available and one administrative employee, whereas the social worker had resigned. The National Public Health Organization Unit (former Centre for Diseases Control and Prevention) that operated in the reception and identification center had only two doctors who barely coped with medical emergencies. As a result, the Hellenic Police had to transfer detainees in need of medical or pharmaceutical assistance to the Mytilini General Hospital. In short, despite the obvious efforts that were made, there were many persisting severe unresolved issues regarding healthcare that had been identified in the Mechanism's previous reports.<sup>40</sup>

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<sup>40</sup> Greek Ombudsman, National Preventive Mechanism Against Torture and Ill-treatment - Annual Special Report 2016 , p.22-24 [https://www.synigoros.gr/resources/docs/opcat\\_2016\\_en.pdf](https://www.synigoros.gr/resources/docs/opcat_2016_en.pdf), National Preventive Mechanism Against Torture and Ill-treatment - Annual Special Report 2017, p.48, [https://www.synigoros.gr/resources/opcat\\_2017\\_en.pdf](https://www.synigoros.gr/resources/opcat_2017_en.pdf), National Preventive Mechanism Against Torture and Ill-treatment - Annual Special Report 2018, p.46 , <https://www.synigoros.gr/resources/annual-special-report-2018-national-preventive-mechanism-against-torture-and-ill-treatment.pdf>



#### 4.c.2. Kos Pre-removal Detention Center

During the time of our inspection, 376 detainees were held in the premises. The capacity of the center amounted to 505 persons, but there were functional beds for only 420 persons and the administration denied increasing that number for security reasons. The center was divided in seven wards but only six of them were open. Two wards were specifically reserved for families and vulnerable groups and there was a playground inside a container in one of the wings. The overcrowding of the Reception and Identification Center in Kos and its practice to send people for detention in the pre-removal center without a prior psychosocial identification process is likely to cause problems to the latter's function.

Only 65 police officers were involved in the guarding and function of the center although the center required a much larger number for security reasons and due to its capacity. Staff positions were covered with postings or month to month transfers, resulting in the lack of a trained police force. There were only four nurses on day and afternoon shifts who had annual contracts with the Health Units SA.<sup>41</sup> Incidents that occurred during the night were given priority in the morning by the nurses. There was no doctor, psychologist or social worker available. Incidents that required psychiatric treatment were referred to the military psychiatrist who offered his services once a week in both centers. Official vehicles were used to transfer detainees to the hospital as there was only one ambulance on the island. Furthermore, the hospital lacked many medical specialties such as otorhinolaryngologists or dermatologists, and there were great delays in acquiring a medical appointment for available specialties.

#### 4.c.3. Xanthi Pre-removal Detention Center

During the time of our inspection, 142 persons were held in the center with a reported capacity of 250 persons. The center is situated in one of buildings of the former School of Urban Police Officers and has three buildings. Medical services were provided in cooperation with Health Units S.A (one doctor, five nurses, a psychologist, social worker and interpreter) and there was also good cooperation with the hospital and social pharmacy. During our inspection in building B, where 91

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<sup>41</sup> The Health Units SA is supervised by the Ministry of Health and Social Solidarity. The management and financial operation of Health Units SA, as a state –owned company, is governed by the provisions of L. 3429/2005.

persons were held, we faced a situation of complete abandonment: cracked unpainted walls, damaged plumbing with constant leaks, destroyed furniture, evident lack of cleaning services and intense odor. The wards had no doors, they were covered with improvised curtains and detainees complained about skin conditions.

#### 4.c.4. Thessaloniki Pre-removal Detention Center

In this case, the cells of the Directorate of third-country nationals were improperly used as a pre-removal detention center. In fact, the Mechanism had pointed out<sup>42</sup> in the past that the layout of the building did not allow for a yard area for the detainees. Furthermore, the provision of built-in beds in cells seemed to pose problems for the structural integrity of the building and thus, detainees were forced to sleep on mattresses that were placed in rows on the ground. During the day of our inspection, nine minors and 55 adults were detained. Adults were detained for 20 to 30 days in average and minors up to three weeks. The former usually received a return decision and their detention was lifted, provided there were no other pending issues, and the latter were sent to facilities for minors when there were openings.

