EUROPEAN COURT OF HUMAN RIGHTS

Council of Europe

Strasbourg, France

APPLICATION

under Article 34 of the European Convention on Human Rights

and Rules 45 and 47 of the Rules of Court

IMPORTANT: This application is a formal legal document and may affect your rights and obligations.

I. THE PARTIES

A. *THE APPLICANT*

1. *Surname:* Câmpeanu

2. *First name(s):* Valentin

3. *Sex:* male

4. *Nationality:* Romanian

5. *Occupation:* unemployed

6. *Date and place of birth:* 15 September 1985, Băileşti, Romania

7. *Permanent address* N/A

8. *Name of representative*

Centre for Legal Resources

INTERIGHTS, the International Centre for the Legal Protection of Human Rights, acts in this case as Advisor to Counsel

9. *Occupation of representative*

10. *Address of representative*

Str. Arcului nr. 19, Sector 2, Cod 021034, Bucuresti, Romania

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B. *THE HIGH CONTRACTING PARTY*

12. **ROMANIA**

II. STATEMENT OF THE FACTS

13. The following is a non-exhaustive account of the facts based on the documents included in the official investigation file. As will be shown subsequently (see below, §229), the prosecution failed to collect documents crucial to clarifying the circumstances which led to the applicant's death. Other documents, although collected have not been included in the investigation file, and therefore were inaccessible to the applicant's representatives. We therefore reserve the right to request copies of these documents at a later stage in the proceedings before the Court.

14. Valentin Câmpeanu (*"the applicant"*) was an abandoned child and lived most of his brief life in a social care institution for children. He had a severe intellectual disability, suffered from an HIV infection and other additional diseases such as hepatitis and tuberculosis. After he turned 18, Câmpeanu was discharged from the social care institution he had lived in and transferred to an institution for adults. He stayed there for more than a week, before being transferred to a Psychiatric Hospital. There he lived for another week before he suffered a lonely, agonising death. His ultimate demise was due to the negligence and carelessness of the authorities and individuals involved in his care and treatment over the last months of his life.

The period before the transfer to the Cetate Centre for Medico-social Care

15. Valentin Câmpeanu, a man of Roma ethnicity, was born on 15 September 1985, in Băileşti, Dolj County, a village situated in south-west Romania[1], from a casual relationship between his mother, Valentina Câmpeanu and an unknown man. The applicant's mother, who died on 20 July 2000, abandoned him immediately after birth in the maternity ward of the Băileşti Hospital[2]. She did not maintain any contact with her son after abandoning him.

16. Immediately after his birth, the applicant was transferred to the dystrophy ward of the same hospital. Subsequently, the applicant was transferred to the Corlate Hospital Home (*"Căminul Spital Corlate"*)[3]. In 1990, the applicant was found for the first time to be HIV-positive[4]. In March 1992 the applicant was transferred to the Craiova Hospital Home for Deficient Minors (*"Căminul spital pentru minori deficienți Craiova"*), which at the time was under the authority of the Dolj County Inspectorate for Persons with Handicap[5].

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[1] Letter by the Department, 5 March 2004, annex 24.
[2] Idem.
[3] Idem.
[4] More than 10,000 children were infected with HIV in the 1980s in hospitals and orphanages as a direct result of government policies that resulted in large numbers of children being exposed to contaminated needles and "microtransfusions" of unscreened blood. See Human Rights Watch, *"Life Doesn't Wait": Romania's Failure to Protect and Support Children and Youth Living with HIV*, August 2006, p. 4, accessible at http://www.hrw.org/en/reports/2006/08/01/life-doesnt-wait .
[5] Idem

17. As part of a reshuffle of the Romanian social care system that took place in 2000, the Hospital Home for Deficient Minors became the Placement Centre No. 7 (*"Centru de plasament", "the placement centre"*) and was placed under the authority of the Dolj County Department for the Protection of the Rights of the Child (*"the department"*). On the same occasion full medical examinations of all residents at the Placement Centre, including the applicant, were carried out. The applicant's medical diagnosis was "severe mental retardation, IQ of 30, HIV infection" and he was placed in the severe handicap group (*"handicap grav"*)[6].

18. The following is the legal characterisation of "severe metal retardation":

> *Severe mental retardation (imbecility), IQ 20-34. They have a reduced psychomotor development and they have very little or no language skills, they can learn to talk, they can get familiarized with the alphabet and basic counting. They may be capable to carry out simple tasks under strict supervision. They can adapt to life in the community in care homes or in their families, as long as they don't have another handicap which necessitates special care.*[7]

This is the second most severe form of "mental retardation", the first being "profound mental retardation", corresponding to an IQ of less than 20 or 25.

19. Starting from 2000, the HIV/AIDS Clinic (*"Dispensarul HIV/SIDA", 'the Clinic'*) affiliated with the Craiova Clinical Hospital for Infectious Diseases Victor Babeş (*"Spitalul clinic de boli infecţioase şi pneumoftiziologie"*) monitored the applicant's HIV infection. The applicant visited the clinic for regular tests accompanied each time by a member of staff from the Placement Centre[8]. During these visits, the medical staff from the Clinic carried out tests and other investigations and prescribed medication, including anti-retroviral drugs (*"ARV"*)[9]. The Clinic provided the ARV, and staff at the Placement Centre administered it to the applicant. The Clinic staff noted that the applicant's reaction to the ARV treatment was generally positive[10]. In addition to ARV, the applicant received vitamins as well as age-specific shots[11].

20. The applicant's general physical development during his stay at the Placement Centre was positive[12]. A doctor from the Clinic who consulted the applicant on several occasions noted that he "was well taken care of, with an adequate personal hygiene, with

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[6] Idem

[7] Order no. 726/2002 concerning the criteria on the basis of which the handicap group for adults is established and the measures of special social protection in their favour are established, appendix 86.

[8] Statement by Tereza Poajga, 26 October 2005, annex 62.

[9] Letter of the National Authority for the Protection of the Child and Adoption, 27 October 2004, annex 55.

[10] Statement by Tereza Poajga, 26 October 2005, annex 62.

[11] Idem.

[12] An official document exemplified this positive development by noting that the applicant's weight increased constantly before 2004 as follows: in January 2002 – 40 kilos, in June 2002 – 43 kilos, in December 2003 – 42.5 kilos, in January 2004 – 45 kilos, Letter of the National Authority for the Protection of the Child and Adoption, 27 October 2004, p.2, also statement by Maria Vieru, 21 October 2006, annex 61.

a balanced diet rich in proteins and vitamins, without any significant dietary restrictions" [13].

21. In March 2003, the applicant was diagnosed with pulmonary tuberculosis[14]. At a later date, the applicant was also diagnosed with chronic hepatitis.

22. The last examination carried out by the Clinic before the applicant's discharge from the Placement Centre took place in January 2003. Its conclusions were generally positive; the only problem identified was an oral candidiasis, for which the applicant received treatment[15].

23. On 14 October 2003 the Commission for the Medical Examination of Adults with Handicap affiliated with the Dolj County Council (*"Comisia de expertiza medicala a persoanelor cu handicap pentru adulti"*) examined the applicant and established a new diagnosis. According to the certificate issued by the Commission, the applicant only suffered from a "HIV infection" which meant that he was placed in the medium handicap group[16]. The certificate did not include any reason for the change in diagnosis. Although the certificate could in theory be challenged, it is not clear whether it was communicated.

24. The second part of the form on which the certificate was printed contained an "Individual program for the recovery, re-adaptation and social integration' of the applicant. The program devised for the applicant was very brief and stated as follows:

1. *Medical actions: [ambulatory treatment]*
2. *Educational actions: none*
3. *Professional actions: Institutionalised*
4. *Social actions: Socially integrated*[17].

25. A medico-social evaluation of the applicant was carried out by a social assistant and a doctor from the Placement Centre at a date subsequent to the issuing of the new certificate of handicap, probably in October/November 2003[18]. This evaluation was required in order to have the applicant placed in a centre for medico-social assistance. The space in the evaluation form corresponding to 'the legal representative' simply stated: "abandoned upon birth" while the space on "the person to contact in case of emergency" was left blank. The document also included the results of several medical tests carried out on this occasion, and the applicant's weight (45 kg) and height (1.68 metres). The results of the examinations were generally positive, in line with the applicant's previously stable health condition. The diagnosis established was of "severe mental retardation, HIV positive". The authors of the document did not attempt to clarify

[13] Statement of Poajga Tereza, 26 October 2005, annex 62.
[14] Idem.
[15] Statement by Florentina Dumitrescu, annex 63.
[16] Certificate of placement in disability group no. 16143/14 October 2003 issued by the Commission for the Medical Examination of Adults with Handicap affiliated with the Dolj County Council, Annex 2.
[17] Idem
[18] Medico-social evaluation, Annex 4.

the contradiction between their diagnosis and that established earlier when the applicant had been placed in the medium handicap group.

26. The section concerning "the evaluation of the person's autonomy" includes the following information:

> *"Requires supervision and intermittent assistance with personal care. He cannot use means of transport by himself or use means of communication from a distance; he cannot do shopping and cannot carry out treatment by himself"*[19]

The conclusion of this analysis was that the applicant was able to take care of himself, but at the same he required considerable support.

27. According to the evaluation, the applicant had been registered with a family doctor, who could in theory provide the required medical care at the applicant's domicile. However the evaluation did not identify this doctor and did not set out their contact details.

28. The applicant attended his last regular test at the Clinic on 20 November 2003. The results of the test were positive; the doctor who examined the applicant stated that she did not notice any "acute conditions"[20].

The applicant's discharge from the Placement Centre and the search for an institution willing to accept him

29. On 15 September 2003, the applicant turned 18, the majority age under domestic law. This event had major implications for *inter alia*, his legal status and place of abode.

30. On 30 September 2003 the Dolj County Commission for the Protection of the Child (*"the Commission"*) met to discuss the measures required in view of the fact the applicant had reached the age of majority. The social assistant in charge of the applicant's file noted that given his age, and considering that he did not attend any form of education, the measure of protection under the authority of the Commission was no longer justified. Consequently, the social assistant recommended that Decision No. 1657/27 December 2001, entrusting the applicant to the Commission, be cancelled and that the applicant be transferred to a Centre of Recovery and Neuropsychological Rehabilitation ("*Centru de recuperare si reabilitare neurologica"*)[21].

31. The Commission agreed partially with the social assistant and cancelled Decision No. 1657. At the same time however it ordered the social assistant to undertake the applicant's transfer to the Poiana Mare Psychiatric Hospital (*"Poiana Mare Hospital"*)[22].

[19] Idem.
[20] Statement by Tereza Poajga, 26 October 2005, annex 62.
[21] Decision No. 1125/30 September 2003 of the Dolj County Commission for the Protection of the Child. Annex 1.
[22] Idem.

The applicant was not present in person, and was not represented, at the Commission's hearing. Although the decision could in theory be challenged before a court, it is not clear whether it was communicated.

32. On 5 October 2003 the Department appointed Larisa Coderie to be in charge of the applicant's file, and to achieve his transfer from the Placement Centre[23]. As instructed by the Department, Coderie sent a letter to Poiana Mare Hospital, inquiring whether it would be willing to accept the applicant. On 16 October 2003, the hospital responded negatively, on the basis that the applicant was infected with HIV and thus did not fit its profile[24].

33. Following this refusal, between October 2003 and January 2004 the Commission and the Department contacted a series of institutions asking for assistance with identifying a social or a psychiatric establishment willing to host the applicant. Thus, letters were sent to the Dolj Public Health Department[25], the Dolj Social Assistance Department[26] and the seven centres for medico-social care which started to operate in Dolj County on 1 January 2004.

34. On 10 November 2003 the Dolj Public Health Department replied stating that according to legislation in force, "hospitalisation could be justified only on the basis of a referral from a specialised doctor or by the family doctor on the basis a medico-surgical emergency, an acute or a chronic medical condition in an acute stage and consists of the provision of treatment for a fixed duration of time" [27]. The letter noted that "Câmpeanu's condition did not necessitate hospitalisation, but rather continuous supervision in a specialised institution". The Health Department finally suggested that the solution to the problem was to place the applicant in the Craiova Centre for Recovery and Rehabilitation of Persons with Handicap, or, starting with 1 January 2004, in one of the seven medico-social facilities that would start operating in Dolj County. The Dolj Social Assistance Department suggested the applicant be placed in a Centre for Recovery and Rehabilitation of Persons with Handicap [28].

35. However, when contacted by telephone by Larisa Coderie, the Centre for Recovery and Rehabilitation of Persons with Handicap refused to accept the applicant on the basis that he 'was infested with the HIV infection"[29]. On a different account, the refusal was justified by the fact that the Centre was full and that there was a long waiting list[30].

[23] Statement by Larisa Coderie, 21 July 2004, annex 40.
[24] Letter of the Poiana Mare Hospital, 16 October 2003, Annex 3.
[25] Letter of the Commission for the Protection of Children, 22 October 2003, Annex 5.
[26] Letter of the Dolj County Department for the Protection of the Rights of the Child, 26 November 2003, Annex 7.
[27] Letter of the Dolj Public Health Department, 10 November 2003, Annex 6.
[28] Letter of the Dolj County Social Assistance Department, 11 December 2003, Annex 8.
[29] Statement by Larisa Coderie, 21 July 2004, annex 40.
[30] Letter of the National Authority for the Protection of the Child and Adoption, 27 October 2004, annex 55.

36. In response to a request from the Commission[31], the Dolj Public Health Department provided a list of medico-social facilities which had started to operate in the Dolj County on 1 January 2004[32]. In addition, the Public Health Department mentioned that "any patient with a chronic disease who is at the same time a social case will be hospitalised in these facilities based on a medical examination carried out by a medical unit belonging to the public network and on the basis of a social investigation carried out by the competent bodies of the local public administration". Based on the list, the Department contacted all seven medico-social centres in writing and by telephone inquiring whether they would be willing to admit the applicant into care[33]. All refused the request, with the exception of the Cetate Medico-Social Care Centre (*"unitate de ingrijire medico-socială", "Cetate Hospital"*)[34], which agreed to hospitalise the applicant, provided that his diagnosis - HIV infection - was correct[35].

37. In all correspondence aimed at identifying a social and/or medical establishment willing to host the applicant, the authorities mentioned his old, and as it turned out, accurate diagnosis, despite the more recent diagnosis set on 14 October 2003. However, in the letters sent to the seven medico-social centres, the Department reverted to the less severe diagnosis set in October 2003[36].

The transfer and hospitalisation at the Cetate Hospital

38. The Department transferred the applicant from the Placement Centre to the Cetate Hospital on 5 February 2004[37]. The versions of events provided by those involved in the transfer vary greatly to the point of being contradictory.

39. In a letter sent to the CLR soon after the applicant died, Doctor Elena Onel, the director of the Cetate Hospital, stated that when he was brought to the hospital, "the patient was in a state of "somatic and psychiatric degradation", wearing only a tattered tracksuit, without any underwear, shoes or ARV"[38].

40. Florin Coanda, the educational therapist at the Cetate Hospital, noted in an inventory that upon transfer, the applicant was in possession of the following items: a pair of shoes, a pair of socks, a pair of underpants, one track suit, one t-shirt, one pullover, one hat and one coat[39]. The inventory did not mention the persons accompanying the applicant from the Placement Centre, or whether any medication or food had been handed to the staff at the Cetate Hospital on this occasion. However, the

[31] Letter of the County Department for the Protection of the Rights of the Child, 21 January 2004, Annex 9.
[32] Letter of the Dolj County Public Health Department, 29 January 2004, Annex 10.
[33] Letters of the County Department for the Protection of the Rights of the Child, 28 January 2004, Annex 11.
[34] Statement by Larisa Coderie, 21 July 2004, annex 40.
[35] Letter by the Cetate Hospital, 5 March 2004, annex 25.
[36] Letters of the DPRC, 28 January 2004.
[37] Referral note, 5 February 2004, Annex 12.
[38] Letter by the Cetate Hospital, 5 March 2004, annex 25; also statement by Elena Onel, 19 July 2004, annex 38.
[39] Inventory Record, 24 February 2004, Annex 13.

authenticity of the inventory is doubtful, given that it is dated 24 February 2004, almost three weeks after the applicant's transfer to Cetate and after he died[40].

41. Both Larisa Coderie and Maria Vieru (the doctor who treated the applicant at the Placement Centre) stated that they accompanied the applicant to the Cetate Hospital, denying that the applicant's clothing was inadequate[41]. Vieru claimed she handed Maria Onel a bag containing "the medicine necessary for the applicant to continue his treatment"[42] and some food[43].

42. A report issued by the National Authority for the Protection of Children and Adoption mentions that the applicant's reception at the Cetate Hospital was also witnessed by the mayor of Cetate[44]. According to the report, the applicant received from the storage room of the Placement Centre one kilo of sweet bread, two breads and two cans of preserves. Maria Vieru provided staff at Cetate with information concerning the applicant's behaviour and habits. Finally, more documentary sources mention that Cetate Hospital staff also received the applicant's medical file and the medico-social evaluation.

43. It is established that the Cetate Hospital staff did not receive any ARV on 5 February 2004. Maria Vieru justified this oversight on the basis that "she did not know whether, depending on the results of the most recent investigation, it would be necessary to modify his treatment"[45]. According to Vieru, she immediately consulted the Clinic upon her return from Cetate, receiving confirmation that the applicant's treatment remained unchanged. Vieru sent the ARV to Cetate through an acquaintance who commuted daily from Cetate to Craiova[46]. The staff from the Cetate Hospital only received the medication on 9 February 2004. This does not coincide with the Elena Onel's statement, who stated that on 9 February she had to send somebody to Craiova to collect the ARV[47].

44. Adelița Ștefania Deliu, the person who commuted between Cetate and Craiova, confirmed that she handed the ARV to the Cetate Hospital staff on 9 February[48]. She also mentioned that she took part in the discussion which took place between Onel and Vieru when the applicant was transferred to the Cetate Hospital. It appears that the two expressed the opinion that since the applicant was HIV positive, a hospital for contagious diseases would have been a more appropriate option for his treatment[49].

[40] Idem.
[41] Statement by Maria Vieru, 22 July 2004, annex 41, Statement by Larisa Coderie, 21 July 2004, annex 40.
[42] Statement by Larisa Coderie, 21 July 2004, annex 40.
[43] Statement by Maria Vieru, 22 July 2004
[44] Letter of the National Authority for the Protection of the Child and Adoption, 27 October 2004, annex 55.
[45] Statement by Maria Vieru, 22 July 2004, annex 41.
[46] Idem.
[47] Statement by Elena Onel, 19 July 2004, annex 38.
[48] Statement by Adelita Stefania Deliu, 14 December 2005, annex 66
[49] Idem.

45. The applicant was examined after his admission to the Cetate Hospital and received treatment[50]. The diagnosis set on that occasion was "severe mental retardation, HIV infection, state of malnutrition, the patient having a weight of 45 kilos, at a height of 1.68". The applicant's medical record mentioned that he "could not orient himself in time and space and that he could not eat or care for his personal hygiene by himself"[51]. However, the investigations carried out on this occasion concluded that all his physical parameters where within normal limits[52]. The applicant was in a "generally good state"[53] and had a "good appetite"[54].The Hospital then bought the applicant clothes, shoes and underwear[55].

46. In two remarkably similar statements, Elena Onel[56] and Natalia Ispas[57], a nurse at the Cetate Hospital, declared that during the evening of 6 February 2004 the applicant became 'agitated'. In the morning of 7 February 2008, the applicant "became violent, assaulted the other patients"[58], he "broke the window, tore up the mattress and his clothes, he tore the sheets, he urinated in a glass and drank the contents'[59]. The applicant was administered "*fenobarbital*" to calm him down.

47. It is claimed that the state of "psychomotor agitation" with violent outbreaks continued on 8 and 9 February[60]. On 8 February, the applicant received *diazepam*. On 9 February, given that the applicant's state had not improved, the Cetate Hospital sent him to the Poiana Mare Hospital for a psychiatric examination and therapeutic instructions. At the same time, Elena Onel called the Placement Centre, communicating her intention to return the applicant, on the basis that the Cetate Hospital was a facility for the treatment of chronic somatic diseases, and not psychiatric conditions[61]. The Placement Centre refused her request, stating that the applicant "was out of their jurisdiction"[62].

48. According to Lidia Ghițulescu, the psychiatrist who examined the applicant at the Poiana Mare Hospital on 9 September, his condition did not constitute a "psychiatric emergency", and that he "was not agitated"[63]. Ghițulescu diagnosed him with 'medium mental retardation' and prescribed sedative medication (*carbamazepina* and *diazepam*)[64].

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[50] *Viplex*, *fenobarbital*, observation notes, Cetate Hospital, annex 14.
[51] Observation notes, Cetate Hospital, annex 14.
[52] Idem.
[53] Idem.
[54] Letter by the Cetate Hospital, 5 March 2004, annex 25
[55] Idem.
[56] Statement by Elena Onel, 19 July 2004, annex 38.
[57] Statement by Natalia Ispas, 9 July 2004, annex 37.
[58] Letter by the Cetate Hospital, 5 March 2004, annex 25
[59] Statement by Natalia Ispas, 9 July 2004, annex 37, Statement by Elena Onel, 19 July 2004, annex 38.
[60] Observation notes, Cetate Hospital, annex 14.
[61] Letter by the Cetate Hospital, 5 March 2004, annex 25
[62] Idem.
[63] Statement by Lidia Ghițulescu, 19 July 2004, annex 39.
[64] Written note, 9 February 2004, annex 15, statement by Lidia Ghițulescu, 19 July 2004, annex 39.

49. On 9 September the applicant's ARV treatment was resumed, in addition to the medication prescribed at the Poiana Mare Hospital[65]. Despite these measures, his situation did not improve, the medical records mentioning that he continued to be "agitated" and "violent"[66].

50. On 11 February 2004, Elena Onel called the Public Health Department and asked them to provide a solution for transferring the applicant to a facility which was more suitable to treating his health problems[67]. On 13 February the Public Health Department recommended to Onel to transfer the applicant to the Poiana Mare Hospital for a period of 4 to 5 days for psychiatric therapy[68].

The hospitalization in the Poiana Mare Hospital and the death of the applicant

51. On 13 February 2004, at 12.00 hrs, the applicant was admitted to the Poiana Mare Hospital[69]. According to the statement by Florina Peşea, the doctor who completed the admission formalities, the applicant was brought to the Poiana Mare Hospital by the driver of the Cetate Hospital, without being accompanied by a member of their medical staff[70]. Upon hospitalisation, "the applicant was extremely agitated, with aggressive manifestations"[71]. Peşea called Onel and tried to convince her that the applicant should be hospitalised at the Craiova Hospital for Contagious Diseases. She also got in touch with Radu Radoveanu, a doctor working at the Dolj County Public Health Department, who recommended she keep the applicant at the Poiana Mare Hospital "for four to five days"[72]. The applicant was placed in Section V Psychiatry.

52. On 15 February 2004, the applicant was taken into the charge of Lidia Ghițulescu[73]. She examined him, opened an observation record, and prescribed psychiatric treatment[74], in addition to ARV. Given that the applicant was HIV positive, Ghițulescu decided to transfer him to Section VI Psychiatry of the hospital, which had two generalist doctors on staff[75]. She continued however to be in charge with his psychiatric treatment, given that Section VI did not have any psychiatrists[76].

53. Lidia Ghițulescu, stated that the applicant "was not agitated" at any point during his hospitalisation at the Poiana Mare Hospital[77], which calls into questions the reports of violent behaviour given by staff at the Cetate Hospital.

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[65] Observation notes, Cetate Hospital, annex 14.
[66] Idem
[67] Letter by the Cetate Hospital, 5 March 2004, annex 25.
[68] Statement by Elena Onel, 19 July 2004, annex 38.
[69] Referral note, 13 February 2004, annex 16, observation notes, Cetate Hospital, annex 14.
[70] Statement of Florina Pesea, annex 26.
[71] Idem
[72] Idem.
[73] Statement by Lidia Ghițulescu, 19 July 2004, annex 39.
[74] Clordelazin and fenobarbital, Statement of Florina Pesea, annex 26.
[75] Statement by Lidia Ghițulescu, 19 July 2004, annex 39.
[76] Statement by Lidia Ghitulescu, annex 26.
[77] Statement by Lidia Ghițulescu, 19 July 2004, annex 39.

54. The transfer to Section VI took place on 16 February. The generalist doctor on watch that day, Dorina Ionete , stated that "she carried out a general clinical examination [of the applicant] which hadn't been done at hospitalisation on 13 February 2004, as well as the tests that in theory should have been carried out"[78]; however, "no entry had been made in the observation notes in relation to these tests"[79]. According to the observation notes, the medical staff could not obtain any information concerning the applicant's medical history (including personal, physiological and pathologic data), given that the "patient did not cooperate"[80].

55. According to the statement of Dorina Ionete the applicant's condition while he was under her watch was 'stable'. The fields in the observation notes from the Poiana Mare Hospital concerning the examinations that had to be carried out at hospitalisation and the justification for the treatment prescribed were left empty[81]. A police record prepared subsequently concludes that the examinations had not been carried out[82]. In addition, the observation notes do not include any mention proving that the ARV therapy had been effectively administered. Finally these notes fail to record any information about the applicant's health condition for entire days (for example no information exists for 17 and 18 February).

56. When a police officer questioned her subsequently, Ionete declared that the ARV was administered to the applicant in conformity with the instructions on the box received from the Cetate Hospital, but no entry confirming this was made in the observation log[83]. Ionete justified this omission on the basis that the ARV had not been prescribed by the doctors at the Poiana Mare Hospital and because no RVN existed in the pharmacy of the hospital[84]. Ionete showed the police officer the RVN containers in her cabinet, which he took to be sufficient evidence for her assertion, without checking how much medicine remained in the container, or otherwise corroborating her statement with other evidence[85].

57. On 19 February 2004 the applicant "stopped eating and refused to swallow his medicine"[86]. Therefore, Dorina Ionete prescribed an intravenous treatment which included Glucose 10% and vitamins[87]. During 19 February 2004 the applicant was examined twice more. Daniela Mitroaica, a generalist doctor, found the applicant to be

[78] Statement by Dorina Ionete, 8 December 2005, annex 64.
[79] Police reports, 8 December 2005, annex 67.
[80] Observation notes, Poiana Mare Hospital, annex 17.
[81] Idem.
[82] Police reports, 8 December 2005, annex 67.
[83] Police reports, 8 December 2005, annex 67.
[84] Statement of Dorina Ionete, annex 26.
[85] Police reports, 8 December 2005, annex 67.
[86] Observation notes, Poiana Mare Hospital, annex 17, statement of Dorina Ionete, annex 26.
[87] Statement of Dorina Ionete, annex 26

"in a general altered state"[88]. Gheorghiță Prodan (a psychiatrist) examined the applicant later in the day and found the applicant to be in a "general average state" and afebrile[89].

