EUROPEAN COURT OF HUMAN RIGHTS

Council of Europe

Strasbourg, France

APPLICATION

In the case of

MALACU and Others v. ROMANIA

Application No. 55093/09

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 APPLICANTS*

1. The First Applicant

Surname:	Barbu
First name(s):	Maricica
Sex:	female
Nationality:	Romanian
Occupation:	unemployed
Date and place of birth:	25 April 1969 Murgaşi Village Dolj County
Date of death:	15 January 2004
Permanent address	n/a

2. The Second Applicant

Surname:	Beştea
First name(s):	Maria
Sex:	female
Nationality:	Romanian
Occupation:	unemployed
Date and place of birth:	4 June 1937 Brazda lui Novac Village, Dolj County,
Date of death:	17 January 2004
Permanent address	n/a

3. The Third Applicant

Surname:	Ticu
First name(s):	Dumitru
Sex:	male
Nationality:	Romanian
Occupation:	unemployed
Date and place of birth:	1942 (precise date unknown), place of birth unknown

Date of death: 28 January 2004
Permanent address n/a

4. The Fourth Applicant

Surname: Istrate
First name(s): Ioana

Sex: female
Nationality: Romanian
Occupation: unemployed
Date and place of birth: 2 February 2004, Călăraşi Village, Dolj County
Date of death: 28 January 2004
Permanent address n/a

5. The Fifth Applicant

Surname: Malacu
First name(s): Miorița

Sex: female
Nationality: Romanian
Occupation: unemployed
Date and place of birth: 1972 (precise date unknown), place of birth unknown
Date of death: 7 February 2004
Permanent address n/a

6. *Name of representative* ***Centre for Legal Resources***

7. *Occupation of representative:* Nongovernmental organization

8. *Address of representative*: Str. Arcului nr. 19, Sector 2, Cod 021034, Bucuresti, Romania

9. *Tel:* +40 21 212 06 90 *Fax:* +40 21 212 05 19

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

B. *THE HIGH CONTRACTING PARTY*

11. **ROMANIA**

II. STATEMENT OF THE FACTS

Introductory observations

12. This application concerns the circumstances surrounding the deaths of the five applicants and the official investigation arising out of those deaths. The applicants died during the period January to February 2004 at the Poiana Mare "Hospital of Psychiatry for Maximum Security Measures" ("*the Hospital*"), a large residential complex for people with disabilities situated in an isolated countryside location in the South Eastern part of Romania and run by the country's Ministry of Health. The applicants' deaths were a part of a long-lasting and well-documented pattern. When the Council of Europe Committee for the Prevention of Torture ("*the CPT*") visited the establishment for the first time in 1995, it found that 61 patients died during just seven months (21 February – 28 September 1995)[1]. The third visit of the CPT was prompted by another spike in the mortality rate – 68 deaths in 2002, 87 deaths in 2003, and 28 in the first five months of 2004, with most deaths having occurred during winter time[2]. Even today reports of suspicious deaths and other abuses committed at the Hospital continue to come to public attention (see below §157).

13. The applicants were aged between 32 and 66 years old when they died. According to information entered in their death certificates, all applicants but one died because of heart-related conditions. At least two applicants were severely underweight when they died. One applicant, Maria Beştea, died because of a cranial traumatism in circumstances which have not yet been fully clarified. Two applicants suffered from intellectual disabilities, two suffered from schizophrenia and one from depression. Two applicants had lived all their lives in social care institutions, having been transferred to the Hospital directly from placement centres for disabled minors. The other three applicants had spent between eight and ten years of continuous hospitalisation before they died. All applicants either lacked any known relatives, or were effectively abandoned by their families. All applicants were hospitalised on a so-called "voluntary" basis, at the initiative of their family members and/or authorities, on the basis of outdated legislation, with scant regard for their rights to liberty or to live in the community.

14. All applicants belonged to the group of so-called "social cases", socially-marginalised people, with no family, income or home, who may or may not have had an associated mental health problem at the time they were hospitalised. Instead of devising adequate community-based support measures, authorities are placing "social cases" in social care institutions where they are subjected to extremely difficult circumstances. As exemplified by the case at hand, the Hospital does not provide any mental health treatment, but instead is aimed at restricting the freedom of movement and controlling certain people portrayed as disabled. The system is not targeted at rehabilitation and

[1] 1995 CPT report, § 177, exhibit 175.
[2] 2004 CPT report, §11, exhibit 177; list of patients who died at the Hospital in 2002 and 2003, exhibit 178; List of patients who died at the Hospital between January 2004 -May 2005, exhibit 179.

increasing the chances of people concerned to live in the community, but rather it aims to isolate them from society subjecting them to extremely sub-standard living conditions amounting to inhuman and degrading treatment in the process.