Detainees remained locked in their cells (each had two toilets and one shower) without out-of-cell time and without access to the hallway in front of the cells. They smoked inside their cells. Pay phones were available in front of the cells, which were often damaged or destroyed because parts were difficult or impossible to find for old models. There were seven TV sets available. The detainees slept on the floor and they were given blankets that were only occasionally disinfected. Mattresses and blankets seemed old and dirty. There were no built-in beds because of the structural integrity of the building. Cleaning services were provided seven times a week from a cleaning agency but at the time of the inspection the detainees cleaned their own cells with sanitation products that were distributed to them by the administration. Garbage bags were placed on the bars of each cell. There was shortage in sanitation equipment and materials, clothes and shoes. There was an air conditioning system for the summer and central heating for the winter, but the fuse box could not support the electric load when all air-condition units functioned at the same time. Furthermore, the boiler could not support all hot water demand and thus, detainees

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<sup>42</sup> The Greek Ombudsman, National Preventive Mechanism Against Torture and Ill-treatment - Annual Special Report 2018, <https://www.synigoros.gr/resources/annual-special-report-2018-national-preventive-mechanism-against-torture-and-ill-treatment.pdf>



Furthermore, the boiler could not support all hot water demand and thus, detainees took turns using it.

There was no medical staff available and no medical check-up was performed upon arrival. In case medical care was required, detainees were transferred to the community health center and less frequently to an on-duty hospital in Thessaloniki. There was no nurse available for the regular administration of medicaments and police officers were usually charged with a duty they lacked the proper training for. The lack of social services was dealt with occasional NGO visits (approximately once a week).

In conclusion, the center faces persistent problems. It is thus necessary to establish a new detention facility but that requires a decision at a central administration level. It is noted that if the aforementioned problems remain unresolved, the detainees' fundamental rights will continue to get violated and poor working conditions for the police staff shall persist.

#### **4.c.5. Corinth Pre-removal Detention Center**

It is imperative to hire doctors from the Health Units S.A and to extend the personnel's existing contracts (one doctor, four nurses, two social workers, two psychologists, two interpreters). There was a persisting problem of cleaning and sanitation services in the wards and a shortage in blankets and individual hygiene products as private donations did not suffice.

#### **4.c.6. Amygdaleza Pre-removal Detention Center**

##### **a. Adult Department**

During our inspection, 526 persons were held in the center, the average detention time being one to two months. Seven wards were in use while the rest remained closed due to technical problems. Living conditions were poor. Vital space conditions (at least 4m<sup>2</sup> per person) were not met, as detainees were packed inside the containers (eight persons per container). In most cases, there was no air condition or heat in the containers because the broken air condition units were not replaced. Furthermore, there were often no full functioning water taps, showers nor toilets and we observed damages, litter, danger of electrocution from naked wires, even containers burnt to the ground that were sources of infection.

The yard area did not have any shadow or equipment for leisure activities, apart from a Wi-Fi service. Cleaning regimes were insufficient due to the understaffing (only three short-term contract employees, assisted by the detainees). The

Municipality refused to undertake the garbage disposal and as a result tons of garbage and insects were piled up in the center's perimeter, creating a source of contamination. During our visit to the infirmary, we reported shortages in drugs, namely for the outbreak of skin conditions. There was also a shortage in personal hygiene products.

**b. Minors department**

During our inspection, 75 unaccompanied male minors were held in the center. That number changed constantly due to the entrance of new minors and the placement of others in accommodation facilities via the National Center for Social Solidarity (NCSS). In average, the center received 40 to 50 children per month. In most cases, the children were between 16 and 18. In case of doubt, they were accompanied to



Amygdaleza Pre-removal Detention Center (Attica) - inspection on 18/7/19

the Agioi Anargyroi Hospital in order to go through an age assessment examination that is an X-ray test of a hand bone. The minors were separated according to nationality and age criteria.