58. On 20 February 2004, two representatives of the CLR visited the Poiana Mare Hospital, one day after a visit undertaken by representatives of the Ministry of Health. The applicant's situation was described in a report issued a few days later:

> *"[The applicant] was alone in an unheated room, with only a pyjama top on, lying in a bed without bedding. He could not feed himself and could not walk to the toilet by himself. The patient should have been fed and his clothes changed but the staff manifested fear when they were asked to touch him. The patient did not benefit from conditions of care adequate to his disease – caloric supplement, vitamins, adequate medication (as could be verified in the observation notes), being fed only intravenously with glucose."*[90]

59. Alarmed by the gravity of the applicant's situation, the CLR representatives asked a nurse to alert Lidia Ghițulescu, who at that time was in charge of the hospital. When she came, they requested her to order the applicant's immediate transfer to the Hospital for Contagious Diseases in Craiova where he could receive the urgent treatment he needed[91]. However, Ghițulescu decided against it, estimating that he would not able to withstand the trip[92].

60. The applicant died shortly after the CLR visit, in the evening of 20 February 2004, at 8.00 pm[93]. According to the death certificate prepared by Lidia Ghițulescu three days later on 23 February, the immediate cause of death was a cardio-respiratory insufficiency (*"stop cardio-respirator"*). The certificate also noted that the HIV infection was the "initial morbid state" and designated "mental retardation" as "another important morbid state".

61. The Poiana Mare Hospital did not carry out an autopsy of the body as required by law[94]. Lidia Ghițulescu justified this omission on the basis that "she did not believe this to be a suspicious death, taking into consideration the two serious conditions displayed by [the applicant]" (i.e. mental retardation and HIV infection)[95].

62. Unaware that the applicant had died soon after their visit, on 21 February 2004 the CLR sent urgent appeal letters to a number of local and central officials, including the Minister of Health, the prefect of Dolj County, the mayor of Poiana Mare, the general

[88] Statement by Daniela Mitroaica, 8 December 2005, annex 68.
[89] Statement by Gheorghiță Prodan, 8 December 2005, annex 65.
[90] CLR Report on the visit to the Poiana Mare Hospital, annex 18.
[91] Statement by Lidia Ghițulescu, 19 July 2004, annex 39.
[92] Idem
[93] Death certificate no. 15/23 February 2004, annex 21.
[94] Art. 34 of Procedural Rules of 25 May 2000, annex 86.
[95] Statement by Lidia Ghițulescu, 19 July 2004, annex 39.

director of the Department, and the director of Dolj County Public Health Department[96]. In these letters, the CLR noted that the applicant's health condition was extremely critical and that he was placed in an institution which was not equipped to provide HIV treatment. The CLR noted that given the inadequate nutrition, poor conditions and inadequate treatment at the Poiana Mare Hospital, emergency measures had to be taken aimed at addressing the situation. It was imperative to transfer the applicant to a hospital for contagious diseases. The treatment prescribed at the Poiana Mare Hospital – namely Haldol and Diazepam – did not justify his continued placement in a psychiatric hospital. The CLR stated that the applicant's hospitalisation and transfer to the Poiana Mare Hospital was a breach of his human rights, and requested that an investigation be initiated which could lead to the identification and punishment of those responsible.

63. On 22 February 2004, the CLR issued a press release in which it made an urgent appeal for the immediate improvement in the conditions and in the treatment of patients at the Poiana Mare Hospital. It singled out the applicant's plight and called for urgent action[97].

The criminal investigation

64. On 23 February 2004, the CLR filed a criminal complaint with the General Prosecutor of Romania in relation to the circumstances which led to the applicant's death[98].

65. On 15 June 2004 the CLR filed two more criminal complaints; with the Prosecution Service of the Craiova First Instance Court[99] and the Prosecution Service of the Craiova Tribunal[100]. The CLR renewed its request that a criminal investigation be opened in relation to the circumstances surrounding the applicant's death, alleging that the following crimes had been committed:

> - 'negligence at service' by employees of the Department and of the Placement Centre (Art. 249 of the Criminal Code 1997);
> -'malfeasance and nonfeasance against persons' interests' (Art. 246);
> -'endangering a person unable to care for herself/himself' (Art. 314) by employees of the Cetate Hospital;
> -'homicide by negligence' (Art. 178)
> -'endangering a person unable to care for herself/himself' by employees of the Poiana Mare Hospital.

66. The CLR argued that the Commission for the Medical Examination of Adults with Handicap affiliated with the Dolj County Council wrongfully placed the applicant in

[96] Letters sent by the CLR to various officials, 21 February 2004, annex 20.
[97] CLR press release: "Tragic Situation at the Psychiatric Hospital Poiana Mare", 22 February 2003.
[98] According to the letter sent to the General Prosecutor of Romania, 15 June 2004, annex 33.
[99] Complaint to the Prosecution Service affiliated with the Craiova First Instance Court, 15 June 2004, annex 34.
[100] Complaint to the Prosecution Service affiliated with the Craiova Tribunal, 15 June 2004, annex 35.

the medium group of disability, contrary to previous and subsequent diagnoses. In turn, the Department failed to institute proceedings for the appointment of a guardian for the applicant when he reached majority age, in breach of existing legislation. The Placement Centre failed to provide the required ARV treatment to Cetate Hospital staff when the applicant was transferred there on 5 February 2004 which may have caused his death two weeks later. The CLR also claimed that the transfer from the Cetate Hospital to the Poiana Mare Hospital was unnecessary and abusive, and contrary to existing legislation. Finally, the CLR argued that the applicant lacked adequate care, treatment and nutrition at the Poiana Mare Hospital.

67. On 29 July 2004 the Prosecution Office of the Dolj Tribunal requested the Craiova Forensic Institute to establish whether the type and dosage of the treatment administered to the applicant in the Cetate Hospital and the Poiana Mare Hospital was adequate in view of his diagnosis (HIV infection and "mental retardation")[101]. This examination was to be carried out solely on the basis of the observation notes kept by the two hospitals and a brief description of the factual background as follows:

> *"In the case at hand, it is recorded that patient Câmpeanu Valentin, aged 19, was hospitalised at the Medico-Social Centre with the following diagnosis: mental retardation, HIV infection. Subsequently, he was transferred to the Psychiatric Hospital Poiana Mare where he died on 20 February 2004."*[102]

68. The Forensic Institute submitted its report on the 14 September 2004[103]. However, since only the first page of the report was included in the investigation file, the applicant did not have access to its full contents.

69. On 31 August 2004 the Prosecution Service of the Dolj Tribunal informed the CLR that a criminal file had been opened in response to the complaint they filed, and that the investigation was allocated to the Criminal Investigation Service of the Dolj County Police Inspectorate[104].

70. By a resolution dated 15 September 2004, the Prosecution Service of the Dolj Tribunal requested the Craiova Forensic Institute to supplement its previous report by identifying "the type of death and its medical cause"[105]. The request was worded in the following terms:

> *"1. The undertaking of a forensic examination of the documents in the file in order to establish the following:*
> - *the type of the death of the patient Câmpeanu Valentin;*
> - *the medical cause of death;*

[101] Request sent by Prosecution Office of the Dolj Tribunal to the Craiova Forensic Institute, 29 July 2004, annex 43.
[102] Idem.
[103] Forensic Report 3180/A3/14 September 2004 (first page only), annex 44.
[104] Letter of the Prosecution Service of the Dolj Tribunal, 31 August 2004, annex 48.
[105] Resolution of the Prosecution Service of the Dolj Tribunal, 15 September 2004, annex 50.

- *if there was a causality relation between the therapeutic decisions and the death of the patient Câmpeanu Valentin.*

In this regard we submit to your consideration file no. 758/P/2004, which includes the observation notes of the patient Câmpeanu Valentin from the medical establishments where he was hospitalised.

2. If the file and the forensic documents attached are not capable of elucidating the type of the death and the medical cause of death we ask you to inform us whether the exhumation of the body would facilitate achieving these objectives."

71. The Institute stated in reply that any exhumation "would lack any objective scientific finality taking into account the period of time passed from the date of death until present day, with the modifications associated with putrefaction inherent in the evolution of the state of the body" [106]. The Institute added that in any case they would not be able to respond to the questions formulated by the Prosecution Service without an autopsy of the body. On 24 September 2004 the Prosecution Service ordered the exhumation and autopsy of the applicant's body[107].

72. On 3 December 2004 the Prosecution Service of the Dolj Tribunal took over the investigation from the Police Inspectorate[108].

73. The exhumation and autopsy of the applicant's body was carried out on 22 October 2004, and the forensic report issued on 2 February 2005[109].According to the report, at the time of the exhumation, the corpse was in "an advanced state of putrefaction". An advanced state of cachexia[110] at the time of death was established. The conclusions of the report were the following:

"1. The death of Câmpeanu Valentin of 18 years old was not violent.

2. [The death] was due to a cardio-respiratory insufficiency caused by pneumonia, a complication suffered during the evolution of HIV syndrome, diagnosed upon hospitalisation.

3. At exhumation, no traces of violence were noticed.

4. The death may date from 20 February 2004. "

74. On 19 May 2005, the Prosecution Service of the Dolj Tribunal issued a decision of non-indictment in relation to the circumstances surrounding the death of the applicant. This was justified mainly on the basis of the conclusions of the forensic reports according to which "the death […] was not violent being the result of a cardio-respiratory deficiency caused in turn by pneumonia, a complication which occurred during the evolution of the HIV syndrome, which had been diagnosed upon hospitalisation"[111].

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[106] Letter by the Craiova Forensic Institute, 16 September 2004, annex 51.
[107] Resolution of the Prosecution Service of the Dolj Tribunal, 24 September 2004, annex 52.
[108] Information note of the Prosecution Service of the Dolj Tribunal, 3 December 2004, annex 56.
[109] Forensic report, 2 February 2005, annex 57.
110 Cachexia: general physical wasting and malnutrition usually associated with chronic disease (according to the Merriam-Webster's Online Dictionary).
[111] Resolution of the Prosecution Service of the Dolj Tribunal, 19 May 2005, annex 58.

75. The CLR complained against the resolution, on the basis that it was slow and inefficient[112]. The CLR relied on a number of grounds as follows:

- The complaints based on Articles 246, 249 and 314 of the Criminal Code were not analysed or resolved (see above §65);
- The prosecution failed to examine the living conditions and the treatment at the Poiana Mare Hospital;
- The Prosecution failed to examine comprehensively the state of the applicant's health and its evolution; respectively the stage of development of the HIV infection, the treatment required, including the treatment which was administered effectively (including the gaps in the administration of ARV); the extent to which the diseases which led to the applicant's death were associated with his HIV status, and the treatment required for those diseases – in all three establishments where the applicant was placed during the final months of his life.
- The prosecution failed to examine the nature of the medical treatment received by the applicant in view of the ailments he suffered from (intellectual disability, pneumonia and chronic hepatitis);
- The prosecution failed to examine the calorific level of the food the applicant received in the three establishments, especially considering the legal provisions in force concerning the alimentation of persons carrying the HIV virus;
- The prosecution failed to examine the living conditions in the three establishments, and in particular in the Poiana Mare Hospital;
- The prosecution failed to question important witnesses – the majority of the staff at the three establishments as well as the CLR staff who visited the Poiana Mare Hospital on the day the applicant died;
- The prosecution failed to collect crucial documentary evidence such as the medical file from the Poiana Mare Hospital;
- The conclusions of the forensic reports were not corroborated by any other evidence;
- The autopsy was carried out almost a year after the applicant's death and therefore could not yield any useful information regarding the treatment received by the applicant before he died.

76. On 23 August 2005, the Head Prosecutor of the Prosecution Service of the Dolj Tribunal quashed the decision of non-indictment and ordered that the investigation be reopened under the supervision of the Dolj County Police Inspectorate[113]. The Head Prosecutor decided that the investigation "failed to elucidate all circumstances and conditions" which led to the applicant's death. The Head Prosecutor ordered that the following steps be taken in order to establish "the evolution in time of the morbid phenomenon which determined the applicant's death, the causes which were determinative of the outcome and those that favoured it":

[112] CLR Complaint, 8 August 2005, annex 59.
[113] Ordinance of the Prosecution Service of the Dolj Tribunal, 23 August 2005, annex 60.

1. The following documents will be collected from the HIV/AIDS Clinic, in photocopy, certified as to their authenticity:

- *the patient's medical record;*
- *survey examinations ("examene de bilanț");*
- *Records of clinical and paraclinical examinations;*
- *Medicine (or pharmacy) records;*
- *Documents proving that the medication and the instructions of treatment had been transferred to the institutions of care and treatment where the patient was hospitalised.*

The doctor [who treated the applicant] will be questioned in relation to the medical care provided through the Clinic, the sanitary-hygienic measures that had to be taken, the dietary regime recommended, the stage of development of the HIV/AIDS syndrome at the time of the last medical examination carried out.

2. The following documents of relevance for the evolution of the minor's health condition will be collected from the Craiova Placement Centre No. 7:

- *the patient's medical records (the observation notes);*
- *survey examinations;*
- *the medicine records or other similar document to prove the transfer of ARV;*

The head doctor, the doctor [who treated the applicant], and the nurses will be questioned in relation to the health state, the evolution of the disease, including the intervening conditions (chronic hepatitis, pneumonia, pulmonary tuberculosis) mentioned in the observation logs as pathologic antecedents.

The medication and other hygienic-dietary treatment applied will be ascertained, collecting the supporting documents (prescriptions, medical letters, observation notes) to the investigation file.

The staff of the care establishment will also be questioned in relation to the living conditions and the sanitary-hygienic conditions at the time of the hospitalisation.

The interruption of the ARV between 5 and 9 February 2004 will be established with certitude.

For that purpose the person who transmitted the medication and the treatment plan recommended to the Cetate Medico-Social Centre will be questioned, collecting the document proving the transfer of the medication.

During questioning, it will be noted that the first entry in the observation log no. 7/2004 of the Cetate Medico-Social Centre on administration of ARV dates from 9 February 2004, 13.00 pm.

3. The following aspects pertaining to the treatment administered for the primary disease, as mentioned in the observation notes 70/2004, and as to whether the treatment was administered in reality, will be examined at the Cetate Medico-Social Centre; in addition the medical documents available as described above will be collected.

The individuals who had the applicant in their care during his hospitalisation will be questioned in relation to the medication administered, the hygienic-sanitary and nutritional conditions.

4. Taking into account the gaps in the Observation notes 100/2004, the following aspects will be examined at the Psychiatric Hospital Poiana Mare:

- *the forensic documents on the basis of which the applicant's transfer and hospitalisation were carried out, taking into account that no information regarding the personal, physiological, pathological and the medication administered before hospitalisation is included under the section on "case history" (the relevant documents will be collected in photocopy).*
- *The clinical and paraclinical tests undertaken, taking into account that they were recommended according to the respective entry included in the photocopy of the Observation Notes 100/2004 and the section "laboratory test".*
- *The photocopies of the test bulletins if they exist or alternatively to certify that they do not exist in a report.*
- *The documents proving that the ARV was effectively administered (medication notes) will be collected to the file, taking into account that no entry in this respect was made in the observation log.*
- *The doctors Ioana Grigorescu, Adi Mitroaica, Gheorghita Prodan, Lidia Ghitulescu will be questioned, who had the applicant in care, in connection to the evolution of his health state during hospitalisation, the therapeutic decisions and the dietary-medical regime adopted.*
- *Given the entries made on 19 and 20 February 2004, explanations will be requested regarding the traces (facial and legs edema, TA -90/50 mm Hg) mentioned in the observation notes, regarding the nature of the edema[114] and its origin (allergic edema, neurogen, cardiac, renal etc.), its cause, the investigations carried out and the correctitude of the therapeutic approach adopted, taking into account the hypotension installed, which would have required the treatment of the case as a medical emergency.*
- *The nurses who administered the medication and supervised the patient during his hospitalisation will be questioned in relation to: the evolution of the disease, the drug and hygienic-dietary treatment, the living and hygienic conditions etc.*
- *The medical staff above will provide information in relation to the intervening conditions, superimposed during hospitalisation, taking into account that the medical autopsy report mentions that the cardio-respiratory deficiency is the consequence of pneumonia.*
- *The bulletin on HIV testing will be collected to the file.*

After all evidence is collected, the file of the case will be presented to the Dolj Doctors' Commission and to the Central Doctors' Commission for an opinion

114 Edema: an abnormal infiltration and excess accumulation of serous fluid in connective tissue or in a serous cavity —called also dropsy (according to the Merriam-Webster's Online Dictionary)

regarding the therapeutic approach adopted as well as to the Craiova Forensic Institute to reformulate their conclusions depending on the new data obtained".

77. The Dolj Police Inspectorate requested the Clinic and Placement Centre to submit copies of the records concerning the applicant in conformity with the instructions in the decision of 23 August 2005. The two institutions complied with the request and submitted the documents requested[115]. However, these documents had never been attached to the investigation file, and therefore the CLR did not have access to them.

78. On 11 January 2006 the Police Inspectorate requested the Dolj County Doctors' Association (*"Colegiul medicilor"*) to provide it with an opinion on "whether the therapeutic approach adopted was correct in view of the [applicant's] diagnoses or if it contains elements pertaining to a medical malpractice" [116]. The Inspectorate also supplied the Doctors' Association with a series of medical documents obtained from the Placement Centre and the Clinic, the two observation logs from the Poiana Mare Hospital and the Cetate Hospital as well as the forensic report of 2 February 2005.

79. On 20 July 2006, the Disciplinary Commission of the Doctors' Association decided that no grounds for a disciplinary action against staff at the Poiana Mare Hospital existed[117]. The reports drafted on this occasion concluded that "the psychotropic therapy, as noted in the general clinic observation notes from the Poiana Mare Hospital was adequate"; in addition "the information received suggests that the doctors' decisions were correct, without any suspicion of medical malpractice concerning an opportunistic infection associated with the HIV virus incorrectly treated".

80. The Police Inspectorate challenged this decision before the Romanian Doctors' Association (*"Colegiul Doctorilor din România"*) although the basis on which this challenge was grounded is unclear. The challenge was in any case rejected for having been submitted out of time[118]. The Association also opined that the original request filed with Dolj County Doctors' Association was out of time as well.

81. On 11 December 2006, the Prosecution Service of the Dolj Tribunal transferred jurisdiction over the investigation file to the Prosecution Service of the Calafat County Court on the basis of recent changes in law[119].

82. On 30 March 2007, the Prosecution Service of the Calafat County Court issued a new decision of non-indictment which was largely based on the medical opinions collected in the investigation file[120]. The CLR filed a complaint against this decision,

[115] Correspondence with the Clinic and the Placement Centre, annex 70.
[116] Request of the Dolj County Police Inspectorate, 11 January 2006, annex 71.
[117] Decision of the Discipline Commission of the Dolj County Medics' Association, 20 July 2006, annex 72.
[118] Decision of the Romanian Doctors' Association, 23 November 2006, annex 73.
[119] Ordinance by the Prosecution Service of the Dolj Tribunal, 11 December 2006, annex 74.
[120] Resolution of non-indictment by the Prosecution Office of the Calafat County Court, 30 March 2007, annex 75.

mainly on account of the fact that most of the instructions included in the decision of 23 August 2005 were not complied with[121]. On 4 June 2007 the Head Prosecutor of the Prosecution Service of the Calafat County Court rejected the complaint and upheld the decision of non-indictment[122].

83. The CLR appealed the decision of non-indictment with the Calafat First Instance Court, among others for failing to collect crucial evidence and to elucidate essential aspects of the case[123]. The CLR also pointed out that the instructions included in decision of 23 August 2005 were mostly ignored.

84. During the final hearing before the Calafat First-Instance Court, one of the two defendants in the case, Lidia Ghițulescu, stated that the applicant could not receive adequate treatment at the Poiana Mare Hospital, given the lack of adequate facilities and the overcrowding prevalent there[124]. In its judgment, dated 3 October 2007, the Calafat First Instance Court accepted the arguments put forward by the CLR, quashed the decision of non-indictment, and returned the case to the Prosecution Office to complete the investigation[125].

85. The Calafat First Instance Court highlighted a number of shortcomings in the investigation. Thus, most of the documents which were supposed to be collected from the Clinic and the Placement Centre were not actually added to the investigation file (see above §76). The contradictions in the statements of those involved in the transfer to the Cetate Hospital as well as the circumstances related to the interruption of the ARV treatment after the transfer were not clarified. In addition, the contradictory claims of medical personnel from the Cetate Hospital and the Poiana Mare Hospital regarding the alleged "state of agitation" the applicant was in were not clarified. The investigators also failed to clarify whether the medical staff at the Poiana Mare Hospital made the necessary tests after the applicant was hospitalised there and whether he received the ARV medication. The investigators failed to establish the origin of the edema the applicant suffered from and whether the therapeutic approach adopted at the Poiana Mare Hospital was correct. From that perspective the request for an opinion from the Doctors' Association was premature.

86. The Prosecution Office appealed this judgment with the Dolj Tribunal[126]. In their complaint, the Prosecution Office did not respond in any way to the objections raised in the first instance court judgment. Instead, the Prosecution Office again relied on the medical opinions collected in the investigation file, considering that "no causality relationship between the death and the activities of the two defendants had been

[121] CLR Complaint, annex 76.
[122] Resolution by the Head Prosecutor of the Prosecution Service of the Calafat County Court, 4 June 2007, annex 77.
[123] CLR Complaint, 10 August 2007, annex 78.
[124] Criminal judgment no. 186/3 October 2007 of the Calafat County Court, annex 79.
[125] Idem.
[126] Appeal brief, The Prosecution Service of the Calafat First Instance Court, 31 January 2008, annex 80.

established" and that, in relation to the defendants, "the two fulfilled their duties adequately".

87. By a judgment dated 4 April 2008, the Dolj Tribunal decided to quash the instance court judgment and upheld the solution of non-indictment dated 30 March 2007[127]. Like the Prosecution Office, the Tribunal chose not to respond in any way to the objections raised in the first instance court judgment, and relied instead on the medical opinions collected in the investigation file in order to justify their verdict.

88. Throughout the duration of proceedings, the CLR filed a number of requests asking that the investigation be expedited – for instance the letters sent on 15 June 2004[128] and on 16 December 2005[129].

Other proceedings

89. In letters dated 24 February 2004[130] and 5 March 2004[131], the Department denied any knowledge of the circumstances leading to the applicant's hospitalisation at the Poiana Mare Hospital.

90. In response to the complaints filed by the CLR, on 8 March 2004 the Prefect of Dolj County established a commission tasked with carrying out an investigation into the circumstances surrounding the applicant's death[132]. The commission was made up of representatives of the Department and of the Public Health Department, the Criminal Investigations Department of the Dolj County Police Inspectorate and the Prefect's Office. The commission was given 10 days to finalise the investigation and submit a report on its findings.

91. The report of the commission concluded that all procedures involved in the applicant's treatment after his discharge from the Placement Centre were legal and justified in view of his diagnosis[133]. The commission found only one irregularity in that an autopsy was not carried out immediately after the applicant died, in breach of existing legislation. The report contains obvious factual errors, claiming for example that the applicant benefited from ARV throughout his stay at the Cetate Hospital and the Poiana Mare Hospital. Subsequent letters from the National Authority for the Protection of the Child and Adoption (*"the Authority"*)[134] and the Department of Control of the Dolj County Prefect[135] reiterated the conclusions set out in this report.

[127] Criminal decision no. 191/4 April 2008, Dolj Tribunal, annex 82.
[128] Letter to the General Prosecutor of Romania, 15 June 2004, annex 33.
[129] CLR Request, 16 December 2005, annex 69.
[130] Letter by the Department, 24 February 2004, annex 22.
[131] Letter by the Department, 5 March 2004, annex 24.
[132] Order of the Dolj County Prefect, 8 March 2004, annex 27.
[133] Report by the commission of control set up in accordance with the Prefect's Order, annex 30.
[134] Letter sent by the National Authority for the Protection of the Child and Adoption, 18 March 2004, annex 31.
[135] Letter by the Department of Control of the Dolj County Prefect, 22 March 2003, annex 32.

92. On 24 March 2004 the Dolj Public Health Department informed the CLR that a commission made up of various county-level officials concluded that 'no human rights have been breached' in connection to the applicant's death as his successive hospitalisations have been undertaken in accordance with Article 9 of Law 584/2002 regarding the measures for the protection of the spreading of HIV infection and protection of persons infected with HIV or suffering from AIDS[136].

93. On 15 June 2004 the CLR requested the Authority to take measures against those sharing responsibility for the applicant's death[137]. The letter is similar to the criminal complaint filed on the same date (see above, §65).

94. On 29 July 2004 representatives of the CLR had a meeting with the Control Bureau of the Department. In a memo sent on 2 August 2004 the CLR expressed dissatisfaction about the fact that the representatives of the Control Bureau present at the meeting of 29 July were not sufficiently prepared and their answers were deficient[138]. In addition, the CLR made a series of observations in relation to the applicant's death as follows:

- The decision 1125 of the Commission whereby the applicant was transferred to the Poiana Mare Hospital was illegal and contrary to the provisions of Article 5§1 of the Convention; the CLR emphasized that since the decision was not cancelled or changed subsequently it remained formally valid;
- The Commission for the Medical Examination of Adults with Handicap affiliated with the Dolj County Council wrongly concluded that the applicant belonged to the medium group of disability, as according to existing legislation, an IQ of 30 corresponded to severe mental retardation;
- At the time of his transfer to the Cetate Hospital, the applicant was malnourished, weighing only 45 kilos, which raised questions in relation to the living conditions at the Placement Centre; the CLR consequently considered that a visit to the Placement Centre by representatives of the Authority was necessary in order to examine the way in which the standards of care and protection of children with handicap were complied with;
- The CLR noted that the circumstances in which the applicant was transferred to the Cetate Hospital were not clear, and it was not clear why this particular facility was selected.

95. In a separate memo sent on the same date to the head of the Authority, the CLR reiterated the concerns above and in addition highlighted the problem of the systematic transfer of young people with intellectual disabilities from placement centres to the psychiatric hospitals between 2000 and 2004[139].