15. As illustrated at paragraphs 76-92 living conditions at the Hospital during the winter of 2003/2004 when most deaths occurred were extremely unsatisfactory. The patients' diet was very basic and quantitatively insufficient. Most of the time there would be no heating in the Hospital wards, during a time when temperatures outside frequently fell below -10° Celsius. Likewise, Hospital hygiene was very poor, which led to frequent outbreaks of pediculosis and other infections. The Hospital wards were frequently overcrowded, with patients lacking adequate clothing and any control over their private space.

16. As illustrated at paragraphs 93-107, the quality of treatment and care provided by the Hospital was extremely poor. The Hospital was severely understaffed, personnel lacked adequate qualifications to deal with psychiatric patients, essential professionals such as psychotherapists, occupational therapists, or psychologists were absent altogether. The Hospital lacked sufficient supplies of essential medicine and adequate medical equipment. Despite the paucity of means at the Hospital, referrals to specialised external establishments of patients with aggravated health conditions were extremely rare.

17. It is submitted that the wholesale placement of "social cases" (a group to which the applicants belong) in psychiatric hospitals thereby depriving them of any chances to live in the community amounts to inhuman and degrading treatment in violation of Articles 3 and 8. Furthermore, a combination of factors including substandard living conditions and inadequate medical care and treatment greatly contributed to the applicants' deaths, in breach of their right to life, as well as being in breach of the prohibition against torture and inhuman and degrading treatment. The official investigation into the circumstances surrounding the applicants' deaths was profoundly flawed, completely failing either to establish the causes of the tragedy, bring those responsible to justice or trigger the reform of the mental health system in Romania. In addition, it is submitted that the treatment of the applicants before their deaths, the circumstances of their deaths and the subsequent investigation were discriminatory on account of disability and social status.

18. It is submitted that the unique and extreme circumstances of the case justify adapting the standing requirements set by the Court in order to allow the Centre for Legal Resources ("*the CLR*") to bring an application on the applicants' behalf. This is supported by the applicants' extreme vulnerability, as persons with disabilities isolated in a psychiatric hospital for a long period of time, the lack of any alternative sources of representation for the applicants - in particular the demonstrable absence of a family, the fact that the CLR has been recognised standing to pursue proceedings on the applicants' behalf by the highest domestic court in Romania, and finally, the paramount general interest in ensuring adequate and effective protection to persons with disabilities under

the Convention, also taking into account the Court's mission to provide effective protection to vulnerable minority groups.

The applicants' individual circumstances

(i) Maricica Barbu

19. Maricica Barbu died on 15 January 2004 at the age of 34, after having spent most of her life in social care institutions. Early on during her hospitalisation, her medical record ("*foaie de observaţie clinică*") indicated that she was "friendly and kind"[3], that she was participating in cleaning chores and that she was very helpful towards auxiliary personnel as well as towards other patients in her ward[4].

20. In 1974 at the age of 5, Maricica Barbu was hospitalised at the juvenile neuropsychiatry ward of the hospital in the Poiana Mare village[5]. She remained there until 19 June 1985, when she was transferred to the Hospital, with the diagnosis of "microcephaly, infantile encephalopathy and severe retardation" ("*encefalopatie infantila, microcefalie, oligofrenie gr. III*"). Her symptoms at the time were "psychomotor agitation, stereotypical behaviour and verbal expressions" ("*neliniste psihomotorie, expresii verbale si comportament stereotip*")[6]. During the first period of her stay at the Hospital, the entries in her medical record reflected a consistently positive state of mental health[7].

21. On 7 January 1986 Barbu underwent an abortion which was justified on the basis that she was a "psychiatric patient" and that "she lacked capacity"[8]. Medical personnel do not appear to have sought her consent for undertaking this operation.

22. Barbu was formally discharged from the Hospital on 26 July 2002 and readmitted "upon her request" three days later on 29 July 2002[9]. Also on this occasion a full medical examination was carried out. The psychiatric diagnosis remained the same and symptoms at hospitalisation were "psychomotor agitation, classical crises, verbal and behavioural stereotypes" ("*neliniste psihomotorie, crize clasice, stereotipii verbale si de comportament*")[10]. The entries in her medical record until she died were both consistent and brief, stating that Barbu was either "uncooperative and peaceful" or "uncooperative and restive"[11]. Throughout hospitalisation, Barbu had been administered neuroleptics, sedatives and tranquilisers[12].