The Minors Department comprised containers that were separated with a wired fence from the detention area for adults. Wired fences were also used between the minors' containers. The containers were equipped with hot and cold air conditioners and lighting. However, most units did not function and there were severe issues with electrical installations which posed a high risk of electrocution. We got the impression that those issues were mainly due to the detainees own interventions as they wanted to use electricity for other purposes (e.g cooking). There were also



issues with plumbing (leakage outside the container that flooded the rooms of the containers) and, as a result, detainees were forced to make improvised barriers using their bedding. With the exception of the wing that had just opened, the cleaning regime inside and outside the containers was poor. The same thing also applied for the beddings.

In the Minors Department, apart from the on-duty police officer, there was a Coordinator who was responsible for the minors and personnel that provided healthcare, psychological and social support services. During the time of the inspection, these services were undertaken by the Health Units S.A that provided a social worker and psychologist to the center. The Health Units S.A informed us that minors' appointments with a psychologist or social worker were made following a doctor's reference which meant that there were minors who had never seen a social worker or psychologist during protective custody. Furthermore, there were many reported violent incidents according to the book of incidents that were mostly related with bullying, pressures and extortion between detainees. Furthermore, there was no equipment for leisure activities in the detention area for unaccompanied minors or families with small children. Minors wandered around aimlessly, doing nothing, which undoubtedly undermined their own condition but also their co-existence with others in the center. The limited yard area around the containers had no sports equipment available.

In its inspection report, the Mechanism reiterates its solid position that the accommodation of unaccompanied minors in detention facilities constitutes an explicit violation of their rights and puts their development in immediate danger. In order to comply with its international obligations, Greece must establish more specialized accommodation facilities and guest houses for minors where children will be placed right after they are tracked in a manner that shall ensure the protection of their rights. Notwithstanding the illegal character of the detention of minors, which has been the cause for numerous ECHR convictions against Greece, it must be stressed that the deprivation of freedom in the case of unaccompanied children takes place in utterly unsuitable conditions because the Pre-removal Detention Centers lack the proper infrastructure and necessary human resources to function, even for short periods of time, as facilities for the deprivation of freedom in the form of protective custody or/and administrative detention.

5

## INVOLUNTARY PSYCHIATRIC TREATMENT







## 5. INVOLUNTARY PSYCHIATRIC TREATMENT

### 5.a. Institutional intervention: Transfer of persons with mental disorder symptoms for involuntary examination and hospitalization

The general provisions regarding the duties of police personnel make no explicit reference to involuntary psychiatric treatment and namely to the recommended manner to treat patients during their transfer for involuntary psychiatric treatment or hospitalization. In many cases, patients are treated as dangerous individuals for public order and safety. They are transferred in a police car, in handcuffs and many times restrained behind their back (article 147 of P.D 141/1991 on the mechanical restriction of transferees) and under police custody, even when the sight of uniformed personnel intensifies their agitation and potential health issues. Many times they are not even given an explanation for their "arrest" or where they are taken and on occasions the police personnel uses improper expressions, namely "you are crazy", "we will take you to the madhouse", etc. At times, the patients ask the police officers to allow them to dress properly, as they are forced to leave their home without notice and they are not allowed to put on proper clothes. It has also been observed that transferred patients are held in the police station for hours or even overnight or for days until they are finally transferred to the proper institution, especially if this is situated in another prefecture or until a second on-duty psychiatrist becomes available. They are being held in custody suites or in a different area. This is partly justified by article 188 of P.D 141/91 regarding protective custody.