[136] Letter by the Dolj Public Health Department, 24 March 2004, annex 29.
[137] Complaint to the National Authority for the Child's Protection and Adoption, 15 June 2004, annex 36.
[138] Memo sent to the Control Department of the Authority, 2 August 2004, annex 45.
[139] Memo sent to the Head of the Authority, 2 August 2004, annex 46.

96. In a response dated 10 August 2004, the Authority stated that statistics on the situation of young people discharged from placement centre when they turn 18 did not exist[140]. In relation to the applicant's case, the Authority stated that a number of avenues were pursued. The authority stated that it had contacted the relevant officials to ascertain the circumstances in which the applicant died and to examine the possibility of initiating an investigation at the Department and the Commission in order to verify the way in which the applicant was transferred to the Cetate Hospital. It also stated it had enquired as to whether there were any other cases of young people 'without psychiatric problems' who had been transferred to the Poiana Mare Hospital. No information as to whether an investigation along the lines suggested in this letter took place was provided to the CLR subsequently.

97. On 1 September the CLR sent a letter to the Commission for the Medical Examination of Adults with Handicap affiliated with the Dolj County Council requesting various information regarding the process whereby the applicant was placed in the medium disability group (see above §23)[141]. The Commission never replied to this request.

98. On 27 October 2004, the Authority sent a more substantial report on the circumstances surrounding the applicant's death[142]. The Authority acknowledged that the Commission acted *ultra vires* when ordering the applicant to be hospitalised at the Poiana Mare Hospital. The Authority stated that in any case, this order did not have any consequences, given that the Poiana Mare Hospital initially refused to accept the applicant anyways (see above §32). The Authority concluded that the Department acted in line with the principles of professional deontology when it transferred the applicant to the Cetate Hospital. At the same time, the Authority stated that it was not entitled to pass judgment on the subsequent hospitalisation at the Poiana Mare Hospital. Similarly, the Authority declined to express an opinion on the allegedly wrongful allocation of the applicant to the medium group of disability, or on the events which occurred after the transfer to the Cetate Hospital.

Background information

The Romanian social care system

99. A major reform of the previously heavily centralised Romanian social assistance system was initiated in 2001. The reform focused on two broad areas – decentralisation and a more rational distribution of responsibilities. First, the system was decentralised, and the local authorities, especially those at the county level, were entrusted with key responsibilities in the implementation of the policies set at the central level. The Ministry of Work, Social Solidarity and Family kept within its mandate the coordination of policies in the field of social assistance. In addition the main governmental agencies with

[140] Letter by the Authority, 10 August 2004, annex 47.
[141] CLR Letter, 1 September 2004, annex 49.
[142] Letter of the Authority, 27 October 2004, annex 55.

attributions in the field – the National Authority of Persons with Handicap, the National Authority for the Protection of the Child and Adoption and the National Agency for the Protection of the Family – were placed under the authority of the Ministry.

100. According to Law no. 705/2001 concerning the national system of social assistance[143], social assistance was defined as "the system of institutions and measures through which the State, the public authorities and civil society ensure the prevention, the limitation or the removal of the temporary or permanent consequences of situations that may generate marginalisation or social exclusion of some persons" (Art. 2). The main objective of social assistance was "to protect the persons who, due to reasons of economical, physical, mental or social nature, do not have the possibility to fulfil their social needs, to develop their own capacities and competencies of social integration" (Art. 3). Finally, the system's guiding principles were the respect for human dignity, universality, social solidarity, partnership and subsidiarity (Art. 6).

101. Ordinance no. 68/2003 concerning social services identified an additional objective of social services, namely "the preservation of the autonomy of the person" (Art.1). The principles guiding the allocation of social services were: respect for each person's individuality, liberty to choose the social service depending on social need; equal access to social services; provision of services of quality, which are accessible, flexible, and adapted to social need; ensuring the rights and the safety of beneficiaries; ensuring access to information concerning fundamental rights and legal safeguards, and ensuring the right to challenge the decision to provide a social service; respect for private life and confidentiality; and development of a partnership between the parties involved in the process of service provision (Art. 3).

102. The National Authority for the Child's Protection and Adoption is entrusted with applying policies and elaborating strategies in the field of the promotion of the rights of the child, care and protection of children in difficulty and those with handicap, as well as in the field of adoption[144]. The Authority has *inter alia* a wide range of monitoring duties, with the aim of ensuring respect for the principles and provisions of the Convention on the Rights of the Child. The authority may propose disciplinary measures against offenders as well as closing down institutions where standards are inadequate[145].

103. The main two bodies with competencies in the field of social protection for children at the county level are the Commission for the Protection of Children and the Public Service Specialised in the Protection of the Child. In the circumstances of this particular case, the Department was designated to act as the "Public Service Specialised in the Protection of the Child" at Dolj County level. Broadly speaking, the Commission is the decision-making and policy-making body, whereas the Department implements the Commission's decisions.

[143] Annex 86.
[144] Art. 1 of Emergency Ordinance no. 12/2001 concerning the Establishment of the National Authority for the Child's Protection and Adoption, annex 86.
[145] Art. 7 of Governmental Decision no. 770/2003 concerning the Organisation and Functioning of the National Authority for the Child's Protection and Adoption, annex 86.

104. The Commission has inter alia the power to adopt or terminate a measure of protection in relation to a child in difficulty, to place children in a disability group, and to coordinate the activities undertaken at municipality level by the guardianship authorities and other authorities with competencies in relation to the rights of the child, with the aim of preventing situations which endanger the security and the development of the child[146].

105. The Department has, inter alia, the following responsibilities, as provided in Methodological Norm of 1 March 1999[147]:

- monitors and analyses the situation of children in difficulty in the country, as well as ensuring respect for and realisation of their rights (Art. 27§4)
- identifies the children in difficulty in the county and prepares the measures of protection to be adopted (Art. 27§6)
- prepares the report concerning the investigation of the psychosocial situation of the child in difficulty and proposes to the commission a measure of protection (Art. 27§7)
- identifies the position of the capable child regarding the measure proposed; ensuring that the child understands the factual and legal situation they are in (Art. 27§8)
- provides the capable child with assistance and support for exercising their right to free speech (Art. 27§9)
- undertakes the necessary actions in order to clarify the legal status of the child (Art. 27§10)
- implements the decisions taken by the commission (Art. 27§13);
- examines and evaluates, at least every three months, the circumstances related to the placement of the child and proposes to the commission that the measure be taken, maintained or terminated (Art. 27§20);
- ensures the harmonious development of the child, as well as providing? an adequate family environment for the children whose placement it is supervising ; for this purpose placement centres for children with severe handicap in difficulty will be established under its supervision (Art. 27§29);

106. A number of safeguards are built into the decision-making process concerning the allocation of social services. For instance, Ordinance No. 68/2003[148] sets out in detail the procedure for allocating social services, which comprises the following:

- the initial evaluation (undertaken by a social assistant working for the Department, and which aims to identify the individuals' needs);
- preparing the intervention plan, which comprises the measures necessary for resolving the situation of social risk by allocating the social service;
- the complex evaluation, undertaken by a multidisciplinary teams, aiming to prepare a support strategy including the body of measures and services suitable

[146] Methodology of 27 November 2001 concerning the Functioning of the Commission for the protection of the Child.
[147] Annex 86.
[148] Annex 86.

and individualised according to the social needs identified; the process of complex evaluation facilitates identifying the possibility of family integration or other forms of placement, establishing the handicap or dependency group; of the type and level of the existing dysfunction;
- preparing the individualised plan of assistance and care;
- implementing the measures included in the intervention plan and individualised plan;
- monitoring;
- re-evaluation.

107. Social services may be of two types: services of social assistance and services of medico-social care, which in turn may be residential or day services[149]. The services of medico-social care are defined as a system of activities which are provided within an integrated medical and social system, whose principal aim is "to maintain the autonomy of the person, as well as to prevent the aggravation of their situation of dependency"[150]. The services of medico-social care are provided to persons, including persons with handicap or with chronic diseases who necessitate a large range of social services, including services of care, support, treatment, functional recovery, rehabilitation and social insertion. Every placement in a medico-social establishment is done on the basis of a "table of medico-social evaluation" of the person concerned[151].

108. Cetate Hospital is a small sized centre for medico-social care, with a capacity of 20 beds at the beginning of 2004[152]. Before 1 January 2004 – the date when it was designated as a service of medico-social care – Cetate Hospital was a psychiatric hospital. According the accreditation certificate valid for the period 2006-2009, Cetate Hospital is authorised to provide services for adults experiencing situations of difficulty in their families, with an emphasis on the social component of medico-social care. An inspection which took place as recently as 2008 concluded that standards of care at Cetate are minimal and that it continued to be organised as a hospital, contrary to the stated aim of providing individualised care to its beneficiaries[153].

The Poiana Mare Psychiatric Hospital

109. The Poiana Mare Hospital is one of the eight psychiatric hospitals in Romania and functions under the authority of the Ministry of Health. It is situated in Dolj County, in the south-eastern region of Romania. The hospital occupies a former army base and is notorious for having been used as a place of detention for political prisoners during the Communist regime. The hospital occupies an area of 26 hectares.

[149] Art. 5 of Ordinance no. 68/2003 concerning Social Services and Art. 2 of the Norm of 2003 Concerning the Organisation, Functioning and Financing of Medico-Social Assistance Units, annex 86.
[150] Art. 9 of Ordinance no. 68/2003 concerning Social Services, annex 86.
[151] Art. 1§3 of the Norm of 2 April 2003 concerning the organisation, functioning and funding of the centers for medico-social assistance, annex 86.
[152] Letter of the Dolj County Public Health Department, 29 January 2004, Annex 10.
153 Rapport au Gouvernement de la Roumanie relatif à la visite effectuée par le Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT) en Roumanie du 24 septembre au 6 octobre 1995, available at http://www.cpt.coe.int/en/states/rom.htm .

110. The Poiana Mare Hospital became known after 1989 for numerous human rights abuses. The Committee for the Prevention of Torture ("CPT") documented the situation there during three visits: in 1995, 1999 and 2004.

111. In 1995 the living conditions at the Poiana Mare Hospital were so deplorable, that the CPT decided to make use of Article 8§5 of the Convention for the prevention of Torture which enables it, in exceptional circumstances, to make certain observations to the Government concerned during the visit itself. In particular the CPT noted that in a period of seven months in 1995 61 patients died, of whom 21 were "severely malnourished" (§177). The CPT decided to ask the Romanian Government to take urgent measures to ensure that "certain fundamental living conditions" exist at Poiana Mare. Other areas of concern identified by the CPT on this occasion were the practice of secluding patients in isolation rooms as a form of punishment, and the lack of safeguards in relation to involuntary commitment.

112. In 1999 the CPT returned to the Poiana Mare Hospital[154]. The most serious deficiencies found on this occasion referred to the fact that the number of staff – both specialised and auxiliary – was diminished compared to the 1995 levels, and to the lack of progress in relation to involuntary commitment.

113. In June 2004 the CPT visited the Poiana Mare Hospital for the third time, this time in response to reports concerning the increase in the number patients who died[155]. At the time of the visit, the hospital, with a capacity of 500 beds, accommodated 472 patients, of whom 246 were placed there on the basis of Article 114 of the Romanian Criminal Code (forced hospitalisation by a criminal court).

114. The CPT noted in its report that 81 patients died in 2003 and 28 died in the first five months of 2004. The increase in the number of deaths occurred despite the transfer from the Hospital in 2002 of patients suffering from active tuberculosis. The main causes of death were cardio-respiratory attacks, myocardial infarction, or bronchopneumonia. The average age of the dead patients was 56, with 16 being less than 40 years old. The CPT stated that "such premature deaths could not be explained exclusively on the basis of the pathology of the patients at the time of their hospitalisation" (§13). The CPT also noted that some of these patients "did not apparently benefit from sufficient care" (§14). The CPT noted with concern "the poverty of human and material means" available to the hospital (§16). It singled out the serious deficiencies in the nutrition of the patients and the lack of heating in the hospital.

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[154] Rapport au Gouvernement de la Roumanie relatif à la visite effectuée en Roumanie par le Comité européen pour la prevention de la torture et des peines ou traitements inhumains ou dégradants (CPT) du 24 janvier au 5 février 1999, available at http://www.cpt.coe.int/en/states/rom.htm .

[155] Rapport au Gouvernement de la Roumanie relatif à la visite effectuée en Roumanie par le Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT) du 15 au 21 juin 2004, available at http://www.cpt.coe.int/en/states/rom.htm .

115. In view of the deficiencies found at the Poiana Mare Hospital, the CPT made the following statement:

> *[…] we can not exclude the fact that the combined impact of difficult living conditions – in particular the shortages of food and heating – resulted in the progressive deterioration of the general state of health of some of the weakest patients, and that the poor state of medical supplies available could not prevent their death in most cases.*
>
> *In the opinion of the CPT, the situation found at the Poiana Mare Hospital is very preoccupying and justified the adoption of energetic measures aiming to ameliorate of living conditions and also the care provided to patients. Following the thri visit of the CPT at the Poiana Mare hospital in less than ten years, it is high time the authorities finally took the real measure of the situation prevailing in the establishment." (§20)*

116. Finally, in relation to involuntary civil commitment, the CPT noted that the recently adopted law on mental health and the protection of persons suffering from mental problems was not implemented comprehensively, having met involuntary patients who were hospitalised in breach of the safeguards included in the law.

The guardianship system in Romania

117. The system of guardianship (*"tutela"*) for persons with limited capacity or lacking capacity, (respectively, according to Romanian law, minors up to the age of 18 and persons with disabilities (both children and adults)), is regulated by the Family Code[156], as well as by Article 8§1 of the Emergency Ordinance no. 26/1997 regarding the protection of a child in difficulty[157]. Three types of guardianship exist in accordance with these provisions.

(i) Guardianship over minors

118. Articles 113 to 141 of the Family Code regulate guardianship over a minor whose parents are dead, unknown, deprived of their parental rights, incapacitated, disappeared or declared dead by a court. This section regulates the conditions making guardianship necessary, the appointment of a guardian (*"tutore"*), the responsibilities of the guardian, the dismissal of the guardian, and the end of guardianship. The institution with the widest range of responsibilities in this field is the guardianship authority (*"autoritatea tutelară"*), entrusted inter alia with supervising the activity of the guardian.

(ii) The incapacitation procedure and the guardianship over persons with disabilities

[156] Annex 86.
[157] Annex 86.

119. Articles 142 to 151 of the Family Code regulate the procedure of incapacitation (*"interdicție"*), instituting a 'one-size-fits-all' approach to guardianship, wherein a person is proved to be incapable, that person will lose their legal capacity. The measure of incapacitation is instituted and revoked by a court to "those lacking capacity to take care of their interests, because of mental alienation or mental debility", and may be initiated by a wide group of persons. Once a person is incapacitated, a guardian will be appointed to represent them, and his powers are similar to those of a guardian over a minor. Although the procedure of incapacitation may be equally applied to minors, it is geared especially towards disabled adults.

(iii) the special guardianship rights instituted by Article 8§1 of Ordinance no. 26/1997

120. Emergency Ordinance no. 26/1997 derogates from the provisions on guardianship in the Family Code. Article 8§1 of the Ordinance provides that "if the parents of the child are dead, unknown, incapacitated, declared dead by a court, disappeared, deprived of their parental rights, and if guardianship was not instituted, if the child was declared abandoned by a final court judgment, and if a court did not decide the placement of the child with a family or a person, according to the law, the parental rights will be exercised by the County Council, […] through the commission". This article therefore institutes an alternative system of guardianship over minors, which differs from the two aforementioned systems. The County Council exercises full 'parental rights' which appear to be equivalent to the powers attributed to parents over their natural children, regulated in Articles 97-112 of the Family Cody. It is not clear whether other notions included in that section are equally applicable under the procedure provided by Article 8§1, respectively the 'parental duties' correlative to 'parental rights', the limited capacity accrued at the age of 14 or the supervision exercised by the Guardianship Authority over the way in which those exercising 'parental rights' perform their functions.

III. RELEVANT DOMESTIC AND INTERNATIONAL LAW

A. Domestic law

121. A compilation of relevant legislation in the original language is attached to this application as exhibit 86.

B. International law

122. The United Nations Convention on the Rights of Persons with Disabilities ("CPRD") was adopted by the UN General Assembly on 13 December 2006, and, fittingly, was the first comprehensive human rights treaty of the 21st Century. The CRPD came into force on 3 May 2008. As of 23 April 2009, 139 States of the Council of signed the CRPD, including Romania on 26 September 2007 as well as the European Community, and 51 ratified it[158].

[158] A full list of signatories available at: http://www.un.org/disabilities/

123. The fundamental purpose of the CRPD is to:

> *promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. (Article 1)*

The guiding values or principles of the CRPD include respect for inherent dignity, autonomy, including the freedom to make one's own choices and independence, non-discrimination, full and effective participation in society, respect for difference, equality of opportunities, accessibility, respect for the evolving capacities of children (Article 3). The CRPD is underpinned by the "social model" or "human rights" model of disability which views persons with disabilities as subjects and not objects and places emphasis on respect for their equal human rights. The "social model" is placed in opposition to the "medical model" tends to view persons with disabilities as "objects" who are to be managed or cared for. The applicant urges that the Court takes into consideration the central values embedded in the CRPD when examining the issues raised by the case at hand.

IV. STATEMENT RELATIVE TO ARTICLE 34 OF THE CONVENTION

124. It is submitted that the CLR has standing to submit an application on behalf of the applicant, in conformity with Article 34 of the Convention.

125. The Court is urged to consider the arguments below in light of the special circumstances surrounding the death of the applicant, his extremely vulnerable situation and respectively the recent trend signalled by the U.N. Disability Convention which points to an end to the exceptional regime applied to persons with disabilities and an end to impunity for abuses against their human rights (see above §122-123).

General principles

126. The victim status requirement included in article 34 of the Convention implies that the applicant has been directly affected by the measure at issue (*Amuur v. France*, judgment of 25 June 1996, Reports of Judgments and Decisions 1996 III, § 36). In principle this means that any person claiming to be the direct victim of a violation of one of the rights included in the Convention may bring a complaint to the Court either in person or through a duly-appointed representative, with the exclusion of all other categories of individuals not complying with these conditions.

127. The Court has however allowed a number of exceptions to this general rule, in consideration of the particular circumstances of cases it was presented with. The Court justified these exceptions on the basis that the rules of admissibility must be applied with some degree of flexibility and without excessive formalism (*Cardot v. France* judgment of 19 March 1991, Series A no. 200, p. 18, § 34). Other relevant considerations include the object and purpose of the rules of admissibility (*Worm v. Austria* judgment of 29 August 1997, *Reports* 1997-V, § 33) and of the Convention in general, which, in so far as

it constitutes a treaty for the collective enforcement of human rights and fundamental freedoms, must be interpreted and applied so as to make its safeguards practical and effective (*Yaşa v. Turkey* judgment of 2 September 1998, *Reports* 1998-VI, § 64). The following is a general review of the exceptions to the 'direct victim' rule recognised by the Court, followed by an examination of the factors taken into account by the Court in discerning whether such exceptions exist.

Persons with standing to bring/continue proceedings before the Court

128. According to the case-law of the Court three categories of persons have standing to bring a complaint to the Court. A fourth situation may be discerned where the Court may decide to continue with the examination of a duly-introduced application ex officio, even in the absence of an applicant.

129. The first group is made up of direct victims of a violation of one of the rights included in the Convention filing applications in their personal capacity. The Court has widened the concept of direct victim to include for example individuals complaining about the existence of secret surveillance measures or of legislation permitting secret measures, without having to demonstrate that such measures were in fact applied to them (*Klass v. Germany*, judgment of 6 September 1978, Series A no. 28). This exception to evidentiary rules acknowledges the inherent difficulties faced by the victims if they had to prove that they had been the direct target of such measures.

130. Non-governmental organisations may be regarded as direct victims for the purposes of Article 34 in addition to natural persons if they show that they are affected in some way by the measure complained of. The Court has emphasized on numerous occasions the crucial role that non-governmental organisations play in ensuring respect for human rights. Thus, in *Gorraiz Lizarriga and Others v. Spain*, the Court noted that when citizens are confronted with particularly complex administrative decisions, recourse to collective bodies such as associations is sometimes the only means whereby they can defend their interests properly (*Gorraiz Lizarriga and Others v. Spain*, no. 62543/00, 27 April 2004). In a different case the Court has likened the role of non-governmental organisations to that of the press in a freedom of speech context, their participation in public affairs being essential for a democratic society (*Vides Aizsardzibas Klubs v. Latvia*, no. 57829/00 ,§ 42, 27 May 2004).

131. In principle, non-governmental organizations may not be able to claim to be a victim of measures which affect the rights of its members (*Norris v. Ireland*, no. 10581/83, 26 October *1988*). However, in *Gorraiz Lizarriga and Others v. Spain* the Court endorsed a less formal approach to the notion of victim, by recognizing that both the individual members and the association set up to defend the rights of a group of people in relation to the proposed construction of a dam were victims of any violations arising from domestic proceedings.

132. The Court does not accept applications in the form of *actio popularis*, where individuals complain *in abstracto* about a law applicable to all citizens of a country or

about a decision they were not parties to (*Ada Rossi v. Italy*, n°. 55185/08 16 December 2008). In this context, the Court stated that the victim status rule as well as the rule of exhaustion of domestic remedies are the consequence of the philosophical foundations of the Convention which provides a mechanism of a posteriori control of human rights violations (*Ada Rossi v. Italy*).

133. The second group is made up of the so-called indirect victims, who can bring claims on behalf of a person who died or disappeared, without a specific authorization to do so. So far only the victims' next of kin have been able to claim 'indirect victim' status and could consequently file complaints with the Court. This hypothesis has generally arisen where the primary victim has died or disappeared in circumstances raising issues under Article 2 of the Convention. This exception is justified by "the nature of the violation alleged and considerations of the effective implementation of one of the most fundamental provisions of the Convention system" (*Farfield and Others v. UK (2005)*). Thus, the Court recognized that unless it widened the group of individuals with standing to bring complaints concerning deaths or disappearances, Article 2 of the Convention would become effectively inapplicable. Also considering the importance of the right to life, this would have compromised the "object and spirit" of the Convention:

> *It must also be borne in mind that, as a provision (art. 2) which not only safeguards the right to life but sets out the circumstances when the deprivation of life may be justified, Article 2 ranks as one of the most fundamental provisions in the Convention - indeed one which, in peacetime, admits of no derogation under Article 15 (art. 15). Together with Article 3 (art. 15+3) of the Convention, it also enshrines one of the basic values of the democratic societies making up the Council of Europe.*

134. The third group is made up of third parties, persons who have not suffered a violation of a right included in the Convention either as direct or indirect victims. The aforementioned general rule on 'victim status' manifests itself in two obvious ways. The first hypothesis is when the victim appoints a third party, usually a lawyer, to represent them before the Court on the basis of a signed letter of authority. The second hypothesis is when the victim is a person with limited or no capacity such as a minor or a person with intellectual disabilities. In this situation, the victim will be represented by their legal representative, who may be either their custodial parents or their legal guardians.

135. However, the Court (or the former Commission) also identified a number of exceptions to this rule. Thus, it recognized standing to a solicitor appointed to represent the applicants, three children, in domestic care proceedings (*S.P., D.P., and A.T. v. United Kingdom* no. 23715/94, 20 May 1996); the Official Solicitor, acting on behalf of children abused by their parents (*Z. v. United Kingdom*, no. 29392/95, 10 May 2001); the de facto carer of about 200 Vietnamese children threatened with expulsion (*Becker v. Denmark*, no 7011/75, 3 October 1975); the natural parent of a child born out of wedlock and lacking custody over her (*Siebert v. Germany* no. 59008/00, 23 March 2006)); the husband of a woman subjected to a forced medical examination (*Y.F. v. Turkey*, no. 24209/94, 22 July 2003*)*, etc.

136. Third parties may also play a role in the proceedings before the Court if the applicant dies after having filed an application. In principle the application may be continued by a spouse or a close relative with a legitimate interest who adopts it. In *Malhous v. Czech Republic* the Court has allowed the nephew of the deceased applicant to continue the application, even though at the time he was locked in an inheritance dispute with the deceased applicant's children (*Malhous v. Czech Republic* no. 33071/96, 13 December 2000). The proceedings before the Court concerned the attempts to recover nationalized property from the State. The Court did not attach decisive importance to the fact that the nephew was not the applicant's next of kin and that his heir status was not confirmed domestically. Instead, the Court recognized that he had a legitimate interest in pursuing the case and stated that generally human rights cases also have a moral dimension and persons near to an applicant may thus have a legitimate interest in seeing to it that justice is done even after the applicant's death. This was all the more true if the leading issue raised by the case transcended the person and the interests of the applicant and his heirs and could affect other persons.

137. The fourth situation is when the applicant dies and there is no next of kin to continue the application. The Court may choose to continue examining the application of its own motion, 'in the interest of human rights', even where no heir can be found to continue the application (*Karner v. Austria*, no. 40016/98, § 28, 24 July 2003; *Gagiu v. Romania*, no 63258/00, 24 February 2009).

Relevant factors in examining compliance with the requirements of standing and victims status

138. In shaping the contents of the requirements of standing and victim status, the Court has taken into consideration a number of factors such as the vulnerability of the victim, the link between the representative and the victim or the existence of alternative representation.

139. The vulnerability of the victim, due for example to their age, sex or disability is a relevant consideration in this context. The case *S.P., D.P., and A.T. v. UK* concerned three children who were aged between 6 and 11 at the time when the application had been filed with the Court. The children had been subjected to abuse and neglect and placed with temporary foster parents. Luke Clements, a solicitor, was appointed by the court to represent the children in the care proceedings concerning their placement with long-term foster children. Mr. Clements complained to the Commission on behalf of the children in relation to the length of those proceedings. The government contested that Mr. Clements had any valid authority to file a complaint with the Commission. The Commission however rejected that objection, in consideration of a number of factors, which included the vulnerability of children which required a less "restrictive or technical approach" in the area of standing/victim status:

> *The Commission would emphasise first of all that the involvement of children is a special feature which attracts considerations not necessarily applicable where*

adult applicants are concerned. It observes that there has been a growing recognition of the vulnerability of children and the need to provide them with specific protection of their interests eg. the UN Convention on the Rights of the Child and the European Convention on the Exercise of Children's Rights recently opened for signature. The Commission and Court have consistently underlined that the object and purpose of the Convention as an instrument for the protection of individual human beings requires that its provisions, both procedural and substantive, be interpreted and applied so as to make its safeguards practical and effective. In the context of Article 25, the position of children qualifies for careful consideration: children must generally rely on other persons to present their claims and represent their interests and may not be of an age or capacity to authorise steps to be taken on their behalf in any real sense. The Commission considers that a restrictive or technical approach in this area is to be avoided.

140. In a different case concerning the failure to provide adequate protection to abused children, the Court declared admissible a complaint filed by the Official Solicitor on behalf of four children who had been subjected to abuse (*Z. v. United Kingdom*). The Official Solicitor intervened in domestic proceedings against the local authority acting as the applicant's Best Friend.

141. In *Y.F. v. Turkey* the applicant complained under Article 8 on his wife's behalf, claiming that she had been subjected to a gynaecological examination without her consent. Although the Turkish Government did not raise the issue of standing, the Court specifically mentioned that the applicant had standing to make this complaint, "in particular having regard to [his wife's] vulnerable position in the special circumstances of this case" (§29).

142. In cases where no formal links in the form of specific authority to act or formal standing to act as legal representative exist, the Court will examine the nature of the links between the victim and the person filing the complaint. In *Becker v. Denmark*, a case concerning the threatened expulsion from Denmark of approximately 200 Vietnamese orphans, placed in the applicant's de facto care, the Government contested the applicant's standing to bring this claim on the basis that he neither had the custody nor guardianship of the children. He merely had an authorisation from the Vietnamese Government to leave Vietnam with the children with the consequential right and obligation to care for them. The Court recognised the validity of the application in view of the 'vulnerability of the children, who were "orphan or depended on the applicant". In addition, the applicant had been entrusted with at least the care of the children, and therefore he "had a valid personal interest in the welfare of the children".

143. In the aforementioned case *S.P., D.P., and A.T. v. UK*, the Court also examined the relationship between the children and the solicitor acting on their behalf. The Commission stated that the letters of support for Mr. Clements filed by the applicants' temporary foster parents "did not constitute authority to act in any formal sense". At the same time, whereas one of the applicants was old enough for his views on the matter to be taken into consideration, the Commission did not deem it "necessary or desirable to

require or expect more than an informal indication of this kind". At the same time, the Commission noted that Mr. Clements was appointed by an independent guardian ad litem, that no conflict of interests between him and the applicants was identified, that he had the requisite competence to pursue these matters before it, and finally that the object of the proceedings before it was limited to procedural questions.

144. The Commission has however rejected an application filed by a psychologist who complained on behalf of patients locked up in a nursing home, without being duly authorised by them (*Skjoldager v. Sweden*, no. 22504/93, 17 May 1995). The Commission noted that the applicant's sole contact with the victims was on the occasion of an inspection carried out at the home and therefore that his connection to them was not sufficiently close. In addition, and crucially, the applicant has not shown that the applicants could not lodge an application in their own names, or with their guardians' support.

145. The Court also takes into account whether more appropriate representation exists or is available for the victims than the one provided by the person introducing the complaint.

146. In *S.P., D.P., and A.T. v. UK*, the Court noted that the only two sources of representation, besides Mr. Clements, available to the children would have been their mother or the local authority. However, the Court noted, since "the mother is apparently disinterested and the local authority is the subject of criticism in the application", Mr. Clements's actions were nether "inappropriate not unnecessary".

147. The problem of identifying the person who is most suitable to represent a victim was raised in cases concerning conflicts between a natural parent and the person appointed by the authorities to act as a child's guardian. What matters in this field is that the child's rights enjoy effective protection under the Convention, and that their interests may be brought to the Court's attention. To the extent in which the state appointed representative does not provide the requisite protection to the child and the state fails to appoint another guardian in litem to represent the child during domestic proceedings, the natural parent will have the requisite standing to bring the case to the Court (Siebert v. Germany).

148. Another significant factor taken into consideration by the Court is whether the leading issue(s) raised by the case transcend the interests of the applicant and could affect other persons to the extent that it is in the interests of respect for human rights to continue examination of the case.[159] This has been accepted by the Court even after the applicant died where the moral dimensions of the case and public policy so require (*Karner v. Austria* §§ 25-26; *Malhous v. Czech Republic).* In *Karner v. Austria*, the original

[159] This is also reflected in Article 37(1) of the Convention which provides inter alia: "The Court may at any stage of the proceedings decide to strike an application out of its list of cases …..**However, the Court shall continue the examination of the application if respect for human rights as defined in the Convention and the Protocols thereto so requires." [emphasis added]**

applicant had complained of his inability to succeed to the tenancy of his homosexual partner when a heterosexual partner would be able to. The original applicant died, his heir waived the right to succeed to her estate. The Court chose not to strike the application out of its list. It noted that its judgments serve not only to decide those cases brought before the Court but, more generally, to elucidate, safeguard and develop the rules instituted by the Convention, thereby contributing to the observance by the States of the engagements undertaken by them as Contracting Parties. In addition, although the primary purpose of the Convention system is to provide individual relief, its mission is also to determine issues on public-policy grounds in the common interest, thereby raising the general standards of protection of human rights and extending human rights jurisprudence throughout the community of Convention States. Finally, the Court noted the subject matter of the application involved an important question of general interest not only for Austria but also for other States Parties to the Convention.

149. The position of principle adopted by the Court is that the concepts of 'victim' and 'standing' are autonomous notions, which do not depend on domestic rules on standing (see *Gorraiz Lizarraga and others v. Spain*, no. 62543/00, § 35, ECHR 2004 III). However, the Court has occasionally taken into account the position of the domestic courts on this matter (*Collectif national d'information et d'opposition à l'usine Melox – Collectif stop Melox et Mox v. France*, §4)

150. The Court has recently clarified that the applicant's particular circumstances may justify the decision to continue the examination of an application after the applicant died. In *Gagiu v. Romania*, the applicant, a shepherd, without any family and lacking representation before the Court, complained under Articles 2 and 3 about prison conditions, including lack of medical care, and under Article 34 about the hindrance of his right to petition. After he died, the court decided to continue the examination of his application on the basis of the applicant's family situation (§5).

Application of the principles to the case at hand

151. The applicant submits to the attention of the Court the following arguments in support of their position on the admissibility of the application at hand.

(a) Considerations related to the applicant

152. The applicant belongs to an extremely vulnerable group of population, suffering from multiple afflictions. He had a severe intellectual disability, with an IQ of 30. According to a test undertaken a few months before died, he had very limited autonomy and needed assistance for basic daily activities such as personal care or eating. He needed considerable support to take decisions related to his place of abode, hospitalization, medication, legal regime. His capacity, limited as it was, deteriorated severely after he was transferred to the Cetate Hospital.

153. The applicant was HIV-positive, a condition that attracted considerable stigma and marginalization from medical personnel and his peers alike (see below §395-397). In

addition the applicant had a history of considerable health problems, having suffered from pulmonary tuberculosis and chronic hepatitis.

154. The applicant was abandoned by his mother immediately after his birth. He has never met his parents. His father is unknown and his mother, who died in 2000, ceased all contact with him after birth. The applicant has lived all his life isolated in a social home for children and had no experience of living in the community.

155. No alternative source of representation for the applicant other than the CLR exists. The applicant's mother is dead, his father is unknown and he has no other known relatives. As shown below, the authorities failed to appoint a guardian to the applicant when he turned 18 (see below 341-343). As such no representative who could potentially act on his behalf exists. There is no other administrative body at the domestic level entitled to represent the applicant.

(b) Considerations related to the standing and expertise of the CLR to represent the applicant

156. The CLR has extensive expertise in relation to the rights of people with mental disabilities placed institutions and has represented the applicant throughout the duration of the domestic proceedings. Furthermore, its standing to act in cases akin to the one at hand has been recognised by the highest court in Romania.

157. The CLR is a non-governmental, non-profit organization which was founded in 2002 and which actively advocates for the establishment and operation of a legal and institutional framework that safeguards the observance of human rights and equal opportunities, free access to fair justice, and which contributes to the capitalization of its legal expertise for the general public interest[160]. The CLR has received 'public utility' status in 2004.

158. One of the programs run by the CLR is "Advocate for dignity" (*"Pledoarie pentru demnitate"*) which aims to contribute to the improvement of the legal and institutional framework in the field of protection of persons with mental disabilities and increase their capacity of integration and acceptance in the community. Within the program, the CLR has carried out since 2003 over 200 monitoring visits to psychiatric hospitals and public are homes through its network of monitors which covers the whole country. The CLR produced a number of reports which were distributed to domestic and international bodies with attributions in the field of protection of persons with disabilities. It has also provided legal representation and advice in relation to abuses of human rights of people with disabilities. The CLR has been instrumental in the decision by Romania to adopt the OPCAT in March 2009. Most notably, in 2009 the manager of the program has been invited to a hearing of the Romanian Senate concerning the adoption of OPCAT. The CLR has provided information concerning the situation of people with mental disabilities in Romania to numerous internationals organisms such as the former

[160] The CLR Statute, exhibit 84; more information about the CLR is available on their website, www.crj.ro .

European Delegation in Bucharest, the European Commission, the European Parliament, the CPT, the Association for the Prevention of Torture or Amnesty International.

159. The CLR saw the applicant on the last day of his life during a monitoring visit at the Poiana Mare Hospital on 20 February 2004. They noticed immediately the desperate situation he was in and promptly requested medical staff to take urgent action aiming at ameliorating his medical condition (see above §59). The very next day, on the 21 February, the CLR sent a series of urgent appeal letters to local and central agencies informing them about the applicant's situation and asking that urgent actions be taken. On 22 February the CLR issued a press release informing the public about the applicant's plight. On 23 September a criminal complaint was filed with the Head Prosecutor of the Prosecution Service of the High Court of Cassation and Justice in relation to the circumstances surrounding the applicant's death. In the intervening years, and until now, the CLR conducted litigation on the applicant's behalf as well as vast correspondence with various state agencies trying to secure a full investigation into the applicant's death.

160. The CLR has acted as a party in the domestic criminal proceedings. Its standing to do so has not been challenged at any stage of this case. However, this has been the object of extensive litigation in a similar case. In 2003, the CLR initiated criminal proceedings in relation to the suspicious deaths of 17 patients hospitalized at the Poiana Mare Hospital. On 1 February 2005 the Prosecution Service of the High Court of Cassation and Justice issued a decision of non-indictment in relation to the complaint. This decision was subsequently cancelled by the Deputy Prosecutor of the Prosecution Service of the High Court of Cassation and Justice on the grounds that the CLR lacked standing to file a complaint against the decision of non-indictment. The Craiova Court of Appeal confirmed this decision on appeal. The CLR filed a final appeal with the High Court of Cassation and Justice which on 15 June 2006 accepted the appeal and recognized the CLR standing to pursue criminal proceedings on behalf of the applicant[161].

161. The High Court stated that the lower court and the Prosecution Office interpreted the expression "any other person" from Article 278[1] of the Criminal Procedure Code too narrowly. Furthermore, the High Court noted that Article 13 of the Convention afforded victims the rights to an effective remedy, meaning that domestic courts were the primary judicial control bodies whereas the Court had a subsidiary role. Therefore, domestic courts had to be the primary adjudicators in relation to the allegations concerning the applicant's death. The High Court noted that the CLR initiated the criminal proceedings on the applicant's behalf and participated in all stages thereof. Furthermore, the CLR was a non-profit organization with public utility status and their object of activity included activities aiming at the protection of human rights and free access to justice as well as "the promotion and strengthening of justice". By filing a complaint on behalf of individuals who died at the Poiana Mare Hospital, the CLR acted within their statutory limits, aiming to safeguard the rights of those individuals, and in particular their right to life and not to be subjected to inhuman and degrading treatment in line with Articles 2 and 3 of the Convention.

[161] Decision no. 3838/15 June 2006, The High Court of Cassation and Justice, annex 85.

162. Finally, it is noted that the application at hand does not represent an *actio popularis*, given that it seeks to obtain remedies for specific injuries, suffered by a specific individual.

(c) Public policy dimension of this case and respect for human rights

163. It is submitted that the public policy and human rights interests of the case, and its very particular circumstances, are such that it should be declared admissible and examined by the Court. Beyond providing justice to the applicant which he would otherwise be denied, the case raises important public policy issues which could contribute to improved standards of protection for extremely vulnerable individuals in a similar position to the applicant.

164. The U. N. Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment has recently released a report concerning the forms of violence and abuse inflicted against persons with disabilities[162]. In the report he noted that people with disabilities are often segregated from society for a long period of time in institutions, including prisons, social care centres, orphanages and mental health institutions. Furthermore, inside the institutions "persons with disabilities are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence". The Special Rapporteur also expressed his concern that such practices "remain invisible and are not recognized as torture or other cruel, inhuman or degrading treatment or punishment".

165. According to a comprehensive report published recently, 1.2 million persons with disabilities live in long-stay residential institutions[163]. The CPT identified numerous problems during the monitoring visits it carried out in such institutions: poor conditions and low quality care, which at times amounted to inhuman and degrading treatment, flawed admission procedures, lack of legal assistance etc. Particularly striking abuses have been documented in countries of Central and Eastern Europe which have inherited from the Communist era social assistance systems relying heavily on large scale institutionalisation.

166. Romania in particular has a very large population of children in institutions. According to an official report 32,821 children lived in placement centres at the beginning of 2005[164]. This problem is compounded by the relatively large number of HIV

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[162] *Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, submitted in accordance with Assembly resolution 62/148*, A/63/17, 28 July 2008, accessible at http://daccessdds.un.org/doc/UNDOC/GEN/N08/440/75/PDF/N0844075.pdf?OpenElement .

[163] Mansell J., Knapp M., Beadle-Brown J., Beecham J., (2007) Deinstitutionalization and community living: outcomes and costs - report of a European Study. Volume 1: Executive Summary. Canterbury: Tizard Center, University of Kent, accessible at http://ec.europa.eu/employment_social/index/vol1_summary_final_en.pdf .

[164] Institutul national de cercetare stiintifica in domeniul muncii si protectiei sociale, Studiu privind situatia tinerilor care parasesc sistemul de protectie a copilului, p. 1-2.

infections in infant population which occurred in the 1980s, and which the Government had to cope with after 1989 (see below §192). Furthermore, the case at hand is an illustration of the difficulties encountered by abandoned children when transitioning from the institutional setting to living in the community[165].

167. The CLR therefore submits that this case would assist in clarifying standards in an important area of human rights law which has not been given much attention so far. The case-law of the Court concerning abuses of human rights in institutional settings is very limited. One of the causes for this is, as emphasized by the UN Special Rapporteur, the invisibility of abuses occurring in institutional settings. More specifically, the vulnerability and powerlessness of persons with disabilities mean that their ability to access judicial remedies is severely restricted.

168. In light of its own principles as well as the new era heralded by the recent adoption of the UN Disability Convention, it is submitted that the admissibility criteria should be construed in such a way as to permit effective access of persons with disabilities to the Court. In the Article 2 context, this means acknowledging the special situation of persons with disabilities and allowing a larger sphere of persons to bring claims on their behalf. Otherwise a very vulnerable group, people with disabilities, would effectively be deprived of the protection afforded under the Convention, especially in relation to breaches of one of their most fundamental rights – the right to life.

V. STATEMENT OF ALLEGED VIOLATIONS OF THE CONVENTION AND/OR PROTOCOLS AND OF RELEVANT ARGUMENTS

VIOLATION OF ARTICLE 2

169. The applicant submits that the inappropriate care and treatment he received during the last months of his life as well as the inappropriate living conditions at the Poiana Mare Hospital directly contributed to his untimely death on 20 February 2004, thus amounting to a breach of his right to life in contradiction with Article 2 of the Convention. The State further failed in its obligations under Article 2 to carry out an effective investigation into the applicant's death.

170. In particular, the medical authorities responsible for the applicant's care and treatment repeatedly failed to take into account his extreme vulnerability as a person who suffered from significant physical and mental afflictions. The applicant was both intellectually disabled and HIV-positive (with associated symptoms such as pulmonary tuberculosis, pneumonia and chronic hepatitis) who had spent his whole life in various state institutions.

A. With respect to the substantive failures to safeguard the applicant's life

[165] UNICEF, Centre for Legal Resources, Monitoring the rights of mentally disabled children and young people in public institutions: Report of Monitoring Project 2005-2006, accessible at http://www.crj.ro/Uploads/CRJAdmin/ReportCRJUNICEFengl.pdf .

As to the law

171. The Court has repeatedly emphasized in its jurisprudence that the State must not only to refrain from the "intentional" taking of life, but must also take appropriate steps to safeguard the lives of those within its jurisdiction (*Calvelli and Ciglio v. Italy* [GC], no. 32967/96, § 48, ECHR 2002-I; *L.C.B. v. the United Kingdom*, judgment of 9 June 1998, Reports of Judgments and Decisions 1998-III, p. 1403, § 36).

172. In particular, the Court has recognized that detained persons are in a vulnerable position and the authorities are under a duty to protect them (*Aktaş v Turkey*, no. 24351/94 § 290, 24 April 2003). Detention in this context can include both those detained under the criminal law and those on medical grounds where medical professionals have complete and effective control over care and movements (*H.L. v United Kingdom* no. 45508/99 § 91, 5 October 2004). This vulnerability can be enhanced by conditions such as mental illness (*Renolde v France* (2008) no. 5608/05 § 84, 16 October 2008; *Aerts v. Belgium*, 30 July 1998, § 66, Reports 1998-V; *Keenan v. the United Kingdom*, no. 27229/95, ECHR 2001-III § 111; and *Rivière v. France*, no. 33834/03 § 63, 11 July 2006) or life threatening diseases such as HIV (*Kats & Ors v Ukraine*, no. 29971/04 § 107, 18 December 2008).

173. In this respect, the Convention imposes an obligation on the State to protect the physical well-being of persons deprived of their liberty, for example by providing them with the requisite medical assistance (*Hurtado v. Switzerland*, 28 January 1994, § 79, Series A no. 280-A; *Dzieciak v Poland*, no. 77766/01 § 91, 9 December 2008). Indeed, the Court has held that Article 2 may be engaged where it is shown that State authorities put an individual's life at risk through the denial of health care which they have undertaken to make available to the population generally (*Cyprus v Turkey* [GC], no. 25781/94 § 219, ECHR 2001-IV and *Nitecki v Poland* (dec.), no. 65653/01 § 1, 21 March 2002; *Pentiacova & Ors v Moldova* no. 14462/03, 4 January 2005).

174. The Court has found a violation of Article 2 where a detainee has not received medical care appropriate to his state of health due to a prison hospital not being sufficiently equipped for dispensing adequate medical care. The Court went on to find that there was a causal link between these deficiencies and the detainee's death (*Tarariyeva v Russia*, no. 4353/03 § 80 and 87-89, 14 December 2006).

175. In relation to detainees who are suffering from HIV, the Court, noting the vulnerability of such persons to other serious diseases, has condemned the lack of medical attention and very basic treatment offered by a non specialist hospital, concluding that the victim's death was indirectly caused by the inadequate medical assistance provided to her while she was in detention (*Kats & Ors v Ukraine*, no. 29971/04 § 107, 18 December 2008).

176. Where a detained individual's medical condition includes a HIV infection and the prison hospital does not have a department specialized in the treatment of HIV/AIDS,

Article 3 requires that the individual be transferred to a specialized hospital (see mutatis mutandis *Aleksanyan v. Russia*, no. 46468/06, §§151-156).

177. In the public health sphere these positive obligations require the State to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives (see *Vo v. France*, [GC], no. 53924/00, § 89, ECHR 2004-VIII; *Calvelli and Ciglio v. Italy*; and *Powell v. the United Kingdom* (dec.), no. 45305/99, ECHR 2000-V). Furthermore, where a hospital is a public institution, the acts and omissions of its medical staff are capable of engaging the responsibility of the respondent State under the Convention (see *Glass v. the United Kingdom*, no. 61827/00, § 71, ECHR 2004-II; *Tarariyeva v Russia*).

178. In the light of the importance of the protection afforded by Article 2, the Court has repeatedly stated that it will subject complaints concerning the deprivation of life to the most careful scrutiny.

179. In particular, recognizing that persons in custody are in a vulnerable position, the authorities are under an obligation to account for their treatment (*Anguelova v Bulgaria*, no. 38361/97 § 110, 13 June 2002). This obligation is particularly stringent where that individual dies (*Keenan v. the United Kingdom*, no. 27229/95, § 91, ECHR 2001-III; *Salman v. Turkey* [GC], no. 21986/93, § 99, ECHR 2000-VII; *Tarariyeva v Russia*; *Dzieciak v Poland*). Where a detainee dies as a result of a health problem, the State is required to offer an explanation as to the cause of death and the treatment administered to the person concerned prior to his or her death (*Kats & Ors v Ukraine*, § 104).

180. This reflects the principle that where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons under their control in detention, strong presumptions of fact will arise in respect of the State's responsibility for the cause of those injuries and death occurring during that detention. Indeed, the burden of proof may lie with the authorities to provide a satisfactory and convincing explanation as to why they failed and/or neglected to provide appropriate medical care (*Salman v Turkey* [GC], no. 21986/93, § 100, ECHR 2000-VII; *Çakıcı v Turkey* [GC], no. 23657/94, § 85, ECHR 1999□IV; Ertak v Turkey, no. 20764/92, § 32, ECHR 2000-V; *Anguelova v Bulgaria*, §111; *Slimani v France*, no. 57671/00 § 27, 27 July 2004).

As to the facts

181. It is submitted that by failing to provide the applicant with appropriate medical care and treatment, combined with the conditions under which he was detained, resulting in his untimely death, the Respondent State violated his right to life as guaranteed by Article 2 of the Convention. In particular these failures contributed significantly to the rapid weakening of the applicant's immunity system, and eventually his demise.

182. The applicant suffered from serious health problems: he was HIV positive, and had suffered from a number of additional ailments such as tuberculosis, pneumonia and

hepatitis. In addition, the applicant had a very severe intellectual disability and was very frail – at the time of his admission to the Cetate Hospital he weighed 45 kilos. However, prior to his transfer from the Placement Centre, his state of health was generally stable (see above §19-28). At the time of his admission to the Cetate Hospital, Elena Onel recorded that the applicant was in a "generally good state" and had a "good appetite". Yet within two weeks the applicant was dead.

(i) Failure to identify a suitable institution after the applicant's discharge from the Placement Centre

183. It is submitted that the applicant's untimely death was significantly due to the authorities' failure to identify and secure adequate and appropriate care arrangements after his discharge from the Placement Centre. In particular, the authorities did not consider the particular needs of the applicant in their efforts to identify an institution willing to admit him. The authorities' primary consideration seemed to be administrative expediency rather than the well-being of the applicant. By acting in this manner the authorities failed to take the necessary preventative measures to safeguard the applicant's welfare and ultimately life.

184. At no stage prior to his discharge from the Placement Centre was the applicant subjected to a comprehensive medical examination in order to devise an individualized treatment and care plan to meet his particular needs. The investigations, which were carried out in October and November 2003 by the Commission for the Medical Examination of Adults with Handicap and the Commission for the Protection of the Child, were superficial at best. The Commission did not undertake the complex and thorough evaluation necessary to ensure the applicant's needs were met.

185. The decision, of 14 October 2003, by the Commission for the Medical Examination of Adults with Handicap, to downgrade the applicant's diagnosis was a serious example of medical malpractice (see above §23). It is not apparent from the certificate issued on that occasion that the Commission actually examined the applicant in person given there is no available documented evidence of his actual condition at the time of the supposed examination. In failing to do so and in arriving at a radically changed diagnosis the Commission failed to comply with existing legislation regulating its activity. There is no conceivable explanation that the applicant's IQ could have suddenly and radically increased from 30 to normal levels. This is reinforced by the fact that the Commission failed to provide any evidence regarding the nature and content of tests carried out in order to substantiate such a finding. In light of all circumstances of the case, the applicant submits that the most plausible explanation for such behaviour was to persuade the relevant medical care institutions into accepting the applicant regardless of the consequences for his safety and welfare.

186. The decision of the Commission to terminate the applicant's assignment at the Placement Centre in September 2003 and hospitalize him at the Poiana Mare Hospital was a blatant abuse of its authority, recognized but not sanctioned by the National Authority for the Protection of the Child and Adoption (see above §98). The Mental Health Law, which sets out the rules for the involuntary commitment to a psychiatric

hospital, does not allocate any role to the Commission in this process. This is also a symptom of a more widespread confusion in the medical profession in Romania concerning the difference between intellectual disabilities and mental health problems. This is reflected in the fact that there is clear documented evidence of how in Romania upon turning 18 intellectually disabled children are transferred from placement centres directly to psychiatric hospitals as a matter of practice[166].

187. Faced with the refusal of the Poiana Mare Hospital to admit the applicant, the Department looked for another institution willing to accept him. The Department contacted a number of institutions and authorities asking whether they would be willing to accept the applicant, only to be turned down repeatedly (see above §29-37).

188. It was only after the Department had intentionally provided the Cetate Hospital with an incorrect diagnosis of the applicant's condition that the the latter mistakenly accepted the applicant. Even after admission the Cetate Hospital had strong misgivings about accepting the applicant with repeated attempts by Director Maria Onel to try and have him transferred. Firstly, Onel called the Department asking them to take the applicant back, only to be told that the applicant was "out of [the Department's] jurisdiction". Secondly, in a conversation with a representative of the Public Health Department, Onel insisted that the applicant be transferred urgently to a different institution.

189. Ultimately, the Cetate Hospital, a small-sized rural establishment, could not provide adequate long term care and treatment to the applicant, given the complexity of his needs. The staff at the hospital did not have the requisite expertise to deal with either HIV-positive patients or patients with mental disabilities (see below §191 et seq.).

190. Ironically after its initial refusal, the applicant was subsequently transferred to the Poiana Mare Hospital where he died, similar to hundreds of other people with disabilities who have also died here (as a result of neglect and lack of appropriate medical care and treatment). This is despite the fact that the Poiana Mare Hospital made it clear as early as October 2003 that it was not prepared to provide treatment for the applicant's HIV infection. This also became apparent during the applicant's brief hospitalization, when staff declared they were not familiar with the procedures involved in the administration of ARV treatment. Ultimately, neither of the two main ailments suffered by the applicant – HIV infection or intellectual disability – could justify his placement in a psychiatric hospital.