The Ombudsman has repeatedly remarked that these circumstances are particular and under no circumstances are these citizens to be treated as arrested offenders nor is their transfer to take place in a manner that constitutes a brutal insult to human dignity. The use of restraint is considered disproportionate as a means of restriction of an arrested individual who does not put on any resistance, let alone for a citizen that is transferred as a patient and is fully cooperative or when police assistance is required in order to provide him with the necessary medical aid. The Ombudsman has addressed a letter to the Prosecution Office of the Supreme Civil and Criminal Court of Justice (Areios Pagos) requesting the issuance of relevant recommendations towards the local prosecution offices and the Hellenic Police.

### 5.b. Special issues that emerged in 2019

In most psychiatric clinics, organizational and functional gaps cause severe difficulties in managing cases of crises that occur in agitated patients. In particular, in



In the Psychiatric Clinic of the General Hospital of Volos, during the transportation of patients for involuntary treatment, armed police officers entered the area in uniform and refused to wait outside the clinic until the admission procedure was completed. Furthermore, in the absence of specially trained nurses, the Clinic requested the assistance of the police in order to mechanically restrain the patients (using sheets), whereas the restraints were not recorded in detail in a special register as it was provided in the relevant legislation.

### 5.c. Remarks on inspected psychiatric clinics: "Achillopouleio" General Hospital Psychiatric Clinic

On the day of our inspection, four patients were involuntarily committed. Their time of involuntary psychiatric treatment varied from three weeks up to one month, whereas the maximum time for involuntary psychiatric treatment was three months and its extension required a special assessment.

The clinic has 14 beds which are allocated in three-bed, two-bed and single bed rooms. After one of the floors had shut down, it was no longer possible to separate voluntary and involuntary psychiatric treatment patients. According to the



"Achillopouleio" Volos General Hospital  
Psychiatric Clinic - inspection on 1/10/19

competent authorities, the arrangement of wards around the long hallway did not allow satisfactory surveillance. Due to the reported lack of funds, the only available activity for voluntary psychiatric treatment patients was the occasional walk with an ergotherapist.

Difficult cases were usually mechanically restrained (belt) as the nurses were not trained to handle crises and could not use physical restraint as required by CPT standards. In practice, the clinic called the police officers inside the premises in order to assist to the restraint. In fact, even in cases of involuntary psychiatric treatment, police officers entered the clinic armed despite contrary recommendations. The restraint took place following a written order from the clinic psychiatrist that was enlisted in a general book without mention of its duration. Furthermore, any temporary interruptions were not recorded in the individual records of restraint, including the measurement of vital signs.



6

## CARE INSTITUTIONS FOR DISABLED PERSONS





## 6. CARE INSTITUTIONS FOR DISABLED PERSONS

### 6.a. Special issues that emerged in 2019

Care institutions for disabled persons face persistent organizational and functional problems. During our visit in the West Attica Treatment Center for Chronic Diseases (Agia Varvara), we found out that the Social Welfare Center of the Prefecture of Attica, under which the center fell, still had no Statute.

### 6.b. Remarks on inspected care institutions

#### 6.b.1. West Attica Treatment Center of Chronic Diseases

Law 4109/2013 stipulates that the West Attica Treatment Center of Chronic Diseases (now "West Attica Division of Disabled Persons") belongs to the new Social Welfare Center of the Prefecture of Attica (SWCPA) which is supervised by the Minister of Labour.<sup>43</sup> But during the time of the inspection the Statute of operation had not entered into force.