(ii) Inadequate HIV treatment

191. ARV treatment has been proved and is universally accepted to be effective in slowing the negative impact of HIV on a person's health by keeping the amount in the body at a low level. This prevents any weakening of the immune system and allows it to recover from any damage that HIV might have caused already. It is vital that ARV

treatment is administered at least daily or twice daily (depending upon the particular drugs) in order to maintain high levels of immunity.167 Consequently, it is vital to ensure adequate stocks and storage of ARVs.[168]

192. In addition to HIV treatment people living with HIV need other elements of care. According to UN AIDS guidelines, good nutrition, safe water, basic hygiene and other important elements of care can help maintain life and prevent deterioration in a patient's health. People with HIV may also need psychosocial support and counselling. None of this was available to an adequate or appropriate standard in Poiana Mare Hospital contrary to both internationally accepted best practice and Romania's own legislation.

193. In the period 1986-1991 10,000 children were infected with the HIV virus in Romanian hospitals. As a result, at the beginning of the 1990s, Romania had the largest group of HIV-positive children in Europe[169]. The Romanian government sought to deal with this situation by adopting legislation which provided wide-ranging rights to HIV-positive individuals. In 2002 the government adopted Law no. 584 concerning the measures of prevention of the spread of AIDS in Romania and the protection of persons infected with HIV or suffering from AIDS170. According to Article 10 of that law the Government undertook to provide ARV medication to all free of charge for as long as was necessary. The law also provided a number of benefits to persons infected with HIV, including special food allocations to those placed in institutional care (Art. 7). According to Article 12 of the law, a central element of the government strategy in the field was ensuring that those providing medical care to HIV/AIDS patients had high professional standards.

194. It is established that prior to his transfer from the Placement Centre the applicant had attended regularly the Clinic in Craiova, which supervised the state of his HIV infection. This practice had generally yielded positive results in that it kept the HIV virus in check. The Department failed however to ensure that the Clinic was aware of the applicant's transfer from the Placement Centre. This was necessary in view of the risks to the applicant's fragile health associated with the transfer to a new environment. The Clinic would have been able to monitor the transfer and provide the necessary instructions to medical staff at the Cetate Hospital or Poiana Mare Hospital.

195. There is clear evidence of a failure by the authorities to administer regular daily doses of ARV treatment to the applicant during his stay at the Cetate Hospital and Poiana Mare Hospital. There is also clear evidence that the applicant did not receive any ARV treatment between 5 and 9 February 2004 after he was transferred to the Cetate Hospital. This critical omission was justified by the person responsible for his transfer to Cetate,

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[167] See *Antiretroviral therapy for hiv infection in adults and adolescents: Recommendations for a public health approach* (WHO HIV/AIDS Programme 2006 revision pp7, 17, 70 and Table of Dosages of ARV Drugs for Adults and Adolescents in Annex 3).
[168] Ibid. p 71
[169] UNICEF, *Copii la limita sperantei: O analiza focalizata asupra situatiei copiilor vulnerabili, exclusi si discriminate in Romania*, Ed. Vanemonde, 2006, p. 90.
[170] Annex xxx.

Maria Vieru, on the basis that "she did not know whether depending on the results of the most recent investigation, it would be necessary to modify his treatment". The applicant submits that there was no sound medical basis for Ms. Vieru arriving at such a conclusion given that it was clear that, as a person suffering from HIV, the applicant should continue to receive ARV treatment without interruption.

196. Instead, there was a critical four day interruption in the ARV treatment while supplies were obtained from Craiova (see above §39-44). The resulting delay in the resumption of the applicant's treatment had, the applicant submits, a serious impact on his health which directly led to his untimely death.

197. In addition, there is a strong likelihood that the applicant was not receiving sufficient or even any doses of ARV during his brief stay at the Poiana Mare Hospital between 13 and 20 February 2004 since there are no relevant entries in the hospital log as to if and when these were administered (see above §55-56).

198. Although staff at the Cetate Hospital and the Poiana Mare Hospital did not have expertise in HIV diagnostics, the possibility of transferring the applicant to a specialized clinic, even when it was evident his medical condition was deteriorating rapidly, was not even considered.

(iii) Inadequate care and treatment and poor living conditions

199. The applicant submits that the shortcomings in the treatment and care he received at the Cetate Hospital and the Poiana Mare Hospital as well as the horrendous living conditions he experienced at the Poiana Mare Hospital contributed to his death.

200. Article 4 of Law no. 270/2003 ("on hospitals"), provides that hospitals have an obligation to "ensure conditions of accommodation, alimentation, prevention of infections"[171]. Article 3 of Law 46/2003 concerning patients' rights, provides that "the patient has benefit from respect as a human being, without discrimination". Article 35 provides that the patient has "the right to continuous medical care until the amelioration of his health state or until they are cured". Furthermore, "the patient has the right to terminal care in order to be able to die in dignity".

201. Beyond the failure to administer ARV, the Poiana Mare Hospital failed to provide adequate care and treatment for the applicant, including appropriate nutrition or accommodation. Lidia Ghitulescu confirmed that the applicant could not receive adequate treatment at the Poiana Mare Hospital, given the lack of adequate facilities and overcrowding prevalent there (see above §84).

202. The applicant was prescribed antipsychotic medication both on his visit to the Poiana Mare on 9 February 2004 and during his subsequent hospitalization there. It is not clear on what basis this was done given that the applicant did not suffer from any mental

[171] Annex 86.

health problems and what effects it had on the applicant's general state of health. One obvious example of incompetence on the part of staff at the Poaina Mare hospital is the identification of intellectual disability as an underlying cause of death in the death certificate issued by Lidia Ghitulescu. This is also further evidence of continuing confusion on the part of the authorities between the mental health problems and the intellectual disability which resulted in the applicant's placement in the Poiana Mare Hospital in the first place.

203. The lack of expert care and treatment was further exacerbated by the appalling conditions in which the applicant was kept at the Poiana Mare Hospital. This was verified by two representatives of the CLR, when, on the day of the applicant's death on 20th April 2004, they visited the institution (see descriptive statement above). The situation described by the CLR may be characterized as "therapeutic abandonment" whereby medical staff have effectively given up on any attempts to ameliorate an individual's state of health and instead left them to die[172].

204. The CLR's account is corroborated by the reports issued by the CPT on the visits it carried out at the Poiana Mare Hospital in 1995, 1999 and, most recently 2004, the year of the applicant's death. In particular, the CPT highlighted the scarcity of medical and auxiliary personnel at the Poiana Mare Hospital, which was also evident in the applicant's case (see above §111-116).

B. With respect to the failures to carry out an effective investigation into the applicant's death

205. The applicant alleges that by failing to carry out an effective investigation into his death and the circumstances surrounding it Romania violated the procedural obligations under Article 2 of the Convention.

As to the law

206. The effective protection of the right to life entails a procedural duty on the State to investigate deaths that have occurred in circumstances potentially engaging the responsibility of the State. This obligation is of particular importance in relation to intentional deprivations of life, whether by state agents or private individuals. It also extends however to cases of medical negligence, where the State has an obligation to set up an effective judicial system for establishing the cause of death and where

[172] The CPT noted a similar situation in one of their reports on the visits to the Poiana Mare Hospital: *Au service B0 (patients internés en vertu de l'article 114 du Code pénal), un patient âgé a été trouvé dans la chambre dite d'isolement dans une situation pouvant aisément être qualifiée d'abandon thérapeutique. Incapable de se lever, ce patient, présentant un encombrement bronchique et une diarrhée, était couché dans ses matières. Il était dans un état de grande faiblesse, et notamment, plus en mesure de manger seul. Le personnel ne s'occupait en aucune manière de ce patient qui dépendait entièrement de la bonne volonté des autres occupants de la chambre.* Rapport au Gouvernement de la Roumanie relatif à la visite effectuée par le Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT) en Roumanie du 24 septembre au 6 octobre 1995, available at http://www.cpt.coe.int/en/states/rom.htm , p. 95.

responsibility for that death lies (*Calvelli and Ciglio v. Italy*, §49). In cases where the death was not caused intentionally, the obligation to set up an "effective judicial system" does not necessarily require a criminal remedy and may be satisfied by making available civil, administrative or even disciplinary remedies (*Oneryildiz v. Turkey*, [GC], no. 48939/99, ECHR 2004-XII, §92).

207. The obligation to carry out a criminal investigation is not however restricted to violent deaths. It can also apply under certain circumstances where the deprivation of life has been caused intentionally through the lack of appropriate medical care and treatment (*Tarariyeva v Russia*, §75).

208. The Court has analyzed the relevant factors in a case concerning State responsibility to protect the right to life in relation to dangerous activities (*Oneryildiz v. Turkey*) and it is submitted similar principles apply mutatis mutandis to cases of medical neglect and ill treatment.

209. The procedural obligation to carry out official investigations in cases of homicide is not justified solely because any allegations of such an offence normally give rise to criminal liability. It is also the only means to establish the true circumstances of the death where these circumstances are largely confined within the knowledge of State officials or authorities (*Oneryildiz v. Turkey*, §93). Applying these considerations in the context of dangerous activities, the Court found that an official investigation will be required "when lives have been lost as a result of events occurring under the responsibility of the public authorities, which are often the only entities to have sufficient relevant knowledge to identify and establish the complex phenomena that might have caused such incidents" (*Oneryildiz v. Turkey*, §93).

210. The Court established on this occasion that the intent/negligence distinction is not decisive for defining the type of remedy required under the procedural limb of Article 2

> *Where it is established that the negligence attributable to State officials or bodies on that account goes beyond an error of judgment or carelessness, in that the authorities in question, fully realising the likely consequences and disregarding the powers vested in them, failed to take measures that were necessary and sufficient to avert the risks inherent in a dangerous activity, the fact that those responsible for endangering life have not been charged with a criminal offence or prosecuted may amount to a violation of Article 2, irrespective of any other types of remedy which individuals may exercise on their own initiative. (Oneryildiz v. Turkey*, §93*)*

The Court went on to describe the contents of the procedural obligation to carry out an investigation in such cases:

> *To sum up, the judicial system required by Article 2 must make provision for an independent and impartial official investigation procedure that satisfies certain minimum standards as to effectiveness and is capable of ensuring that criminal*

penalties are applied where lives are lost as a result of a dangerous activity if and to the extent that this is justified by the findings of the investigation (see, mutatis mutandis, Hugh Jordan v. the United Kingdom, no. 24746/94, §§ 105-09, 4 May 2001, and Paul and Audrey Edwards, cited above, §§ 69-73). In such cases, the competent authorities must act with exemplary diligence and promptness and must of their own motion initiate investigations capable of, firstly, ascertaining the circumstances in which the incident took place and any shortcomings in the operation of the regulatory system and, secondly, identifying the State officials or authorities involved in whatever capacity in the chain of events in issue. (Oneryildiz v. Turkey, §94*)*

211. The Court considers that the need for expedition is particularly important in any case in which a person dies while in the custody of the authorities since, with the passing of time, it becomes more and more difficult to gather evidence from which to determine the cause of death (*Slimani v France*).

212. The Court also held that the requirements of Article 2 go beyond official investigations, to cover any court proceedings at the domestic level. National courts should not under any circumstances be prepared to allow life-endangering offences go unpunished; on the contrary they should apply the strict scrutiny required by Article 2. This is essential for maintaining public confidence and ensuring adherence to the rule of law and preventing any appearance of tolerance of or collusion in unlawful acts (*Oneryildiz v. Turkey*, §96).

213. The requirement to carry out an official investigation includes a number of elements.

214. The investigation must be thorough and rigorous, thus being capable of leading to a decision as to the causes and circumstances of the death and the identification and punishment of those responsible (*Jordan v. the United Kingdom (no. 2),* no. 49771/99, §105). In cases concerning killings in south-east Turkey, the Court identified a number of specific failings which undermined the quality of the investigation: ignoring visible evidence, failing to question officers named as suspects, failing to verify custody records, failing to identify security force members involved in incidents and discounting evidence which supported allegations of security force involvement in the killings (See for example *Kiliç v. Turkey*, no 22492/93, ECHR 2000-III, §223).

215. The Court has highlighted the importance of securing evidence concerning the incident, including inter alia eyewitness testimony and forensic evidence (*Jordan v. United Kingdom*, §107). Where appropriate, an autopsy has to be undertaken which "provides a complete and accurate record of injury and an objective analysis of clinical findings", and enables an investigation to establish the facts of the events directly preceding a person's death (*Dzieciak v Poland*). In this respect the Court has found that failure of the autopsy to record morphological data contributed to an investigation lacking the requisite objectivity and thoroughness (*Anguelova v Bulgaria*). Furthermore, "[a]ny deficiency in the investigation which undermines its ability to establish the cause of

death, or the person or persons responsible will risk falling foul of this standard (*Anguelova v Bulgaria*, § 139; *Nachova & Ors v Bulgaria*, nos. 43577/98 and 43579/98, § 113, 6 July 2005; *Slimani v France*, § 32).

216. For example, the Court has found a breach of Article 2 when a criminal investigation into the death of a detainee in a prison hospital was slow and its scope was restricted, leaving out many crucial aspects of the events leading to the conclusion that the State failed to discharge its positive obligation to determine, in an adequate and comprehensive manner, the cause of death and to bring those responsible to account (*Tarariyeva v Russia*, §102-103).

217. The investigation must also be initiated promptly and conducted with "reasonable expedition" (*Jordan v. United Kingdom*, §108).

As to the facts

218. The applicant submits that nothing short of a criminal investigation is capable of satisfying the requirements of the procedural arm of Article 2. Firstly, the circumstances in which the applicant died are particularly serious, and involved a total breakdown in the system of social protection designed to safeguard the welfare of an extremely vulnerable individual. Secondly, numerous agencies and individuals share responsibility for the applicant's demise. In that sense only an official investigation is capable of shedding light on the circumstances surrounding the applicant's the death, which were largely confined to the knowledge of the State authorities. Thirdly, the responsibility of state officials and institutions in relation to the applicant's death goes beyond mere errors of judgment or carelessness. By consistently failing or omitting to take positive steps to secure appropriate protection for the applicant, despite their knowledge of the applicant's condition and circumstances, they were complicit in the applicant's death.

219. The criminal investigation was initiated in the immediate aftermath of the applicant's death, on 23 February 2004, when the CLR filed a criminal complaint in relation to the circumstances in which the applicant died. It ended after more than four years on 4 April 2008, when the Dolj Tribunal issued a final judgment confirming a previous decision of non-indictment. It is submitted that the official investigation was flawed in a number of major respects.

220. The investigation was superficial and perfunctory, limited in scope, lacking in the necessary diligence to properly examine a case of this size, scope and complexity, and overly deferential towards medical opinion.

221. Throughout its course, the investigation was extremely limited in scope, despite the exhortations received from the CLR. Firstly, the investigation only focused on the individual responsibility of two doctors (Lidia Ghitulescu and Maria Onel) and did not examine the responsibility of other individuals and authorities such as staff at the Placement Centre, the Department, the Commission, the Ministry of Employment and Social Protection and the authorities under its supervision, the Ministry of Health and

ultimately the Government. The prosecution lacked the requisite expertise to deal with or failed to recognize the complexity of events leading to the applicant's death, and the fact that responsibility for the death went beyond individual malpractice and extended to failures of the system to provide the necessary support to the applicant in the difficult transitioning process from the placement centre to living in the community. Secondly, the investigators only focused on the immediate causes of the applicant's death and did not attempt to investigate the extent to which relevant critical background factors such as the applicant's living conditions and treatment in the institutions could have influenced the applicant's death.

222. In all decisions of non-indictment, the prosecutors and then the courts were overly deferential to medical opinion. In fact the prosecutors seemed content to rely exclusively on medical opinion to the detriment of all other evidence. However, the questions addressed to forensic experts were formulated in very restrictive terms, being limited for example to the identification of the immediate cause of death. Furthermore, the information available to the experts was very limited in scope and excluded crucial background factors such as living conditions in the Poiana Mare Hospital. In addition, the ability of bodies such as the Doctors' Association to provide independent medical opinion is doubtful.

223. The investigation was also hampered by the excessive significance placed on the distinction between violent and non-violent deaths, grounded on Article 141 of the Criminal Procedure Code. The mandate of the first forensic expert was limited to identifying the manner of the applicant's death, and the subsequent non-indictment decision was based exclusively on the finding that the applicant's death had been non-violent. This reflects a structural weakness whereby non-violent deaths are subject to a less stringent scrutiny by the prosecuting authorities in Romania.

224. The investigation failed to collect critical items of evidence, including documentation, and failed to question key witnesses or clarify contradictory testimony. These flaws were comprehensively analyzed in the decision of 23 August 2005 and that of 3 October 2007.

225. The investigation also failed to clarify crucial episodes that were the object of contradictory evidence, such as the applicant's transfer to the Cetate Hospital or whether the applicant received ARV treatment while at the Cetate Hospital or the Poiana Mare Hospital, and the likely consequences of an interruption in such treatment.

226. No autopsy was performed at the time of the applicant's death, contrary to accepted practice and to Romania's own legislation.[173] Instead, the applicant's body was exhumed and an autopsy was carried out more than eight months after his death on 22 October 2005. As also mentioned by the Craiova Forensic Institute, this delay clearly meant that the autopsy was of limited value in identifying the precise cause of death (see above §71).

[173] Art. 34 of Procedural Rules of 25 May 2000, annex 86.

227. On two occasions the shortcomings of the investigation were acknowledged and analyzed by the Head Prosecutor and the Calafat First Instance Court. The file was then returned to the investigation authority with extensive instructions in relation to the steps that had to be taken in order to ascertain the circumstances in which the applicant died. Subsequently the authorities which dealt with the file mostly ignored those objections and, instead, continued to proceed with their ultimately successful attempt to secure a decision of non-indictment.

228. Equally, the authorities did not feel the need to respond to the objections repeatedly raised by the CLR. Where they acknowledged directly or indirectly that some misconduct had taken place, the authorities chose to do nothing, without providing any reasons for their decision. Thus, the records at the Poiana Mare Hospital confirmed that the applicant did not receive ARV medication during his hospitalization there, and that major tests had either not been undertaken at all, or were only undertaken after a period of delay following his hospitalization in contradiction with accepted practice and legislation (see above §55-56). Lidia Ghitulescu confirmed before the Calafat First Instance Court that the applicant did not receive adequate treatment at the Poiana Mare Hospital, given the lack of adequate facilities and the overcrowding prevalent there. In a different context, the National Authority for the Protection of the Child and Adoption confirmed that the Department did not have the power to order the applicant's transfer to the Poiana Mare Hospital and yet still chose to do so.

229. It appears that although the applicant's personal records from the Placement Centre and the Clinic had been submitted to the prosecuting authorities they were inexplicably not attached to the investigation file and thus avoided judicial scrutiny (see above §229).

230. Domestic courts had ample opportunities to remedy the flaws of the investigation but failed to do so (although the Calafat First Instance Court did find a number of shortcomings and returned the case for reinvestigation). It is clear from the facts that judicial supervision of the decisions of the prosecutor was mostly superficial.

231. Finally the investigation was subject to inordinate, inexcusable and unexplained delays, despite repeated appeals by the CLR asking that procedures be expedited.

VIOLATION OF ARTICLE 3

232. The applicant submits that serious flaws in his care and treatment at the Cetate Hospital and the Poiana Mare Hospital, the living conditions at the Poiana Mare Hospital, as well as the general attitude of the authorities and individuals involved in his care and treatment over the last months of his life taken together or separately amount to inhuman and degrading treatment in contradiction with Article 3 of the Convention. In addition the official investigation into his allegations of ill-treatment did not comply with the procedural obligation of the State under Article 3.

As to the law

Ill Treatment

233. This Court has recalled in its jurisprudence that ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum level is relative: it depends on all the circumstances of the case, such as the nature and context of the treatment, its duration, its physical and mental effects and, in some instances, the sex, age and state of health of the victim *(Price v. the United Kingdom*, no. 33394/96, § 24, ECHR 2001-VII; *Elci and Others v. Turkey*, nos. 23145/93 and 25091/94, § 633, 13 November 2003; Costello-Roberts v. the United Kingdom judgment of 25 March 1993, Series A no. 247-C, § 30). In *Tyrer v. United Kingdom*, Judge Fitzmaurice further stated that "the age, general health, bodily characteristics and current physical and mental condition of the person concerned" are to be taken into consideration as factors that increase or diminish the seriousness of ill-treatment (*Tyrer v. the United Kingdom*, judgment of 25 April 1978, Series A no. 26, Separate opinion of Judge Fitzmaurice, §3).

234. This Court has considered treatment to be "inhuman" when, inter alia, it was applied for a long period of time and caused either actual bodily injury or intense physical or mental suffering and psychological suffering (*Moldovan v. Romania* (no. 2), nos. 41138/98 and 64320/01, § 113, ECHR 2005-VII).

235. In assessing violations under Article 3, the Court will look at the extent of the consequences for the victim and their related feelings and personal responses. (*Menteş and Others v. Turkey*, judgment of 28 November 1997, Reports of Judgments and Decisions 1997-VIII, § 76). Where treatment humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3 (*Pretty v. the United Kingdom*, no. 2346/02, § 52, ECHR 2002-III).

236. The State need not have intended to humiliate or debase the individual in order for the Court to find a violation under Article 3 (*Peers v. Greece*, April 19, 2001, ECHR 2001-III, §74).

Living conditions in detention

237. The State must ensure that a person who is detained is kept in conditions which are compatible with respect for human dignity, that the manner and method of the execution of the measure of detention does not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of detention, his health and well-being are adequately secured (*Kudła v. Poland* [GC], no. 30210/96, §§ 92-94, ECHR 2000-XI; Popov v.

Russia, no. 26853/04, § 208, 13 July 2006; *Mouisel v France*, no. 67263/01, § 40, 14 November 2002).

238. In this regard, the Court has repeatedly ruled that poor detention conditions can amount to inhuman treatment. It is irrelevant that the authorities did not intend to cause physical or mental suffering to the victim. Where the cumulative facts of the case are sufficient to cause distress and hardship of an intensity exceeding the unavoidable level of suffering inherent in detention there will be a breach of Article 3. In this respect the vulnerability of the person, including their state of health, will be a relevant factor in determining whether their overall living conditions will amount to a breach of Article 3 (*Alver v Estonia*, no. 64812/01, §§ 50 and 56, 8 November 2005)

239. Detention conditions which are unsuited to the applicant's health leading to a situation in which the detainee suffers permanent anxiety and a sense of inferiority and humiliation can amount to "degrading treatment" (*Farbtuhs v Latvia*, no 4672/02).

240. When assessing conditions of detention, account has to be taken of the cumulative effects of those conditions and the duration of the detention (see *Dougoz v. Greece*, no. 40907/98, § 46, ECHR 2001-II, and *Kalashnikov v. Russia*, no. 47095/99, § 102, ECHR 2002-VI); *Bitiyeva and X v Russia*, nos. 57953/00 and 37392/03, § 105, 21 June 2007).

Inadequate medical care and treatment

241. The suffering which flows from a naturally occurring physical or mental illness, may be covered by Article 3, where it is, or risks being, exacerbated by treatment, for which the authorities can be held responsible (*Keenan v. the United Kingdom*, no. 27229/95, ECHR 2001-III § 113; *Pretty v. the United Kingdom*, no. 2346/02, § 52, ECHR 2002-III).

242. Beyond this the Court has found on numerous occasions in relation to the obligation to protect the health of persons deprived of liberty (see *Hurtado v. Switzerland*, judgment of 28 January 1994, Series A no. 280-A, opinion of the Commission, § 79) that a failure to ensure that a person who is in the custody of the State has received appropriate health care can amount to inhuman treatment contrary to Article 3 (*Mouisel v France*, no. 67263/01, § 37, 14 November 2002; *İlhan v. Turkey* [GC], no. 22277/93, § 87, ECHR 2000-VII; *Sarban v. Moldova*, no. 3456/05, § 90, 4 October 2005) *Yakovenko v Ukraine*, no. 15825/06, § 80, 25 October 2007; *Naumenko v. Ukraine*, no. 42023/98, § 112, 10 February 2004; *Farbtuhs v. Latvia*, no. 4672/02, § 51, 2 December 2004).

243. In this respect the Court has observed that there are three particular elements to be considered in relation to the compatibility of an applicant's health with his stay in detention: (a) his medical condition (b) the adequacy of the medical assistance and care provided in detention, and (c) the advisability of maintaining the detention measure in view of the state of health of the applicant (*Mouisel*, no. 67263/01, §§ 40-42, 14

November 2002; *Melnik v. Ukraine*, no. 72286/01, § 94, 28 March 2006; and *Rivière v. France*, no. 33834/03, § 63, 11 July 2006; *Slawomir Musial v Poland*, no. 28300/06, § 88, 20 January 2009).

244. In *Khudobin v Russia*, the applicant was HIV-positive and, while in detention, suffered from a serious mental disorder, and other additional chronic diseases - epilepsy, pancreatitis, chronic viral hepatitis B and C, some contracted in detention. The Court noted that although his illnesses could be partly explained by his past medical history, namely the fact that he was HIV-positive, the sharp deterioration in his state of health in the detention facility raised certain doubts as to the adequacy of medical treatment available in prison (§84). Where, as in this case, an individual suffers from multiple illnesses, including an HIV infection, this can increase the risk associated with any illness he suffers during his detention and intensify his fears on that account (in relation to the risks associated with HIV infection also (see *Aleksanyan v. Russia*, §142). In these circumstances the absence of qualified and timely medical assistance, added to the authorities' refusal to allow an independent medical examination of the applicant's state of health, created a strong feeling of insecurity which, combined with his physical suffering, amounted to degrading treatment (§95-96).

245. The obligation to provide adequate care and treatment includes a requirement for institutions to keep adequate records of a detainee's state of health and the treatment he underwent while in detention (*Khudobin v. Russia*, no. 59696/00, § 83, 26 October 2006). Such a medical record should contain sufficient information specifying what kind of treatment the patient was prescribed, what treatment he actually received, who administered the treatment and when, how the applicant's state of health was monitored etc. In the absence of such information, the Court may draw appropriate inferences (*Aleksanyan*, §147).

246. The combined and cumulative impact on a detainee of both their conditions of detention and lack of adequate medical assistance may result in a breach Article 3 (*Popov v Russia*, no. 26853/04, §§ 220 and 241, 13 July 2006; *Lind v Russia*, no. 25664/05, § 63, 6 December 2007; *Bitiyeva & X v Russia*, cited above, § 107; *Musial v. Poland*, cited above § 96; *Kalashnikov v. Russia*, no. 47095/99, § 98, ECHR 2002-VI).

Mental health treatment

247. The Court has reiterated that, in the case of persons suffering from mental health problems, regard must be had to their particular vulnerability (*Aerts v. Belgium*, 30 July 1998, § 66, Reports 1998-V; *Keenan*, cited above, § 111; and *Rivière v. France*, no. 33834/03, § 63, 11 July 2006).

248. In this respect, the assessment of whether the particular conditions into which they are placed are incompatible with the standards of Article 3 must, in the case of those persons who suffer from mental health problems, take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment (*Herczegfalvy v. Austria*, judgment of

24 September 1992, Series A no. 244, pp. 25-26, § 82; *Aerts v. Belgium*, judgment of 30 July 1998, Reports 1998-V, p. 1966, § 66; *Keenan v UK*, ibid, § 111).

249. Furthermore, the Court has noted that it is necessary, in view of the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals, to be particularly vigilant in reviewing whether Article 3 has been complied with. (*Herczegfalvy v Austria*, ibid., § 82; *Musial v Poland*, ibid., § 96; *Kalashnikov v. Russia*, no. 47095/99, § 98, ECHR 2002-VI *Egmez v. Cyprus*, no. 30873/96, § 77, ECHR 2000-XII; *Labzov v. Russia*, no. 62208/00, § 45, 16 June 2005; and *Mayzit v. Russia*, no. 63378/00, § 42, 20 January 2005).

250. In this regard, the treatment of a person with mental health problems may be incompatible with the standards imposed by Article 3 in the protection of human dignity, even though that person may not be able or in a position to point to any specific ill-effects (see *Keenan*, cited above, § 113; *Renolde v France*, no. 5608/05, § 121, 16 October 2008; *Rohde v Denmark*, no. 69332/01, § 99, 21 July 2005).

251. The Court has examined the practice of solitary confinement in the prison context, and stated that it does not of itself constitute a violation of Article 3. In assessing the severity of solitary confinement, the Court will take into account factors such as the particular conditions, the stringency of the measure, its duration, the objective pursued and its effects on the individual concerned (Reed v. United Kingdom). In the prison context, legitimate reasons for isolating a prisoner may include security reasons, the prevention of collusion, and the nature of the charge against the individual concerned (see for example *Bonzi v. Switzerland*).

252. Similar rules apply to seclusion in the psychiatric context. One permitted justification for placement of a prisoner in solitary confinement is the danger posed by that prisoner to other prisoners (*M. v. United Kingdom*). The CPT standards include more details in relation to the practice of seclusion, applied in the psychiatric context. Thus, the CPT noted that there is a clear trend to avoid seclusion of patients[174]. When in use, seclusion should be subject to a detailed policy spelling out, in particular: the types of cases in which it may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact; the need for staff to be especially attentive. Furthermore, any instances of seclusion should be recorded in the institution's register of restraint (§49-50).

The procedural obligation to investigate

253. As with the right to life, the prohibition of torture and other forms of ill-treatment under Article 3 requires that States engage in effective investigations where persons claim they have been ill-treated by public officials. The Court has stated in a number of cases, that where an individual raises an arguable claim that he has been seriously ill-treated by State agents unlawfully and in breach of Article 3, that provision, read in

[174] The CPT Standards.

conjunction with the State's general duty under Article 1 to "secure to everyone within their jurisdiction the rights and freedoms defined in … [the] Convention", requires by implication that there should be an effective official investigation.

254. Any investigation, as with that under Article 2, should be capable of leading to the identification and punishment of those responsible. If this were not the case, the general legal prohibition of torture and inhuman and degrading treatment and punishment, despite its fundamental importance, would be ineffective in practice and it would be possible in some cases for agents of the State to abuse the rights of those within their control with virtual impunity (*Assenov v Bulgaria*, §102; *Ilhan v Turkey*, §91-92; *Valasninas v Lithuania, §*122).

255. The requirements under the procedural obligation to investigate under Article 2 apply, mutatis mutandis, to situations arising under Article 3 (see above §206-217).

As to the facts

256. The Court's case-law on care and treatment and living conditions in the psychiatric context is relatively underdeveloped for reasons which are examined elsewhere (see above §164-165). Standards developed in cases concerning conditions in prison are applicable mutatis mutandis to the psychiatric context. This case law can be supplemented with guidelines issued by the CPT concerning institutional standards for psychiatric and other related institutions. However, the circumstances applying to situations in psychiatric institutions and prisons are materially different. Detention in a criminal context is punitive in nature; whereas commitment to a social care home or psychiatric hospital is therapeutic, aimed at securing the reintegration of the patient into the community. This distinction also influences discussions concerning, for example, the principle of the equivalence of health care in prison with that in the community (see *Aleksanyan v. Russia*, §139) – in this sense, social care homes and psychiatric hospitals belong to the 'community' and therefore there is no justification for the application of discriminatory standards.

257. The applicant submits that the general manner in which he was treated by the authorities after September 2003 amounts in and of itself to a serious violation of Article 3. The circumstances of the case disclose that the authorities and individuals involved in the applicant's care and treatment treated him as a disposable object thereby debasing and humiliating him. The main reason for the decisions which directly concerned the applicant had less to do with his welfare than with administrative expediency. At no point were the authorities and individuals involved in the decision making process concerned about trying to consult with the applicant and ascertain what he actually thought about the various measures taken in relation to him. This approach reflects more general societal prejudices in Romania with respect to persons with intellectual disabilities, together with the inherent paternalism of the psychiatric profession towards this group. Such behaviour on behalf of the authorities must have caused considerable anguish and suffering to the applicant.

The transfer to and placement at the Cetate Hospital

258. The general difficulties associated with the transitioning process for people with intellectual disabilities from living in a placement centre to alternative arrangements upon reaching majority age have been thoroughly documented[175]. In this case, this process must have been especially traumatic, given his limited intellectual ability, compounded by the absence of support and preparation for the process. The applicant had lived for most of his life at the Placement Centre and during this time it can be reliably presumed that he must have developed attachment to the place, the staff and other residents. From this perspective leaving the Placement Centre, to face an uncertain future must have been particularly difficult for him.

259. The circumstances surrounding his transfer to the Cetate Hospital are subject to considerable controversy. In the absence of reliable independent evidence and given the failure to establish the facts of this episode by the investigating authorities, the Court is respectfully asked to draw inferences based on the available evidence and reasonable conjecture. In particular, there is a high likelihood that the applicant did indeed arrive at the Cetate Hospital in a state of "advanced degradation", without sufficient clothing and without medication or treatment instruction. This version of events is supported by the fact that an inventory list containing the items the applicant carried at the time was only prepared after he died, presumably in order to cover any deficiencies related to the way in which the transfer took place.

260. It should be noted that the February weather in Romania is very cold, with temperatures frequently dropping below 0°Celsius. Inadequate clothing may have facilitated the opportunistic infection of pneumonia, and therefore it is likely that the applicant's state of health started deteriorating at the time of his transfer to Cetate.

261. Serious doubts arise in connection to the uncharacteristically violent outbreaks reported by staff at Cetate Hospital. No similar episodes or other mental health problems were reported either before or after the placement at the Cetate Hospital. Furthermore, reports according to which the applicant tore his mattress and the bed sheet, broke the windows and attacked other residents are improbable given his extreme frailty (he only weighed 45 kilos). At the same time these reports may have been exaggerated in order to support the demands of Cetate's Director that the applicant be moved away from the Cetate Hospital.

262. Alternatively some abnormal behaviour could be understood as the applicant communicating his anxiety and dissatisfaction with leaving the Placement Centre. As

[175] See for example Human Rights Watch, *"Life Doesn't Wait": Romania's Failure to Protect and Support Children and Youth Living with HIV*, August 2006, p. 4, accessible at http://www.hrw.org/en/reports/2006/08/01/life-doesnt-wait; Institutul national de cercetare stiintifica in domeniul muncii si protectiei sociale, *Studiu privind situatia tinerilor care parasesc sistemul de protectie a copilului*; UNICEF, *Centre for Legal Resources, Monitoring the rights of mentally disabled children and young people in public institutions: Report of Monitoring Project 2005-2006*, accessible at http://www.crj.ro/Uploads/CRJAdmin/ReportCRJUNICEFengl.pdf .

stated by Maria Onel, the Cetate Hospital did not have personnel with the required expertise in caring for people with severe intellectual disabilities such as the applicant. Consequently, staff at the Cetate Hospital interpreted these "violent outbursts" as a sign of psychiatric deterioration, and solicited help from the Poiana Mare Hospital, which medicated the applicant with antipsychotic medication.

263. On 13 February 2004, the applicant was transferred to the Poiana Mare Hospital. Conditions at this establishment have been the object of intense criticism by the CPT and other international agencies. This criticism includes the lack of adequate heating, personnel and medicines, shortages of food, inappropriate commitment procedures and use of seclusion etc. Given the applicant's frail condition, these conditions must have contributed greatly to his worsening health.

264. It became apparent during the official investigation that the medical staff at the Poiana Mare Hospital failed to carry out appropriate tests on the applicant on his hospitalization and failed to administer ARV medication. This is despite the fact that these tests are obligatory according to best medical practice and regulations in the medical field. Record keeping in relation to the applicant's hospitalization was severely deficient.

265. It appears that members of staff were scared to touch him for fear of being infected with HIV. It is very likely that the stigma associated with HIV status was the reason for placing the applicant in seclusion.

266. When they visited the Poiana Mare Hospital, the representatives of the CLR found the applicant in a state of extreme deprivation – lonely in an unheated room, with very little clothes on, lying on a soiled bed in an unconscious state. He was receiving limited nutrition intravenously, and could not use the toilet without support.

267. After a few days at the Poiana Mare Hospital the applicant stopped eating altogether, and his medical condition deteriorated rapidly. During hospitalization he developed edema on his face and legs, the origin of which has never been investigated by the authorities.

268. During his placement at both the Cetate Hospital and the Poiana Mare Hospital staff failed to accurately monitor the applicant's condition and take the necessary steps to obtain appropriate treatment and expert diagnosis, including admission to a specialist hospital. The behaviour of staff at the Poiana Mare Hospital was particularly objectionable, since the circumstances of the case permit the conclusion to be drawn that they knowingly left the applicant to die, withdrawing all care and treatment, in complete contradiction of their positive duties to safeguard his life and welfare and not to subject him to inhuman and degrading treatment.

269. The applicant submits that the authorities omitted altogether to carry out a comprehensive investigation into his allegations of inhuman and degrading treatment. As detailed above at §218-231, the official investigation focused entirely on the immediate

cause of death, while the issue of treatment at both Cetate and Poiana Mare prior to the applicant's death was largely ignored.

THE POSITIVE OBLIGATION TO TAKE PRVENTATIVE MEASURES UNDER ARTICLES 2 AND 3

270. The Court has interpreted Articles 2 and 3 to include an obligation to take preventative measures in order to safeguard life or protect against ill-treatment. As noted already, vulnerability may be the basis for more extensive positive obligations, for example in relation to the welfare of children, prisoners, ethnic minorities, witnesses or women.

271. Preventative positive obligations may include the duty to set up a "legislative framework" that provides against ill treatment by state agents or private persons. In *Costello-Roberts v. United Kingdom* the Court held that a state must provide appropriate legal protection against disciplinary corporal punishment in private schools. In another case concerning parental corporal punishment, the Court noted that "Children and other vulnerable individuals are entitled to protection, in the form of effective deterrence, against such serious breaches of person integrity".

272. In the sphere of public health, the Court has stated that Article 2 requires the State to ensure that hospitals have regulations for the protection of patients and to establish an effective system of judicial investigation into medical incidents (*Isiltan v. Turkey*).

273. Article 33 of the CRPD on national implementation and monitoring requires State Parties to "maintain, strengthen, designate or establish within the State Party, a framework, including one or more independent mechanisms, as appropriate, to promote, protect and monitor implementation" of the Convention. In doing so, the Convention demands State Parties to take into account the Paris Principles concerning the establishment of national institutions.

274. The United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment aims to strengthen the protection of persons deprived of their liberty against torture and other inhuman or degrading treatment, including by preventing such acts. The Optional Protocol to the Convention ("OPCAT") refers to the duties of State Parties in the field of prevention, through, inter alia, the establishment at the domestic level of monitoring mechanisms. Although applicable to all detained persons, the provisions of the Optional Protocol are rendered especially urgent in the case of all particularly vulnerable groups such as people with disabilities.

275. The preventative body established in accordance with OPCAT should be granted functional independence and be adequately staffed and funded. The mandate of the preventative body should include at the minimum the power "to regularly examine the treatment of the persons deprived of their liberty in places of detention […] with a view to strengthening […] their protection" and the power to "make recommendations to the relevant authorities" in order to advance its statutory objectives.

276. The CPT has highlighted the importance of regular supervision of places where people with disabilities are detained, including psychiatric hospitals, by an independent outside body:

> *The CPT also attaches considerable importance to psychiatric establishments being visited on a regular basis by an independent outside body (eg. a judge or supervisory committee) which is responsible for the inspection of patients' care. This body should be authorised, in particular, to talk privately with patients, receive directly any complaints which they might have and make any necessary recommendations.*[176]

277. At the national level, many states in the Council of Europe area have in place monitoring mechanisms of mental health and social care institutions of variable effectiveness.

278. The applicant submits that no mechanism either meeting the CPT criteria set out above or mirroring the comparative national bodies described exists in Romania. Consequently, the Government by failing to establish an effective mechanism for monitoring the rights of persons placed in social care homes or psychiatric hospitals and with the power to take action in order to secure their rights and hold those responsible for ill treatment accountable, has breached its positive obligations under Articles 2 and 3 to prevent ill-treatment and protect life.

VIOLATION OF ARTICLE 5

279. It is submitted that the applicant's placement and subsequent hospitalization at the Cetate Hospital from 5 to 13 February 2004 and at the Poiana Mare Hospital from 13 to 20 February 2004 is in breach of Article 5 in several respects.

Violation of Article 5§1

The existence of a deprivation of liberty

As to the law

280. The Court has indicated that to determine whether someone has been deprived of their liberty in breach of Article 5, the starting point must be the concrete situation of the individual concerned. Account must be taken of a range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question (*Guzzardi v. Italy*, judgment of 6 November 1980, Series A no. 39, § 92; *Ashingdane v. the United Kingdom*, judgment of 28 May 1985, Series A no. 93, §41). The same factors are used to determine whether a less restrictive restriction of liberty

[176] §55 of the CPT Principles

falls under the ambit of Article 2 of Protocol 4, the right to liberty of movement (*Ashingdane v. the United Kingdom*, §41), rather than under Article 5.

281. The Court has stated that loss of liberty under Article 5 contains both an 'objective element', where a person is confined in a particular restricted space for a not negligible length of time, and a 'subjective element', where that person did not validly consent to the confinement in question (*H.M. v. Switzerland*, no. 39187/98, § 46, ECHR 2002-II; *Shtukaturov v. Russia*, no. 44009/05, § 106, 27 March 2008).

282. With regard to the objective element of 'deprivation of liberty', the Court has found that Article 5§1 covers detention regimes of variable intensity. In *Ashingdane v. the United Kingdom*, the Court held that the applicant was detained for the purposes of Article 5§1 even during a period when he was in an open ward with regular unescorted access to the unsecured hospital grounds and the possibility of unescorted leave outside the hospital. In *H.L. v. United Kingdom*, a case concerning the detention on medical grounds of a compliant incapacitated individual, the court noted that the decisive factor was whether the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements (at §91). In that regard, the previously contentious issue of whether the ward where the applicant was held was 'locked' or 'lockable' was not determinative of whether there was a deprivation of liberty (at §92).

283. The additional element necessary for the applicability of Article 5§1 is the absence of valid consent of the detained person to the confinement in question. The Court stated that a person incapable of objecting to their detention cannot be regarded as consenting to it. In circumstances analogous the case at hand, the Court, in *H.L. v. the United Kingdom*, did not accept as determinative the fact relied on by the Government that the regime applied to the applicant (as a compliant incapacitated patient) did not materially differ from that applied to a person who had the capacity to consent to hospital treatment, where neither expressly objected to their admission to hospital (at §91). The Court reiterated that the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention, especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action (at §90).

As to the facts

284. It is submitted that during the applicant's placement and subsequent hospitalization at the Cetate Hospital from 5 to 13 February 2004 and at the Poiana Mare Hospital from 13 to 20 February 2004, when he died, he was 'deprived of his liberty' within the meaning of Article 5§1 of the Convention.

285. It is submitted that health care personnel in both establishments exercised complete and effective control over the applicant's care, treatment, movement and

residence. Although in theory the safeguards contained in the Mental Health Law[177] in relation to civil involuntary confinement are solely applicable to hospitalization in psychiatric hospitals, the regime in the Cetate Hospital was not materially different from that in the Poiana Mare Hospital.

286. Neither establishment sought the applicant's consent to hospitalization. The fact that the applicant was incapable of expressing consent or objecting to such measures cannot imply consent by him to those measures. Alternatively, the applicant did not have any representative to express consent on his behalf either.

287. In view of the above it can be said that the medical personnel in the two establishments treated the applicant as a disposable object, exercising decisive control over his life and ultimately, death.

The reason for the applicant's detention is not included in the list of exceptions provided in Article 5§1(e)

As to the law

288. Though the right to liberty and security is not absolute, the essential presumption underpinning Article 5 is in favor of liberty. The exceptions provided for in Article 5§1(e), like all exceptions in the Convention, must be construed narrowly (*Winterwerp v. the Netherlands*, judgment of 24 October 1979, Series A no. 33, §37). The only exceptions to the right of liberty and security are those specifically provided for in Article 5; any other grounds which may be permitted by domestic laws are contrary to Article 5 (*Engel and Others v. the Netherlands*, judgment of 8 June 1976, Series A no. 22, § 57; *Conka v. Belgium*, no. 51564/99, § 41, ECHR 2002-I).

As to the facts

289. It is submitted that that the applicant's placement at the Cetate Hospital was not based on any of the grounds enumerated in Article 5§1.

290. The original reason for the applicant's transfer from the Placement Centre was that he turned 18, and according to the law could no longer stay in a social care home for children. The immediate reason why the applicant was placed at the Cetate Hospital was because no other establishment would take him in, including the Centre for Recovery and Rehabilitation, the Poiana Mare Hospital, and other centres for medico-social care, which had been contacted by the Department.

291. The applicant's transfer was not therefore prompted by the aggravation of his mental health condition which might have justified him being committed for being of unsound mind. In fact the applicant had not been diagnosed with any mental health problems before the transfer to the Cetate Hospital.

[177] Law no. 487/11 July 2002 concerning Mental Health and the Protection of Persons with Mental Problems, annex 86.

292. The applicant's placement and subsequent hospitalisation in Cetate Hospital and the Poiana Mare Hospital was not "in accordance with a procedure prescribed by law" and was not "lawful" within the meaning of Article 5§1(e).

Whether the applicant was of "unsound mind"

As to the law

293. The term 'unsound mind' included in Article 5§1(e) has not been specifically defined. This Court stated in *Winterwerp v. the Netherlands* that "it is a term whose meaning is constantly evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society's attitude to mental illness changes, in particular so that a greater understanding of the problems of mental patients is becoming widespread" (at § 37).

294. The Court has outlined the three minimum conditions for the lawful detention of an individual on the basis of Article 5§1(e). These conditions are:

- The person must be 'reliably shown' by 'objective medical expertise' to be of unsound mind;
- The individual's mental disorder must be of 'a kind or degree warranting compulsory confinement'; and
- The validity of continued confinement depends on the 'persistence of such a disorder', requiring further expert psychiatric evidence (*Winterwerp v. the Netherlands*, §39).

295. A person thought to be of unsound mind cannot be detained in accordance with 5§1(e) without an expert medical opinion. Furthermore, the medical assessment must be based on the actual state of the mental health of the person concerned and not solely on past events. A medical opinion is not sufficient to justify deprivation of liberty if a significant period of time has elapsed (*Varbanov v. Bulgaria*, no. 31365/96, § 47, ECHR 2000-X).

296. It may be appropriate, in urgent cases or where a person is arrested because of their violent behavior, that the opinion of a medical expert is obtained immediately after arrest. In all other cases a prior consultation is necessary. Where no other possibility exists, for instance due to a refusal of the person concerned to appear for an examination, at least an assessment by a medical expert on the basis of the file must be sought, failing which it cannot be maintained that the person has reliably been shown to be of unsound mind (see *Varbanov v. Bulgaria*, § 47; *Shulepova* v. Russia, no. 34449/03, §42).

297. In order to justify detention under Article 5§1(e) the mental disorder has to be of a kind or degree warranting compulsory detention. The Court has held that such confinement may be necessary not only where a person needs therapy, medication or other clinical treatment to cure or alleviate their condition, but also where the person

needs control and supervision to prevent them, for example, from causing harm to themselves or other persons (*Hutchison Reid v. the United Kingdom*, no. 50272/99, § 52, ECHR 2003-IV)

As to the facts

298. It is submitted that when the applicant was transferred to the Cetate Hospital he was not of "unsound mind". The applicant had never been diagnosed with mental health problems, although he did have severe intellectual disabilities. Nor was there an adequate medical examination to prove "unsoundness of mind" carried out before his transfer to Cetate. The socio-medical examination carried out in October/November 2003 was centered on the degree of autonomy of the applicant, and the suitability of placement in a medico-social centre. There are serious doubts that the Commission for the Medical Examination of Adults with Handicap consulted the applicant in person in order to issue the certificate dated 14 October 2003. In any case, the examination undertaken on that occasion was aimed at identifying the handicap group the applicant belonged to for the purposes of benefit allocation, not at ascertaining whether the applicant suffered from a mental disorder of a kind or degree justifying detention.

299. The applicant's transfer to the Poiana Mare Hospital was not based on a medical examination compliant with the requirements of Article 5§1(e) either. The transfer was prompted by the misgivings of the medical staff at the Cetate Hospital concerning his medical health and the pressure exercised on the Poiana Mare Hospital to accept the applicant into its care. The medical personnel at the Cetate Hospital did not in fact have the expertise required for a finding of "unsoundness of mind".

300. The procedure for carrying out psychiatric examinations of individuals for the purpose of involuntary civil commitment is normally regulated by Law no. 487/2002 concerning mental health and the protection of persons with mental problems[178]. In the applicant's case this procedure was completely disregarded.

Lawfulness and protection against arbitrary detention

As to the law

301. All deprivations of liberty under Article 5 must be carried out "in accordance with a procedure prescribed by law". This condition refers back to domestic law, that is, the detention needs to comply with the relevant procedural and substantive aspects of the law (*Benham v. the United Kingdom*, judgment of 10 June 1996, Reports of Judgments and Decisions 1996-III, § 40). In addition all deprivations of liberty must be 'lawful' in the sense of the Convention. First, the law authorizing the detention must be compatible with the rule of law and must be sufficiently accessible, precise and foreseeable as to its effects, in order to avoid all risks of arbitrariness (*Steel and Others v. the United Kingdom*, judgment of 23 September 1998, Reports of Judgments and Decisions 1998-

[178] Annex 86.

VII, § 54). Second, the 'lawfulness' criteria requires that detention must be in conformity with the essential objective of Article 5§1 of the Convention, which is to prevent individuals being deprived of their liberty in an arbitrary fashion. This objective requires the existence in domestic law of adequate legal protections and 'fair and proper procedures'. This includes a requirement that any measure depriving a person of their liberty should issue from, and be executed by, an appropriate authority (*Winterwerp v the Netherlands*, §45, *H.L. v. United Kingdom*, §§114-115).

302. The Court has spelled out the procedural safeguards that have to be in place before a compliant incapacitated person may be detained in conformity with the "lawfulness" requirement in *HL v United Kingdom*:

> *Whether or not the above allows the conclusion that the applicant could, with appropriate advice, have reasonably foreseen his detention on the basis of the doctrine of necessity (see The Sunday Times v. the United Kingdom (no. 1), judgment of 26 April 1979, Series A no. 30, pp. 31-33, §§ 49 and 52), the Court considers that the further element of lawfulness, the aim of avoiding arbitrariness, has not been satisfied.*
>
> *In this latter respect, the Court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted. The contrast between this dearth of regulation and the extensive network of safeguards applicable to psychiatric committals covered by the 1983 Act (see paragraphs 36 and 54 above) is, in the Court's view, significant.*
>
> *In particular and most obviously, the Court notes the lack of any formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions. There is no requirement to fix the exact purpose of admission (for example, for assessment or for treatment) and, consistently, no limits in terms of time, treatment or care attach to that admission. Nor is there any specific provision requiring a continuing clinical assessment of the persistence of a disorder warranting detention. The appointment of a representative of a patient who could make certain objections and applications on his or her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities.*
>
> *The Court observes that, as a result of the lack of procedural regulation and limits, the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit: as Lord Steyn remarked, this left "effective and unqualified control" in their hands. While the Court does not question the good faith of those professionals or that they acted in what they considered to be the applicant's best interests, the very purpose of procedural safeguards is to protect individuals against any "misjudgments and professional lapses" (Lord Steyn, paragraph 49 above).*

303. In view of its seriousness, detention is justified only where other less severe measures have been considered and found to be insufficient to safeguard the individual or public interest. (*Varbanov v. Bulgaria*, §46). In *Witold Litwa v. Poland* the Court held that the applicant's detention under Article 5§1(e) was arbitrary on the basis that although the relevant legislation provided for several alternative measures that did not involve deprivation of liberty, the applicant was nevertheless placed in detention. The Court held that the state had acted in a disproportionate measure given that such alternative measures were available (*Witold Litwa v. Poland*, no. 26629/95, § 78, ECHR 2000-III). Furthermore, the place of detention must bear a relationship to the justification for confinement under Article 5 (*Ashingdane v. the United Kingdom*, §44).

As to the facts

304. The applicant submits that his detention in both the Cetate Hospital and the Poiana Mare Hospital was carried out informally, based on negotiations between the medical or social assistance personnel involved in his care, and without any basis in domestic legislation.

305. Whereas when he was transferred to the Cetate Hospital the applicant maintained some functional capacity, no attempt was made by medical or social assistance personnel involved in his transfer to explain the options at his disposal in a manner which he could understand, or to obtain his consent in relation to the measures taken. The applicant would have lost any functional capacity by the time he was transferred to Poiana Mare Hospital. In any case incapacity to object to the treatment cannot be equated to consent.

306. Involuntary civil commitment is normally regulated by Law no. 487/2002 concerning mental health and the protection of persons with mental problems[179]. These procedural safeguards were however disregarded in the applicant's case, both in relation to his placement at the Cetate Hospital, and the subsequent hospitalization at the Poiana Mare Hospital. To the extent to which the applicant lacked the capacity to consent to these measures, no procedural safeguards concerning the commitment of compliant incapacitated persons exist in Romania, in contradiction with the requirements set out by the Court in *H.L. v. United Kingdom*.