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<sup>43</sup> The former 1st Athens Treatment Center for Chronic Diseases (ATCCD), the former 2nd Athens Treatment Center for Chronic Diseases, the former 3rd Athens Treatment Center for Chronic Diseases and the former Rehabilitation Center for Hansen's disease patients were merged to a unified decentralized social care unit of the 3rd Attica Regional Healthcare and Welfare System. The new unit has a separate administrative structure and budget, its official name is "West Athens Treatment Center for Chronic Diseases" (L.3106/2003, 3172/2003 and 3209/2003) and is seated at the Municipality of Agia Varvara. The ARCCD was transformed to a legal entity of public law under the control and supervision of the 3rd Attica Health District Administration and, following the merge of several health districts (L.3527/2007), its control and supervision was transferred to the 2nd Pireus and Aegean Health District Administration. Ever since the Social Care Units have fallen under the control and supervision of the Ministry of Labour (article 9 of L.4052/2012, article 56 of L.4075/2012 and article 4 of the PD 85/2012). Finally, the five legal entities of public law that fell under the supervision of the Region of Attica, namely the East Athens Treatment Center for Chronic Diseases, the West Athens Treatment Center for Chronic Diseases, the Attica Healing and Rehabilitation Unit for Disabled Children, Child Protection Center of Attica "Mother" and the "Michalineio" Children's Development Center of Attica were merged and formed a new legal entity of public law under the name " Social Welfare Centre of the Region of Attica" under the control and supervision of the Minister of Labour. (article 9, L.4109/2013). The same law (9§3, section 9) renamed the Athens Treatment Center for Chronic Diseases as "West Attica Disabled Persons Department"





The West Attica Division of Disabled Persons is located in an owned building. It provides services to people facing multiple health and social issues (mental disabilities, dementia, movement disabilities, Hansen's disease, homeless people, and destitute senior citizens). It provides healthcare, healthy nutrition, ergotherapy and physical rehabilitation services to bed-ridden and walking patients in the premises of the physiotherapy center. Furthermore, the social services inform patients who are interested to be admitted in the center and refer patients, who do not meet admission criteria, to other appropriate structures.

The center has 157 beds (153 were full on the day of the visit) and accommodated disabled persons, patients with chronic conditions and Hansen's disease. There were five wings in total and the staff amounted to 120 persons (nurses and auxiliary personnel). The patients' needs were not met due to the small number of scientific and auxiliary personnel per accommodated person. In order to meet the needs of the beneficiaries, the administration had requested a greater number of male nurses and additional auxiliary personnel. There were two psychologists and three social workers available in the unit. All doctors were visiting doctors with a fixed-term contract. During the time of the inspection, 10 to 12 scientists (psychologists, social workers, sociologists, nurses, ergotherapists, physiotherapists) were recruited via the annual Manpower Employment Organization program for young scientists. The main aim was a more community-oriented approach, rehabilitation and the



Care Institution Center for Individuals with Heavy Mental Disabilities "White Butterflies" (Volos) - inspection on 1/10/19

availability of specialized professionals during afternoon hours and on weekends. In 2017, 19 adults with autism were transferred in the unit from the Skaramangas Unit of Healing and Rehabilitation for disabled children.

Due to the lack of sufficient caregivers and specialized personnel, accidents were reported, namely in Wing C where disruptive children were accommodated. The NPM team inquired about recent press coverage regarding the use of mechanical restraint to autistic persons in Wing C in order to receive information about the restraining measure practices. The administration and personnel mentioned that the use of restraining measures was exceptionally limited provided that there was a psychiatric order and that the appropriate conditions, as those were described in the book of restraints were met.

The NPM team did not perceive any mechanical restraint measures (belts) but the inspection did not allow for any conclusions regarding chemical (pharmaceutical) restraint. Given that the visit took place in the morning and people sat hypotonic and passive in the hallway, there was probable reason to assume based on lessons of common experience that chemical restraint may had taken place. This should be confirmed during a return visit with examination of the relevant patient files and psychiatric orders in the book of restraints. It is noted that there was an actual restriction of autistic persons in small area (a hallway of a few square meters) with a locked door (the only case in the unit), which impeded free access inside and outside the area, whereas all persons in Wing C were supervised by one caregiver.