307. International standards normally require that individuals in the applicant's situation have a legal proxy appointed to assist them in taking decisions and ensure that their rights are respected. The only such measure available to the authorities, according to domestic law, was to initiate proceedings and appoint a guardian to represent the applicant. The authorities' failure to do so facilitated their abuse of the applicant's right to liberty.

308. The authorities made no attempt to identify less restrictive measures available to the applicant, although the legislation on social assistance in Romania is premised on the avowed aim of increasing the autonomy of the person (see below §100-101). Given that

[179] Annex 86.

the applicant only suffered from an intellectual disability, an arrangement whereby he could live in the community with provision of appropriate support would have been more appropriate than indefinite placement in a medico-social centre or a psychiatric hospital.

Violation of Article 5§2

As to the law

309. The Court outlined the requirements of Article 5§2 in *Fox, Campbell and Hartley v. the United Kingdom*:

> *Paragraph 2 of Article 5 contains the elementary safeguard that any person arrested should know why he is being deprived of his liberty. This provision is an integral part of the scheme of protection afforded by Article 5: by virtue of paragraph 2 any person arrested must be told, in simple, non-technical language that he can understand, the essential legal and factual grounds for his arrest, so as to be able, if he sees fit, to apply to a court to challenge its lawfulness in accordance with paragraph 4). Whilst this information must be conveyed "promptly" (in French: "dans le plus court délai"), it need not be related in its entirety by the arresting officer at the very moment of the arrest. Whether the content and promptness of the information conveyed were sufficient is to be assessed in each case according to its special features.* (*Fox, Campbell and Hartley v. the United Kingdom*, 30 August 1990, Series A, No. 182; (1991) 13 E.H.R.R. 157, §40)

310. Although the language in Article 5§2 seems more appropriate to circumstances related to criminal detentions, the Court has held that it also applies to detentions under Article 5§1(e) (*Van der Leer v. the Netherlands*, judgment of 21 February 1990, Series A no. 170, §40).

311. The contents of Article 5§2 in the context os psychiatric confinement have not been clarified by the Court. In one of the few cases dealing with this issue a patient, initially hospitalized in a psychiatric facility on a voluntary basis, was not informed that the process of involuntary commitment had been completed until ten days after the completion when she was placed in an isolation room. The court found that the failure to inform her of her detention and to provide reasons constituted a breach of Article 5§2:

> *It therefore appears that neither the manner in which she was informed of the measures depriving her of her liberty, nor the time it took to communicate this information to her, corresponded to the requirements of Article 5 § 2 (art. 5-2). In fact it was all the more important to bring the measures in question to her attention since she was already in a psychiatric hospital prior to the Cantonal Court judge's decision, which did not change her situation in factual terms.* (*Van der Leer v. Netherlands*, §31)

As to the facts

312. It is submitted that the applicant was not informed of the reasons for either his placement at the Cetate Hospital or hospitalization at the Poiana Mare Hospital.

313. As to the manner of complying with the obligation to inform under Article 5§2, the applicant submits that the reason for his detention should have been conveyed to him using simple vocabulary and sentence structures, appropriate to his limited ability to understand.

314. As to the extent of the information provided, it should have been sufficient to enable the individual to decide whether to proceed to a hearing under Article 5§4. This obligation was rendered particularly urgent given that the applicant did not have a legal representative to assist him in initiating such proceedings or to initiate such proceedings on his behalf.

315. In this context it is submitted that the duty to provide reasons under Article 5§2 stands on its own as a bulwark against arbitrary detention and is not solely justified by the ability to initiate review proceedings under Article 5§4.

Violation of Article 5§4

As to the law

316. A person of unsound mind who is compulsorily detained in an institution for an indefinite or lengthy period is, in principle, entitled to take proceedings at reasonable intervals before a court to question the 'lawfulness' –within the meaning of the Convention – of their detention. This is especially the case when there is no automatic periodic review of a judicial nature. The applicant should enjoy a right to seek a judicial review of his detention and not have to rely on the initiative or goodwill of the detaining authority (*Rakevich v. Russia*, no. 58973/00, §19).

317. No initial review is required where detention is ordered by a court at the end of judicial proceedings. In these circumstances, the review of lawfulness is regarded as incorporated into those proceedings. An initial review by a court is required, for the purposes of Article 5§4, where the decision to detain is taken by an administrative authority (*Luberti v. Italy*, judgment of 23 February 1984, Series A no. 75, § 31) or by the guardian of the individual concerned (*Shtukaturov v. Russia*, § 122).

318. The Court emphasized in *Winterwerp v. Austria* that under Article 5§4 it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation, failing which he will not have been afforded "the fundamental guarantees of procedure applied in matters of deprivation of liberty". The existence of a mental illness may entail restricting or modifying the manner in which that right is exercised, but it cannot justify restricting the very essence of that right. Indeed, special procedural safeguards may be

necessary in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves. (§60)

319. The Court went further in a subsequent case and stated that Article 5§4 does not require that persons committed to care for "unsoundness of mind" should themselves take the initiative in obtaining legal representation before having recourse to a court. In *Gorshkov v. Ukraine* the Court noted that Article 5 § 4 therefore requires, in the first place, an independent legal device by which the detainee may appear before a judge who will determine the lawfulness of the continued detention. The detainee's access to a judge should not depend on the good will of the detaining authority, activated at the discretion of the medical corps or the hospital administration. (*Gorshkov v. Ukraine*, no. 67531/01, §§ 37-46, 8 November 2005, § 44).

As to the facts

320. The applicant submits that he was deprived of any opportunity to challenge his confinement before a court, either in relation to the period spent at the Cetate Hospital or at the Poiana Mare Hospital. The applicant's limited capacity meant that he could not initiate proceedings by himself. The authorities however failed to provide any support or assistance that would have allowed the applicant access to such a court.

Violation of Article 5§5

321. Article 5§5 requires that those who have been the victim of arrest or detention in breach of the other provisions of this article should have an enforceable right to compensation. The right to compensation is therefore conditioned on the existence of a breach of one of the other four paragraphs of Art. 5. If there is no such finding by a domestic court, the Court must examine whether the applicant is a victim of arrest or detention in contravention of the other provisions of Article 5 before proceeding to Paragraph 5.

322. Where there is no possibility of applying for compensation for a breach of Art. 5§1-4 there will be a violation of Article 5§5 (*Brogan and Others v. the United Kingdom*, 145-B; *Fox, Campbell and Hartley v. United Kingdom*).

323. The possibility of obtaining compensation for breaches of the right to liberty is regulated by Articles 504-507 of the Criminal Procedure Code and is restricted to the criminal detention context (see further *Pantea v. Romania*, no. 33343/96, ECHR 2003-VI, §§151-153 and §§258-271). The fact of this restriction means there was a breach of Article 5§5.

VIOLATION OF ARTICLE 8

General Principles

324. Article 8 is intended to protect individuals from arbitrary interference by the state in their private and family life, home and correspondence. The four concepts included in Article 8§1, namely 'private life', 'family life', 'home' and 'correspondence' are autonomous and have not been exhaustively defined by the Court. Instead, their contents is informed by the principles of 'human dignity' and 'human freedom' that make up "the very essence of the Convention" (*Pretty v. the United Kingdom*, no. 2346/02, § 65, ECHR 2002-III). In principle, the Court has adopted an evolving approach to the interpretation of these four concepts that is responsive to changes in society.

325. Article 8 gives rise to both positive and negative obligations. Where negative obligations are concerned, the applicant has to demonstrate that there has been an interference with one or more of the rights specified under Article 8§1 and if so, whether the interference was justified under Article 8§2. In order to be justified under Article 8§2, the interference must satisfy three requirements. First, it must be in 'accordance with the law' which means that the interference must have been made in accordance with national law which must be compatible with the rule of law. Secondly the measure must then be shown to serve one of the 'legitimate aims' enumerated in Article 8§2. Finally, the measure must be 'necessary in a democratic society', which means that there must be a 'pressing social need for the interference' the establishment of which will depend, inter alia, on whether the measure was proportionate (*Handyside v. the United Kingdom*, judgment of 7 December 1976, Series A no.24, §48-50; *Dudgeon v. the United Kingdom*, judgment of 22 October 1981, Series A no. 45, §50-53).

326. State Parties also have positive obligations to protect the rights specified in Article 8§1 (*Van Kück v. Germany*, no. 35968/97, §70, ECHR 2003-VII). States are required to "set up a system for [the] effective protection and implementation [of private life] in cases of unlawful interference falling within its scope". This in turn could require "the adoption of measures designed to secure respect for private life, including both the provision of a regulatory framework of adjudicatory and enforcement machinery protecting individuals' rights and the implementation, where appropriate, of specific measures" (*Kyriakides v. Cyprus*, no. 39058/05, §51).

327. Unlike cases concerning negative obligations, the focus in cases concerning positive obligation is not on the precise requirements of Art. 8§1 and §2 but on a broader inquiry into whether Article 8§2 is 'applicable' and whether a fair balance has been struck between the competing interests in the case. The grounds listed in Article 8§2 have a 'certain relevance' when determining whether a 'fair' balance has been struck. The Court has made the following observation in this context:

> *[T]he boundaries between the State's positive and negative obligations under Article 8 do not lend themselves to precise definition. The applicable principles are nonetheless similar. In determining whether or not such an obligation exists,*

regard must be had to the fair balance which has to be struck between the general interest and the interests of the individual; and in both contexts the State enjoys a certain margin of appreciation (Van Kück v. Germany, at §71).

328. Article 8 includes an element of procedural fairness. As a general rule, "the decision-making process involved in measures of interference must be fair and such as to ensure due respect for the interests safeguarded by Article 8" (*Görgülü v. Germany*, no. 74969/01, §52, 26 February 2004). Furthermore, a failure to involve an individual in a decision-making process that has implications for his private or family life, such as the removal of a child into care, may be so serious that it will amount to a violation of Article 8 (*X. v. Cro*atia, no. 11223/04, §48, 17 July 2004).

329. In examining a claim under Article 8, the Court will allow national authorities a certain margin of appreciation, justified on the basis that they are better placed than an international court to evaluate local needs and conditions. However, where intimate or key rights are concerned, the margin of appreciation will be narrower:

This margin will vary according to the nature of the Convention right in issue, its importance for the individual and the nature of the activities restricted, as well as the nature of the aim pursued by the restrictions. The margin will tend to be narrower where the right at stake is crucial to the individual's effective enjoyment of intimate or key rights. (Connors v. the United Kingdom, no. 66746/01, §81, 27 May 2004)

The right to private life

330. The Court has included a variety of interests within the scope of 'private life'. The Court acknowledged that 'private life' is 'a broad term not susceptible to exhaustive definition'. Instead a series of statements inform the nature of the interests it encompasses. Thus, private life includes 'the right to establish and develop relationships with other human beings and the outside world' (*Peck v. the United Kingdom*, no. 44647/98, §57, ECHR 2003-I), 'a zone of interaction of a person with others, even in a public context' (*von Hannover v. Germany*, no. 59320/00, §50, ECHR 2004-VI), 'the physical and psychological integrity of a person' (*Pretty v. the United Kingdom*, §61), 'the right to …personal development' (*Peck v. the United Kingdom*, §57) and 'the right to a settled and secure place in the community' (*Connors v. the United Kingdom*, §82).

331. The right to private life encompasses freedom from interference with physical and psychological integrity. The Court has noted in this context, that 'a person's body concerns the most intimate aspect of one's private life'. This category of cases covers physical assaults that do not meet the stricter requirements of Article 3, including compulsory medical interventions. Cases concerning disproportionate search measures or unwanted listening and watching have also fall within the sphere of cases concerning the right to "physical and psychological integrity" (*Mikulić v. Croatia*, no. 53176/99, §§ 53-54, ECHR 2002-I; *Van Kück v. Germany*, §§ 69, 75)

The Court has consistently recognised that 'aspects of an individual's physical and social identity' and the 'right to identity and personal development' are subsumed in the right to private life. The Court has heard cases pertaining to an individual's personal integrity – for example, the right to information about one's parents and early development (Gaskin v. the United Kingdom, judgment of 7 July 1989, Series A no. 160, §§ 39, 41 and 49), the right to recognition of one's gender (*Van Kück v. Germany*, §§ 69, 75) and the right to retain one's name (*Burghartz v. Switzerland*, judgment of 22 February 1994, Series A no. 280-B, § 24) or social identity (*Chapman v. the United Kingdom* [GC], no. 27238/95, §§ 73-74, 78, ECHR 2001-I).

332. The interest in protecting one's identity is instrumental for securing "the ability to establish and develop social, cultural or other relationships with other human beings" (*Ünal Tekeli v. Turkey*, no. 29865/96, §35, ECHR 2004-X).

333. Closely related to the right to one's 'development identity' is the right to live autonomously. The Court has held that '[t]he notion of personal autonomy is an important principle underlying the interpretation of [Convention] guarantees' (*Christine Goodwin v. the United Kingdom* [GC], no. 28957/95, § 90, ECHR 2002-VI). Cases concerning the right to develop sexual and familial relationships fall within the ambit of this aspect of the right to private life, aiming to secure 'the development and fulfilment of one's own personality', 'especially in the emotional field' (*Botta v. Italy*, judgment of 24 February 1998, Reports of Judgments and Decisions 1998-I, §32). Finally, the right to personal autonomy encompasses cases concerning the right to exercise control over one's health and medical treatment. Respondent States have been found in violation for forcibly treating a woman in a private psychiatric unit (*Storck v. Germany*, no. 61603/00, § 143, ECHR 2005) and for administering potentially life-threatening drugs to a severely mentally and physically disabled child against the express wishes of his legal proxy (*Glass v. the United Kingdom*, no. 61827/00, §70, ECHR 2004-II).

(i) Violation of the State's positive obligation to provide support to people with intellectual disabilities in accordance with Article 8

334. The applicant submits that the failure of the State to provide him with any support to take important decisions relating, inter alia, to his placement in an institution and the treatment he received constituted a breach of its positive obligations under Article 8.

335. According to the Court's jurisprudence, decisions in the field of legal capacity will likely have an impact on the private life of the person concerned. In *Shtukaturov v. Russia*, the Court has confirmed that full deprivation of legal capacity, due to the seriousness of the consequences it entails, represents an interference with the right to respect for private life (*Shtukaturov v. Russia*, no. 44009/05, 27 March 2008; also see *Matter v. Slovakia*, app. no. 31534/96, §68). Likewise, in *Berkova v. Slovakia*, the Court agreed that the domestic court interfered with the applicant's private life when it prohibited her from making a full application for full legal capacity for three years (*Berkova v. Slovakia*, Application no. 67149/01, 24 March 2009).

336. Legal capacity is a precondition for accessing the full range of rights normally available to an adult person. As such, it is instrumental in the preservation of the dignity and autonomy of a person. Some persons may lack full capacity to take charge of their own life and to make their own decisions, either due to physiological factors, or as a result of legal provisions authorising a person's "incapacitation". International law requires that States acknowledge these circumstances by providing support to those in need.

337. Article 12 of the CRPD entitled "Equal Recognition before the Law" states that States must recognise the legal capacity of persons with disabilities "on an equal basis with all others in all aspects of life". Capacity, as defined in the CRPD includes both the capacity for a right to recognition everywhere as persons before the law ("legal recognition") and the capacity to "exercise" those rights. Both of these elements are integral to the concept of legal capacity because they establish the rights and responsibilities of persons with disabilities to make their own decisions.

338. Article 12 also addresses situations where persons with disabilities may need support to express their will and preferences, for instance, support and concrete assistance to exercise their legal capacity. In such instances, there is an obligation on the State to provide access to such support and establish safeguards to prevent abuse and ensure its ability to meet individual rights. That support must "…respect the rights, will and preferences of the person." and must be "… free of conflict of interest and undue influence." Therefore, persons with disabilities must be provided with the support they need but can not be required to accept support against their will.

339. The Court also inferred that in certain circumstances an approach whereby the State provides support to people in order to exercise their rights as opposed to depriving them of their rights is preferable in the Article 8 context (*Kutzner v. Germany*, no. 46544/99, ECHR 2002-I, §75).

340. Any approach in this field has to maintain a person's self-determination and autonomy by placing limits on a person's rights to the minimum extent necessary. Currently many states in Central and Eastern Europe favour an "all-or-nothing" approach that annihilates completely the legal capacity of persons with disabilities and entrusts decision-making on behalf of the person concerned to a substitute. This approach is at odds with international trends, as well as with the Court's case law (*Shtukaturov v. Russia*, §94-96). The legislation on incapacitation/guardianship in force in Romania also adopts this "all-or-nothing" approach.

341. In the case at hand, before reaching majority age the applicant was subject to the authority of the Dolj County Council, which exercised full parental rights over him (see above §120). This legal regime (which in itself is at odds with Article 8) ceased automatically to operate when the applicant turned 18, the age when he was presumed to have full capacity to exercise his rights.

342. However, since the applicant was intellectually disabled, he needed considerable support. The only arrangement available to him under Romanian law would have been the incapacitation procedure and placement under full guardianship. Accordingly, the authorities involved in the applicant's care, respectively the Department, the Commission for the Protection of Children, the Commission for the Medical Examination of Adults with Handicap, the Cetate Hospital, the Poiana Mare Hospital had the possibility (but not the obligation) to initiate incapacitation proceedings. They chose not to do it, thereby leaving the applicant to get by on his own.

343. The applicant submits that even had he been incapacitated and placed under guardianship, the situation would not have been fully in line with international standards. However, given the involvement of courts and of the Guardianship Authority in these proceedings, this would have provided the applicant with a modicum of protection against the abuses he suffered from, given that most domestic and international legislation concerning the rights of compliant incapable persons is predicated on consent from a legal representative. As it happened, the absence of a legal representative was instrumental in the abuses perpetrated on the applicant by the authorities and persons involved in his care and treatment throughout the final months of his life.

(ii) Violation of the State's positive obligation to provide community based alternatives to institutionalisation under Article 8

344. In the last thirty years there has been increasing recognition at an international and domestic level of the benefits of community living over institutional living. The CRPD defines community living as a human right. In view of the principles of human dignity and personal freedom which inform the interpretation of Article 8, the applicant respectfully submits that the Court should respond to these developments by interpreting Article 8 to impose a positive obligation on Member States to develop and fund community-based alternatives to institutionalisation. In particular, the authorities failed to satisfy this positive obligation by placing the applicant in a social care home, and failed to consider the possibility of providing him support to live in the community.

As to the law

345. This Court has defined the right to private life to include 'the right to establish and develop relationships with other human beings and the outside world', 'a zone of interaction of a person with others, even in a public context', 'the physical and psychological integrity of a person', 'the right to …personal development', 'the right to a settled and secure place in the community'. Furthermore, the Court has held that in certain circumstances, Article 8 may imply positive obligations to address improper living conditions of an individual with significant impairments (*Marzari v. Italy*, no. 36448/97, § 1, 4 May 1999) or to take special measures to facilitate adequate access to and use of public buildings to people with impaired mobility (*Zehnalova and Zehnal v. Czech Republic*, no. 38621/97, 14 May 2002).

346. In recent years there has been severe and widespread criticism of systems where disabled people are placed in large-scale institutional settings (institutionalisation). Research shows that institutional care is often of an unacceptable standard, facilitating numerous breaches of human rights. Even where physical conditions are acceptable, individuals are effectively segregated from society, fundamentally undermining their human dignity. Institutions operate as warehouses for human beings.

347. It is critical to note that institutionalisation is not a response to the care or other needs of the persons with disabilities – the evidence overwhelmingly indicates that persons with disabilities are much better off in community-based settings. Rather it is a response to the perceived discomfort of mainstream society with disability –"it is better that these people are kept together in the middle of nowhere, locked up and heavily medicated, than living among us." For decades disabled people have been excluded and rejected by society – institutions are a State-sponsored expression of this stereotyping, discrimination and social exclusion.

348. In particular where people with intellectual disabilities are concerned, there is no sound basis for institutional care. Despite that fact, intellectual disabilities continue to be assimilated to mental health problems and receive the same treatment, i.e. institutionalization.

349. The alternative to institutionalisation is 'independent living', the provision of a flexible range of help and resources which can be assembled and adjusted as needed to enable all people with disabilities to live their lives in the way that they want but with the support and protection that they need. A substantial body of professional literature180 evidences that persons such as the applicant benefit far more from placement in community-living arrangements than from being forced to remain in an institution. Thus, people with psychosocial disabilities who reside in a variety of community settings experience improved adaptive behaviour, improved control over decision-making and improved perceived quality of life.

350. The preference for community-based arrangements rather than institutionalisation has increasingly been framed as a human right variably known as a ''right to independent living', 'a right to be free from institutionalisation' or a 'right to community integration'.

351. The right to independent living is recognised in the CRPD – Article 19 makes express provision for 'living independently and being included in the community'. However independent living is a major theme of the whole Convention. For example, the Preamble, significantly, recognizes the importance of persons with disabilities having "autonomy and independence, including the freedom to make their own choices." The general principles set out in Article 3 include 'the freedom to make one's own choices'

[180] Mansell J., Knapp M., Beadle-Brown J., Beecham J., (2007) Deinstitutionalization and community living: outcomes and costs - report of a European Study. Volume 2: Main Report. Canterbury: Tizard Center, University of Kent, accessible at http://ec.europa.eu/employment_social/index/vol2_web_report_en.pdf , p. 2-3, and the sources cited therein.

and full and effective participation of persons'. The purpose of Article 9, which requires States to take action to make a range of areas accessible to disabled people (such as the physical environment, public services and information), is to enable disabled people 'to live independently and participate fully in all aspects of life'. Similarly, Article 26, which deals with rehabilitation services, seeks to enable disabled people 'to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.'

352. The Council of Europe, through the European Social Charter, adopted in 1961, expressly to recognizes the rights of persons with disabilities. Article 15 of the Revised Charter (adopted by the Council of Europe, 3 May 1996) explicitly sets out a right to independent living, social integration and participation in the life of the community. It requires State parties to promote the full social integration and participation in the community of persons with disabilities through measures aimed at overcoming barriers to communication and mobility and enabling access to transport, housing, cultural activities and leisure.

353. This approach is not new. Thirty years ago, the Council of Europe addressed institutionalization within the context of intellectual disability in a 1977 recommendation, encouraging Member States to take long-term measures to reduce dependence on large institutions and to develop wide-spread community based services, with conditions approximating the "normal" environment of individuals.181

354. The Council of Europe renewed its commitment to the rights of people with disabilities to live in the community in 1992 when it recommended that States should "guarantee the right of people with disabilities to an independent life and full integration into society, and recognize society's duty to make this possible."182 The Recommendation also states that services should be provided to people with disabilities to enable persons to "be as free as possible from institutional settings and constraints" except where "unavoidable," and calls on countries to adopt policies "guaranteeing full and active participation in community life."183

355. In May 2003 the Committee of Ministers adopted the Malaga Ministerial Declaration on People with Disabilities. This Declaration reaffirms that the main aim of the next decade is to improve the quality of life of people with disabilities placing emphasis on their integration and full participation in society.184 A resultant Council of Europe Action Plan has been developed for the period 2006-2015.185 Significantly, Action Line 8 — entitled "Community Living"— focuses on enabling people with

[181] European Council, Recommendation 818 (1977) on the Situation of the Mentally Ill, Part II (i).
[182] Committee of Ministers, Recommendation (92) 6 *On a Coherent Policy for People with Disabilities*, adopted April 9, 1992 at the 474th meeting of the Ministers' Deputies, § I.4.
[183] Ibid at §§ I.1 and I.2.
[184] Declaration of Malaga at §17
[185] Committee of Ministers Recommendation Rec (2006) 5 *"Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving quality of life of people with disabilities in Europe 2006-2015"* ["Disability Action Plan"]

disabilities to live as independently as possible, empowering them to make choices on how and where they live. It specifies a need to focus on strategic policies that support the move from institutional care to community-based settings (ranging from independent living arrangements to small group homes) in order to achieve integration for persons with disabilities. Any policy on integration should therefore be flexible, covering programmes which recognize the specific needs of those individuals with disabilities who require a high level of support.186

356. In the European Community, Article 26 of the European Charter of Fundamental Rights (2000) provides that disabled people should benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community'. The European Parliament has similarly emphasized the need to discourage institutionalization in its Resolution on the Rights of Disabled Persons in terms of which it requests Member States to take measures to ensure adequate support to families of persons with disability and to secure the financial protection of persons with disability with a view to preventing their exclusion.187 The Resolution seeks to prevent institutionalization, which it recognizes can never be a substitute for an environment in which persons with disability can live independently.

As to the facts

357. The applicant submits that by failing to consider a community-based arrangement for him after his discharge from the Placement Centre, and placing him by default in long-term institutionalisation, the authorities acted in breach of their positive obligation under Article 8.

358. In Romania, social assistance legislation is premised firmly on the objective of enhancing the "autonomy" of vulnerable individuals, including persons with disabilities. Authorities sought to fulfil this objective by adopting Emergency Ordinance no. 102/1999 concerning the special protection and employment of persons with handicap, which provides persons with disabilities with a range of social benefits aimed at support their "professional and social integration".

359. The main instrument for defining the type of support needed by each disabled person is the "handicap group" ("grad de handicap"). The authority entrusted with examining people with disability and placing them in a disability group is the Commission for the Medical Examination of Adults with Handicap, a multidisciplinary group functioning at county level. In addition, the commission has to prepare an "individual program of recovery, readaptation and social integration" which includes the medical, professional and social measures necessary in order to achieve those purposes. In the process of preparing this program, the commission has to consult with the person with the handicap and/or their legal representatives.

[186] Ibid at § 3.8.1
[187] European Parliament, Resolution on the Rights of Disabled People, A4-0391/1996, § 25.

360. We have examined the flaws in the process whereby the applicant was placed in a disability group above. At this point, it suffices to say that the examination of 14 October 2003 did not serve its intended purpose. Rather it aimed to facilitate the applicant's institutionalization. The "individual program of recovery, readaptation and social integration" prepared on this occasion was extremely superficial and thus failed patently to address the central issue of the type of support the applicant needed in order to live in the community.

361. The possibility of identifying an arrangement whereby the applicant could live in the community after he reached majority age was equally ignored by the Department and the Commission, the institutions in change with the applicant's discharge from the Placement Centre and the identification of an institution willing to accept him.