The NPM team detected pending organizational and functional issues that undermined the operation of the unit: the pending Statute for all SWCPA structures, hiring of specialized staff that will be able to implement specialized projects mainly for the autistic persons of Wing C, completion of the files of the accommodated persons (especially of Wing A) crucial judicial support issues that are pending with an impact on unresolved issues, such as the permission to exit the premises (according to the 46/19.12.2018 decision of the Board of Directors of SWCPA in order to grant such a permission a request must be mandatorily filed from the guardian or judicially appointed guardian of the individual).

The NPM is committed in monitoring all relevant developments and provide any possible assistance to speeding up procedures regarding by addressing documents the Ministry of Labour. Furthermore, the Mechanism will conduct more thorough inspections in order to conduct safe conclusions and ensure that its recommendations regarding living conditions will be forwarded to the relevant authorities.

### 6.b.2. Karditsa Healing and Rehabilitation Unit for Disabled Children

The unit falls under the SWCPA of Thessaly. There are 56 permanent caregivers-nurses, auxiliary personnel, persons employed by the Manpower Employment Organization apprenticeship and alternative services programs and volunteers. It accommodates 91 people, 30-35 of whom are minors and live there since they were infants. The custody of certain children belongs to the unit as well as the judicial support of certain adults, and 40 senior citizens remain in bed-rest.

The building is situated outside the city and is reconstructed and in very good shape. Most rooms have three beds; there are a few two-bed rooms for functional teenagers who go to school and four-bed or five-bed rooms reserved for severe cases. Certain outside guest houses were forced to shut down due to the interruption of NSRF programmes.

On the day of the inspection, the odor in the severe cases rooms was unbearable and there was no leisure activity or participative activities. Many beneficiaries received antiepileptic treatment and antipsychotics. There was no indication of restraint measures but the behavior of many adults gave the impression that chemical restraint was used.



Care Institution Center for  
Individuals with Heavy Mental  
Disabilities "White Butterflies"  
(Volos) - inspection on 1/10/19

### 6.b.3. Care Institution Center of Individuals with Heavy Mental Disabilities "White Butterflies" (Volos)

The institution was founded in 1970 from a charity foundation and it has been operating as Public Entity of Private Law supervised by the Ministry of Health since 1974. It provides a boarding house for 50 persons of all ages suffering with severe mental-psychosocial disabilities (Down syndrome, autism, sensory disabilities). It is funded by donations, grants and billing via Greek National Health Service Organization with no state funding. It employs 29 caregivers –nurses, one neurologist-psychiatrist (external associate) as a scientific responsible and volunteers (doctors and other specialties). It accommodated 50 persons, including two minors under thirteen; the rest were adults under judicial support the oldest being 65 years old.



Care Institution Center for  
Individuals with Heavy Mental  
Disabilities "White Butterflies"  
(Volos) - inspection on 1/10/19

There were three-bed, two-bed and single-bed rooms and one bathroom every two rooms. A model unit of multisensory environment<sup>44</sup> for children and adults with sensory disabilities functioned in the renovated wing. There were ergotherapy services and indoor activities available. Permission to exit the premises was granted to functional children accompanied by their judicially appointed guardian. The NPM team hasn't perceived any restraint measures and the administration declared that they do not use such practice under any circumstances. However, in its talks with the residents the Mechanism got the impression people were socially isolated and lacked contact with the community.

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<sup>44</sup> The unit is equipped with state-of-the art technology that is a donation of the Stavros Niarhos Foundation.



7

## COOPERATION AND INTERNATIONAL NETWORKING





Malandrino detention facility, Fokida - inspection on 25-26/11/19

## 7. COOPERATION AND INTERNATIONAL NETWORKING

### 7.a. Meetings with National Preventive Mechanisms

Teams with senior investigators under the supervision of the Deputy Ombudsman responsible for exercising the competence of NPM G.Nikolopoulos participated in the following international meetings:

- ★ A working meeting with the NPM Network of Southeastern Europe entitled: Special Needs of Juvenile in Places of Detention (Skopje, 2-3 October)
- ★ International meeting for the 10-year anniversary of the Georgia NPM entitled: Measuring and Enhancing the Impact of NPMs" (Tbilisi, 16-17 October)
- ★ Meeting of counterparts from member states of the Council of Europe to celebrate the 30<sup>th</sup> anniversary of the European Committee for the Prevention of Torture (CPT) entitled : Ensuring Effective Implementation of Detention Safeguards in the First Hours of Police Custody in the Council of Europe and OSCE Region: Taking Stock and Moving Forward" (Strasbourg, 4-5 November)

Senior investigators Ch.Antoniou and Ev.Markaki participated in a NPM network of Southeastern Europe meeting entitled: "NPM Policy on Reprisals" (Skopje, 11-12 June).

### 7.b. Conferences and Seminars

Teams with senior investigators under the supervision of the Deputy Ombudsman responsible for exercising the competence of NPM G.Nikolopoulos participated in the following conferences:

- ★ Conference by the Concertation des Associations Actives en Prison (CAAP) entitled: 'Suicide and detention: a review. Thoughts and prospects.'" (Brussels, 29 March)
- ★ Seminar organized by the Centre des Recherches "Pénalité, Sécurité et Déviations" and by the Centre de Droit Public entitled: "Police officers under surveillance. Issues regarding the use of wearable cameras by public order officers." (Brussels, 25 November)

Senior investigators V. Vassilantonopoulou and Ag. Sora participated in working meetings entitled: "Effective alternatives to the detention of migrants" organized by





the European Commission, the Council of Europe and the European Migration Network (Strasbourg, April 4).

### 7.c. Cooperations - visits

- ★ During their visit in Greece (28 March – 9 April), a representation of the European Committee for the Prevention of Torture (CPT) met with a team of NPM members in order to be informed about detention living conditions and cases of detainees' rights violation. The NPM briefed the representation about its activities; it identified problems and informed the Committee of its recommendations towards detention authorities. The CPT explicitly mentions its cooperation with the Greek NPM in its report and addresses recommendations to improve its functions.
- ★ Representatives of the His Majesty Inspectorate of Prisons (HMIP) and the Center of Criminology of the University of Oxford took part in a NPM inspection in Kos Detention Facility (10 September) which was also attended by the Dutch Ombudsman. In that context, a training seminar took place in the Ombudsman's premises with the participation of all NPM members. The seminar focused on inspection methodology in penal and administrative detention facilities, guidelines for writing inspection reports, remarks and recommendations to the administration and follow-up processes.
- ★ During their visit in Greece (2-13 December) the Working Group on Arbitrary Detention met with the Greek Ombudsman and representatives of the NPM in order to be informed on detention conditions. The NPM briefed the working group about its relevant activities and it identified problems and informed them of his recommendations towards competent authorities. The NPM was also invited by the Ministry of Foreign Affairs and presented its findings during a meeting with other stakeholders.

### 7.d. Parliamentary committees

- ★ Deputy Ombudsman G. Nikolopoulos and senior investigators St. Preventis and M.Tsapogas have participated in the session of the special permanent parliamentary committee on the penitentiary system and other forms of confinement of detainees focusing on "Detention

conditions in police stations" (16 March).<sup>45</sup>

- ★ The Greek Ombudsman A. Pottakis and Deputy Ombudsman G. Nikolopoulos have presented the Annual Special Report 2018 of the National Prevention Mechanism in a meeting of the standing parliamentary committee on Public Administration, Public Order and Justice (17 December).<sup>46</sup>

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<sup>45</sup> Hellenic Parliament <https://www.hellenicparliament.gr/Vouli-ton-Ellinon/ToKtirio/Fotografiko-Archeio/#ff78136e-5ba7-4d55-8da5-aa3200b36792> (available in Greek)

<sup>46</sup> Hellenic Parliament <https://www.hellenicparliament.gr/Vouli-ton-Ellinon/ToKtirio/Fotografiko-Archeio/#776a9a65-a30f-4148-859b-ab2700b918f6> (available in Greek)