362. Not only were those institutions not concerned with the applicant's right to community living – they were also bent on transferring him to a psychiatric hospital. We have seen already that this is mostly due to the misconception prevalent within the social assistance and medical professionals in Romania that intellectual disabilities are mental health problems, and that therefore the natural place to be for a person with a severe intellectual disability is a psychiatric institution, as opposed to a community-based arrangement.

(iii) The applicant received medical treatment without his informed consent (breach of negative obligation)

363. The Court has stated on numerous occasions that even a minor interference (including medical treatment) with the physical integrity of an individual must be regarded as an interference with the respect to private life under Article 8 if it is carried out against the individual's will (*Storck v. Germany*, no. 61603/00, § 142, ECHR 2005-V).

364. In the context of psychiatric treatment, international standards require the consent of a patient if they have the capacity to make the treatment decision in question (see, mutatis mutandis, *Storck v. Germany*, §143). If the patient lacks capacity, consent should be provided by a legal representative or tribunal[188]. If case of disagreement between medical professionals and the legal representatives of an incapable patient, the matter will be decided by a court (*Glass v. the United Kingdom*, no. 61827/00, ECHR 2004-II). These principles have been broadly transposed at the domestic level. Law no. 46/2003 concerning patients' rights provides that the patient (personally or through a legal representative) has the right to refuse a medical intervention, and sets out a procedure for seeking consent. The only circumstance where consent is not required is in case of emergency.

[188] Council of Europe Rec (2004) 10, Article 12§2; Council of Europe Recommendation Rec. (1999) 4, Principle 22§2l Convention on Human Rights and Biomedicine, ETS 164, Article 6. The relevant standards have also been included in Glass v. United Kingdom, §58.

365. Throughout his placement and subsequent hospitalisation at the Cetate Hospital and at the Poiana Mare Hospital, the applicant received sedatives and antipsychotic medication on a daily basis, in the absence of clear medical reasons and with uncertain effects on his health. This failure is consistent with the generally dismissive attitude displayed by the individuals and authorities involved in the applicant's care and treatment during the last months of his life. The applicant submits that this represented an interference with right to private life.

366. The applicant submits that the authorities failed to follow the procedure prescribed by Law no. 46/2003. In particular, the authorities failed to seek the applicant's consent for the medical treatment administered to him during his period. To the extent he was not capable to provide consent, the authorities failed to appoint a representative who could have provided him with the requisite support in this context. Therefore the decisions to provide the applicant with medical treatment and the provision of that medical treatment were not carried out in accordance with the law.

367. Finally, the decisions to provide the applicant with psychiatric medication lacked any clinical justification, the applicant had not been known to have any mental health problems, and no comprehensive psychiatric examination of the applicant had been carried out throughout his stay at the Cetate Hospital and subsequently at the Poiana Mare Hospital. Nor may these measures be justified on the basis of an emergency situation. The applicant therefore submits that the decisions to provide him with medical treatment were not "necessary in a democratic society".

VIOLATION OF ARTICLE 13 IN CONJUNCTION WITH ARTICLES 3, 5, 8 AND 14

368. The applicant submits that the absence of effective remedies in respect of the breaches of his rights under Articles 3, 8 and 14 amounted to a violation of Article 13 of the Convention.

369. Article 13 of the Convention guarantees the availability at the national level of a remedy to enforce the substance of the Convention rights and freedoms in whatever form they might happen to be secured in the domestic legal order (*Bayaseva v. Russia*). The effect of Article 13 is therefore to require the provision of a domestic remedy to deal with an 'arguable complaint' under the Convention and to grant appropriate relief. The remedy must be "practical and effective" and must not be unjustifiably hindered by acts or omissions of the authorities of the respondent State (*Aksoy v. Turkey*, 1996 – VI; 23 EHRR 553).

370. The remedy must be effective "in practice as well as in law" (Kudla v. Poland 2000 – XI; 35 EHRR 198 §157 GC). This includes providing a remedy that can prevent the alleged violation or its continuation, or one which can provide "adequate redress for any violation that has already occurred." (*Kudla v. Poland*, §157 – 8). In order to comply with Article 13 the remedy must also be accessible. In particular there must be sufficient procedural safeguards in place to make the remedy meaningful for the applicant. The

Court held this to be the case in *Chahal v. the United Kingdom*, where the applicant faced deportation but was not entitled to legal representation before the adjudicating panel and was only given an outline of the grounds for his deportation (*Chahal v. the United Kingdom*, judgment of 15 November 1996, Reports of Judgments and Decisions 1996 – V, para.154).

371. The Court has held that where an applicant has suffered torture or other ill-treatment contrary to Article 3, Article 13 requires "a thorough and effective investigation capable of leading to the identification and punishment of those responsible and including effective access for the complainant to the investigatory procedure (*Aksoy v. Turkey*, §98). Therefore even where an Article 13 remedy exists, if its exercise is unjustifiably hindered through the acts or omissions of the respondent State or if the investigation is incompetent or incomplete, this will amount to a violation of Article 13.

372. This Court will also have regard to the vulnerability of the victim in order to assess the compliance of a given remedy with Article 13. In *Keenan v. the United Kingdom* the applicant, who was mentally ill, was punished with imprisonment and segregation. The Court stated that if the applicant was incapable of making use of any remedy because of his mental illness that would not exempt the authorities from the obligation to provide a remedy (*Keenan v. the United Kingdom* no. 27229, para. 127, ECHR 2001 – III). The Court has also noted that States have a particular duty to act thoroughly and sensitively in cases concerning other categories of individuals who are particularly vulnerable, such as victims of rape (*Aydin v. Turkey*, §§103 and 107) or of torture (*Aksoy v. Turkey*).

373. The applicant submits that his capacity to access any remedy that might have been available to him under Romanian domestic law was drastically limited through the operation of a number of factors.

374. Firstly, during his stay at the Placement Centre, the Cetate Hospital and the Poiana Mare Hospital for the final months of his life, the applicant was under the complete control of staff in those institutions.

375. Secondly, the authorities failed to inform the applicant of any measures taken in his regard (such as the cancellation of his assignment to the Placement centre or his allocation to the medium disability group) presuming him to be incapable (incapable of understanding?), and thus preventing him from complaining against those measures.

376. Finally, the authorities failed to appoint a representative to the applicant who could have provided him with support in complaining against the measures taken in relation to him. Given his limited intellectual capacity, this omission amounted to a considerable bar to accessing any remedies that might have been available.

377. The applicant submits that the circumstances in which he was held at the Placement Centre, the Cetate Hospital and the Poiana Mare Hospital amounted to a complete bar to accessing any remedies that might have been available to him under

Romanian domestic law. During his stay in those institutions, the applicant was under the complete control of the staff working there.

VIOLATION OF ARTICLE 14 IN CONJUNCTION WITH ARTICLES 2, 3, 5 AND 8

378. Throughout the last months of his life, the applicant has suffered from extensive stigma and discrimination based on two grounds - his intellectual disability and his HIV-positive status. Although related (both may be subsumed to a more inclusive concept of 'disability') the two grounds operated in different ways. The applicant's intellectual disability was the main cause for his institutionalization in breach of Articles 5 and 8, whereas stigma associated with HIV status resulted in denial of medical care and treatment which ultimately led to his death. It is submitted that discrimination – stereotyping and chronic stigmatization based on disability - was at the core of the violations of the applicant's rights, and that accordingly he was subjected to discrimination in contradiction with Article 14 taken together with Articles 2, 3, 5 and 8.

As to the Law

379. In order for Article 14 to be applicable, a complaint of discrimination must fall within the scope of a Convention right, though there need not be a violation of the substantive right for Article 14 to apply (*Belgian linguistic case* (merits), judgment of 23 July 1968, Series A no. 6, § 9).

380. Discrimination involves treating differently, without an objective and reasonable justification, persons in relevantly similar situations (*Willis v. the United Kingdom*, no. 36042/97, § 48, ECHR 2002-IV*)*. If a difference in treatment has been shown by the applicant, the respondent Government must then demonstrate that this difference in treatment has an objective and reasonable justification (*Timishev v. Russia*, nos. 55762/00 and 55974/00, §57, ECHR 2005). "Objective and reasonable justification" is established if the measure in question has a legitimate aim and there is "a reasonable relationship of proportionality between the means employed and the aim sought to be realized" (*Rasmussen v. Denmark*, judgment of 28 November 1984, Series A no. 87, § 38; *Inze v. Austria*, judgment of 28 October 1987, Series A no. 126, § 41).

381. In *Thlimmennos v. Greece*, the Court held that Art. 14 can be breached not only when persons in analogous positions are treated differently without justification, but also when States without an objective and reasonable justification fail to treat differently persons whose situations are significantly different" (*Thlimmenos v. Greece* [GC], no. 34369/97, ECHR 2000-IV, §44).

382. As regards the question of what constitutes prima facie evidence capable of shifting the burden of proof on to the respondent State, the Court stated in *Nachova and Others* that in proceedings before it there are no procedural barriers as to the admissibility of evidence or pre-determined formulae for its assessment (*Nachova and Others v. Bulgaria* [GC], nos. 43577/98 and 43579/98, ECHR 2005-VII, §147). The Court adopts

the conclusions that are, in its view, supported by the free evaluation of all evidence, including such inferences as may flow from the facts and the parties. The level of persuasion necessary for reaching a particular conclusion and, in this connection, the distribution of the burden of proof are intrinsically linked to the specificity of the facts, the nature of the allegation made and the Convention right at stake.

383. Equality is one of the overarching values of the CRPD. Thus, Article 1 proclaims that the purpose of the Convention is to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities and to promote respect for their inherent dignity". Article 5 provides for the right to equality before the law without discrimination. The Convention then incorporates the principle of non-discrimination in many articles on substantive rights. It calls for non-discriminatory treatment and equality in access to justice during institutionalization, while living independently and in the community, in undertaking administrative tasks, in treatment by the courts and by the police, in education, in health care, in the work-place, in family life, in cultural and sporting activities, and when participating in political and public life. Crucially, the Convention ensures that all persons with disabilities are recognized before the law, and that they enjoy legal capacity on an equal basis with others in all aspects of life.

384. Although this Court has not yet found any violation of Article 14 on the ground of disability, other courts have addressed the matter of discrimination due to disability in this context.

385. In the case *Autism-Europe v France* (Complaint No. 13/2002, decision on merits November 2003), the European Committee of Social Rights found a violation of Article 15§1 and 17§1 alone or together with Article E of the Revised European Social Charter. Article E is the Charter's non-discrimination clause and is similar in its formulation and application to Article 14 of the Convention. The Committee considered that disability was adequately covered in the reference to 'other status' from Article E, the non-discrimination clause of the Charter. The Committee observed that this interpenetration of Article E was consistent with both the letter and the spirit of the Political Declaration adopted by Second 2nd European Conference of ministers responsible for integration policies for people with disabilities for people with disabilities (Malaga, April 2003), which reaffirmed the anti-discriminatory and human rights framework as the appropriate one for development of European policy in this field (at §52).

386. Internationally, the Supreme Court of Canada has adopted the clearest standards to be applied in cases involving disability discrimination. The most definitive articulation of disability rights has been in the matter of *Eldridge et al. v. British Columbia (Attorney General).*[189] The case involved the government's refusal to provide sign language interpretation to enable deaf patients to communicate effectively with medical professionals while in hospital. The Supreme Court ruled that the failure to provide sign language interpretation constituted indirect discrimination against deaf

[189] *Eldridge v. British Columbia (A.G.),* [1997] 3 S.C.R. 624

persons. Furthermore, the notion that governments are entitled to provide benefits to the general population without ensuring that disadvantaged members of society have the resources to take full advantage of those benefits was held to "bespeak a thin and impoverished vision of s. 15(1) [the equality provision within the Charter]."[190]

387. Importantly, the Supreme Court contextualised the fact that persons with disability in Canada had largely been excluded and marginalised. It held that:

> *It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization. Persons with disabilities have too often been excluded from the labour force, denied access to opportunities for social interaction and advancement, subjected to invidious stereotyping and relegated to institutions. This historical disadvantage has to a great extent been shaped and perpetuated by the notion that disability is an abnormality or flaw. As a result, disabled persons have not generally been afforded the "equal concern, respect and consideration" that s. 15(1) of the Charter demands. Instead, they have been subjected to paternalistic attitudes of pity and charity, and their entrance into the social mainstream has been conditional upon their emulation of able bodied norms.*[191]

388. The effects of social exclusion on the equal rights of persons with disabilities have been similarly recognized by the U.N. Committee on Economic, Social and Cultural Rights which has stated that:

> *[t]hrough neglect, ignorance, prejudice and false assumptions, as well as through exclusion, distinction or separation, persons with disabilities have very often been prevented from exercising their … rights on an equal basis with persons without disabilities. The effects of disability-based discrimination have been particularly severe in the fields of education, employment, housing, transport, cultural life, and access to public places and services*.[192]

As to the facts

389. It is submitted that the applicant was treated differently without justification on the basis of his intellectual disability and respectively his HIV status, combined and separately.

(i) Discrimination on the basis of intellectual disability

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[190] Ibid § 73
[191] Ibid § 56
[192] ICESCR Committee, General Comment 5, Persons with Disabilities, Eleventh session, 1994, UN Doc. E/1995/22, §15. The 2005 Report by Sheikha Hessa also recommended that governments "recognize that the disabled are persons first, and that their inclusion in society should be based on that criterion;" Report of the Special Rapporteur on Disability of the Commission for Social Development E/CN.5/2005/5 30 November 2004, at §101 and 116

The applicant had been reliably shown to have a very severe intellectual disability with an IQ of 30. On 14 October 2003 the Commission for the Medical Examination of Adults with Handicap issued a radically revised diagnosis which did not include any intellectual impairment. It has already been shown that serious doubts exist concerning the quality of that process and accuracy of the diagnosis. In any case, his care and treatment before and after that date was based on the assumption that he had a severe intellectual disability.

390. It has already been shown that the applicant suffered from extensive interferences with his rights. The violations of the applicant's rights under Articles 5 and 8 of the Convention – liberty, autonomy and physical integrity may be traced back to widely-held stereotypes concerning people with disabilities. The informality of the processes whereby he was deprived of his liberty, placed in institutions, administered treatment, as well as the failure to consult him or appoint any representative to support him as well as the seriousness of the abuses which took place reflect widespread assumptions that people with mental disabilities somehow lack the human quality which is a precondition for enjoying the protection of the laws. The staff and the authorities did not therefore engage in these abuses simply because they could do it (i.e given that the control mechanisms in place at the time where ineffective) but because they thought they were entitled to do it. This attitude is typified by the incantation of the 'severe intellectual disability IQ 30" diagnosis in all official correspondence related to the case, without anything else, as if in itself this justified the extraordinary regime applied to the applicant. This culminated with the insertion of "severe intellectual disability" as an underlying cause of death in the applicant's death certificate, ignoring the fact that intellectual disabilities is not in principle a lethal condition.

391. This case also reflects the long-held confusion between people with intellectual disabilities and people with mental health problems, who are often labelled as having "mental disabilities". In reality, although these groups face similar barriers to their social inclusion – such as widespread and deeply rooted stigma and prejudice and serious human rights abuses – there are significant differences between people with intellectual disabilities and people with mental health problems. "Intellectual disability" (or "developmental disability" or "learning disability") describes a range of generally life-long conditions whereby people have significant difficulties in learning and functional problems such as difficulties with receptive and expressive language. The degree of a person's intellectual disability can range in severity, from mild to profound, and the type of support necessary for the individual will vary accordingly. Intellectual disabilities include conditions such as Downs Syndrome and general "mental retardation". Mental health problems (or "psychosocial disabilities", or "psychiatric illness") on the other hand refers to a psychological or behavioral pattern that occurs in an individual and is understood to cause distress or disability that is not expected as part of normal development or culture. Psychosocial disabilities include dissociative disorders, anxiety disorders, psychotic disorders (such as schizophrenia) and many other categories. People with psychosocial disabilities are often treated with medication and other support, which can substantially mitigate the effects of the disability in certain people. While both groups have a common experience of social exclusion and being legally denied capacity, the daily lives and needs of people with intellectual disabilities differ drastically from

those of people with mental health problems. It is possible for someone with an intellectual disability to also develop mental health problems, but the symptoms and treatment of the two disabilities are completely different.

392. In this case, there is no suggestion that the applicant had mental health problems – he had an intellectual disability, as revealed by IQ tests and the observations of doctors. In the case at hand, the individuals and authorities involved in the applicant's care and treatment constantly treated the applicant as if he had a mental health problem, even in the absence of evidence in that respect. In September 2003 the Commission decided of its own motion and without providing any reasons, that the applicant should be transferred to the Poiana Mare Hospital. The lack of any consideration given to the possibility of identifying an arrangement whereby the applicant could live in the community, with appropriate support throughout the process of identifying an establishment willing to take him in evidences the same confusion. The applicant's is not an exceptional case is either; international agencies have reported that there is a practice in Romania of placing intellectually disabled persons in psychiatric hospitals (see above §258).

393. A failure to distinguish between these two groups may lead to the provision of inappropriate services and perpetuate negative attitudes leading to stigma and discrimination. On the other hand, understanding these differences helps ensuring that policies and other measures are relevant and appropriate to individuals in each of these groups. To the extent in which the Government failed to treat differently people in different situations, there has been a violation of Article 14.

(ii) Discrimination based on HIV status

394. It was already shown that Romania has a very large group of children and youth living with HIV. A comprehensive report published recently concluded that individuals belonging to this group suffer from pervasive stigma and discrimination that frequently impede their access to education, medical care, government services, and employment[193]. The report singled out the absence of a government plan in place to ensure that the thousands of children living with HIV who, at the age of 18, are excluded from existing social protection programs have the skills and support necessary to become productive, integrated adult members of Romanian society, as one of the main problems in this field.

395. The applicant submits that the difficulties associated with identifying an institution willing to accept him after he turned 18 was due to some extent to stigma associated with his HIV status. Thus, six of the seven centres for medico-social care contacted by the Department in January 2004 refused to accept the applicant although he fit their legal profile. Similarly, the Centre for Recovery and Rehabilitation of Persons with Handicap refused to accept the applicant on the basis he was "infested with the HIV infection".

[193] Human Rights Watch, *"Life Doesn't Wait": Romania's Failure to Protect and Support Children and Youth Living with HIV*, August 2006, p. 4, accessible at http://www.hrw.org/en/reports/2006/08/01/life-doesnt-wait .

396. The treatment the applicant received while at the Poiana Mare Hospital was significantly influenced by the applicant's HIV status. In particular the applicant's placement in an isolation room cannot be explained as therapeutic measure. The applicant submits that his isolation was based on widespread fear among staff and patients at the Poiana Mare Hospital in relation to his HIV infection. The CLR noted in their report on the visit to the Poiana Mare Hospital that "the staff manifested fear when they were asked to touch him". This may explain why during the last days of his life the applicant did not receive support with eating or personal care.

VI. STATEMENT RELATIVE TO ARTICLE 35 § 1 OF THE CONVENTION

397. Final decision (date, court or authority and nature of decision)

The final decision in this case is Criminal decision no. 191/4 April 2008, Dolj Tribunal.

398. Other decisions (list in chronological order, giving date, court or authority and nature of decisions for each of them)

- Resolution of the Prosecution Service of the Dolj Tribunal, 15 September 2004.
- Resolution of the Prosecution Service of the Dolj Tribunal, 24 September 2004.
- Resolution of the Prosecution Service of the Dolj Tribunal, 19 May 2005.
- Ordinance of the Prosecution Service of the Dolj Tribunal, 23 August 2005.
- Ordinance by the Prosecution Service of the Dolj Tribunal, 11 December 2006.
- Resolution of non-indictment by the Prosecution Office of the Calafat County Court, 30 March 2007.
- Resolution by the Head Prosecutor of the Prosecution Service of the Calafat County Court, 4 June 2007.
- Criminal judgment no. 186/3 October 2007 of the Calafat County Court
- Criminal decision no. 191/4 April 2008, Dolj Tribunal.

399. Is there or was there any appeal or other remedy available to you which you have not used? If so, explain why you have not used it.

No

VII. STATEMENT OF THE OBJECT OF THE APPLICATION AND PROVISIONAL CLAIMS FOR JUST SATISFACTION

400. The object of this application if for the European Court to find the Responding State in violation of Articles 2,3, 5, 8, 13 and 14 of the Convention.

401. No claims fro just satisfaction will be submitted.

VIII. STATEMENT CONCERNING OTHER INTERNATIONAL PROCEEDINGS

402. Have you submitted the above complaints to any other procedure of international investigation or settlement? If so, give full details.

No.

IX. LIST OF DOCUMENTS (NO ORGINAL DOCUMENTS, ONLY PHOTOCOPIES)

403.

1. Decision of the Commission, 30 September 2003.
2. Certificate of placement in disability group no. 16143/14 October 2003 issued by the Commission for the Medical Examination of Adults with Handicap affiliated with the Dolj County Council.
3. Letter of the Poiana Mare Hospital, 16 October 2003.
4. Medico-social evaluation.
5. Letter of the Commission, 22 October 2003
6. Letter of the Dolj Public Health Department, 10 November 2003.
7. Letter of the Department, 26 November 2003.
8. Letter of the Dolj County Department for Social Assistance, 11 December 2003.
9. Letter of the Department, 21 January 2004.
10. Letter of the Dolj County Public Health Department, 29 January 2004
11. Letters of the Department, 28 January 2004.
12. Referral note, 5 February 2004.
13. Inventory record, 24 February 2004.
14. Observation notes, Cetate Hospital.
15. Written note, 9 February 2004.
16. Referral note, 13 February 2004.
17. Observation notes, Poiana Mare Hospital.
18. CLR Report on the visit to the Poiana Mare Hospital.
19. CLR press release: "Tragic Situation at the Psychiatric Hospital Poiana Mare", 22 February 2003.
20. Letters sent by the CLR to various officials, 21 February 2004.
21. Death certificate no. 15/23 February 2004.
22. Letter by the Department, 24 February 2004.
23. CLR Letter, 1 March 2004.
24. Letter by the Department, 5 March 2004.
25. Letter by the Cetate Hospital, 5 March 2004.
26. Letter of the Poiana Mare Hospital, including statements by staff, 5 March 2004.
27. Order of the Dolj County Prefect, 8 March 2004.
28. CLR Request, 9 March 2004.
29. Letter by the Dolj Public Health Department, 24 March 2004.
30. Report by the commission of control set up in accordance with the Prefect's Order.

31. Letter sent by the National Authority for the Protection of the Child and Adoption, 18 March 2004.
32. Letter by the Department of Control of the Dolj County Prefect, 22 March 2003.
33. Letter to the General Prosecutor of Romania, 15 June 2004.
34. Complaint to the Prosecution Service of the Craiova First Instance Court, 15 June 2004.
35. Complaint to the Prosecution Service of the Craiova Tribunal, 15 June 2004.
36. Complaint to the National Authority for the Child's Protection and Adoption, 15 June 2004.
37. Statement by Natalia Ispas, 9 July 2004.
38. Statement by Elena Onel, 19 July 2004.
39. Statement by Lidia Ghitulescu, 19 July 2004.
40. Statement by Larisa Coderie, 21 July 2004.
41. Statement given by Maria Vieru, 22 July 2004.
42. Letter of the Prosecution Office affiliated with the High Court of Cassation and Justice, 20 August 2004
43. Request sent by Prosecution Office of the Dolj Tribunal to the Craiova Forensic Institute, 29 July 2004.
44. Forensic Report 3180/A3/14 September 2004 (first page only).
45. Memo sent to the Control Department of the Authority, 2 August 2004.
46. Memo sent to the Head of the Authority, 2 August 2004
47. Letter by the Authority, 10 August 2004.
48. Letter of the Prosecution Service of the Dolj Tribunal, 31 August 2004.
49. CLR Letter, 1 September 2004.
50. Resolution of the Prosecution Service of the Dolj Tribunal, 15 September 2004.
51. Letter by the Craiova Forensic Institute, 16 September 2004.
52. Resolution of the Prosecution Service of the Dolj Tribunal, 24 September 2004.
53. CLR information requests.
54. Report by the Prosecution Service of Dolj Tribunal, 25 October 2004.
55. Letter of the Authority, 27 October 2004.
56. Information note of the Prosecution Service of the Dolj Tribunal, 3 December 2004.
57. Forensic report, 2 February 2005.
58. Resolution of the Prosecution Service of the Dolj Tribunal, 19 May 2005.
59. CLR Complaint, 8 August 2005.
60. Ordinance of the Prosecution Service of the Dolj Tribunal, 23 August 2005.
61. Statement by Maria Vieru, 21 October 2006.
62. Statement by Tereza Poajga, 26 October 2005.
63. Statement by Florentina Dumitrescu.
64. Statement by Dorina Ionete, 8 December 2005.
65. Statement by Gheorghița Prodan, 8 December 2005.
66. Statement by Adelita Stefania Deliu, 14 December 2005.
67. Police reports, 8 December 2005
68. Statement by Daniela Mitroaica, 8 December 2005.
69. CLR Request, 16 December 2005.
70. Correspondence with the Clinic and the Placement Centre.

71. Request of the Dolj County Police Inspectorate, 11 January 2006.
72. Decision of the Discipline Commission of the Dolj County Medics' Association, 20 July 2006.
73. Decision of the Romanian Doctors' Association, 23 November 2006.
74. Ordinance by the Prosecution Service of the Dolj Tribunal, 11 December 2006.
75. Resolution of non-indictment by the Prosecution Office of the Calafat County Court, 30 March 2007.
76. CLR Complaint.
77. Resolution by the Head Prosecutor of the Prosecution Service of the Calafat County Court, 4 June 2007.
78. CLR Complaint, 10 August 2007.
79. Criminal judgment no. 186/3 October 2007 of the Calafat County Court.
80. Appeal brief, the Prosecution Service of the Calafat County Court, 31 January 2008.
81. Appeal brief, the CLR, 4 April 2008.
82. Criminal decision no. 191/4 April 2008, Dolj Tribunal.
83. "Deficiente in centrele de asistenta sociala", Gazeta de Sud, 28 august 2008, accessible at http://www.gds.ro/Olt%20si%20Valcea/2008-08-28/Deficiente+in+centrele+de+asistenta+sociala++ .
84. The CLR Statute.
85. Decision no. 3838/15 June 2006, The High Court of Cassation and Justice.
86. Domestic legislation compilation.

X. DECLARATION AND SIGNATURE

I hereby declare that, to the best of my knowledge and belief, the information I have given in the present application form is correct.

Place London
Date 23 April 2009

Padraig Hughes
Litigation Director
Interights

Constantin Cojocariu
Lawyer
Interights

Catalina Radulescu
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