[3] Medical record 19 June 1985-26 July 2002, 27 February 1989, exhibit 1.
[4] Idem, 2 November 1988.
[5] Idem.
[6] Idem.
[7] Idem.
[8] Record of interruption of pregnancy, 7 January 1986, exhibit 3.
[9] Medical record 29 July 2002-15 January 2004, exhibit 2.
[10] Idem.
[11] Idem.
[12] Idem.

23. Just before her death, on 12 January 2004, Barbu suffered from a furuncle in the orbital area, for which she received treatment with antibiotics[13]. Her medical record does not contain indications of any other specific health problems until the day she died when the following entry was made:

> *"The patient displays generally altered state, irregular breathing, there is no heating in the ward when outside there are -10° Celsius."*[14]

24. In view of her state, Barbu received vitamins, antibiotics and a glucose drip. Later that day the doctor on duty pronounced her dead and noted that "there were no indications of a violent death"[15]. According to the death certificate, the immediate cause of death was a cardio-respiratory failure, caused by bronchopneumonia[16].

25. No autopsy was carried out in this case. The forensic examination ordered by the Prosecutor's Office attached to the Dolj Tribunal ("*the Dolj Prosecutor's Office*") concluded as follows:

> 1. *The death of Barbu Maricica aged 34 was not violent (pathologic).*
> 2. *We consider that the diagnosis and the entries in the medical record and the cause of death mentioned in the death certificate are in concordance.*
> 3. *We consider that the treatment administered for the psychiatric condition […] was correct and adequate, and the treatment for the bronchopneumonia mentioned in the medical record was correct but insufficient and applied with delay.*
> 4. *We consider that an exhumation is not necessary.*[17]

26. On two occasions[18], representatives of the Prosecutor's Office attached to the High Court of Cassation and Justice ("*the High Court Prosecutor's Office*") highlighted a series of shortcomings in the official investigation, as follows:

- the causes and those responsible for the delay and insufficiency of the treatment administered for the applicant's pulmonary ailment were not fully determined;
- the causes and those responsible for the precarious state of hygiene which caused the furuncle just before Barbu 's death were not fully determined;
- those responsible for not ordering Barbu's timely transfer to an establishment specialised in pulmonary diseases were not identified.
- the cause for the failure to carry out full clinical and laboratory tests in order to establish Barbu's health state was not clarified.

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[13] Idem.
[14] Idem.
[15] Idem.
[16] Death certificate, 15 January 2004, exhibit 4.
[17] Forensic report, 25 March 2004, exhibit 6.
[18] The "Voicu" and "Sampetru decisions": Resolution of the High Court Prosecutor's Office, 31 August 2004/Maricica Barbu, exhibit 48, Resolution of cancellation, High Court Prosecutor's Office/Maricica Barbu, exhibit 67.

- the notes entered in the medical record were incomplete, irregular and there is no agreement between information included in the medical record and the cause of death entered in the death certificate.

(ii) Maria Beştea

27. Maria Beştea died on 17 January 2004 at the age of 66, after multiple periods of hospitalisation, the latest one lasting for approximately eight years (5 July 1996 – 20 January 2004). Medical staff described Beştea as a "peaceful" person, who "caused no harm"[19].

28. Beştea's diagnosis at hospitalisation was paranoid schizophrenia, with symptoms of "psychomotor agitation, unsystematic delirious idea, and bizarre behaviour" ("*neliniste psihomotorie, idei delirante nesistematizate, bizarerii de comportament"*)[20]. Throughout hospitalisation, she had been administered neuroleptics and tranquilisers. The observations entered weekly in her medical file tend to be fairly repetitive, stating that she was 'cooperating with difficulty", "peaceful", "delirious" or "incoherent"[21]. No relationship appears to exist between the quantity or type of antipsychotic medication administrated and the applicant's actual state of health.

29. Very few notes refer to Beştea's somatic state – she had dental problems a number of times during her hospitalisation, which were treated with antibiotics, and without specialised assistance. Occasionally, she displayed problems with deglutition[22].

30. Although Beştea's medical record is silent on this, it appears that her situation deteriorated considerably towards the end of 2003. On 28 November 2003, without any explanation, she was sent for a multidisciplinary examination to an external medical establishment. The ear, nose and throat doctor noted that she suffered from oesophageal stenosis ("*stenoza esofagiana*"), and referred her to a surgeon. The latter attempted to undertake a medical procedure to address her throat problems ("*tranzit baritat*"), which was ultimately unsuccessful[23]. Beştea was eventually sent back to the Hospital without having received any treatment, and without any amelioration of her state of health.

31. The following notes concerning Beştea's somatic state infrequently registered a major weight loss due to the stenosis which made intake of normal nutrition impossible. Despite the general deterioration in her state of health, she received no specific medication other than vitamins and a glucose drip a few days before her death. The last note made while the applicant was alive on 14 January 2004 indicated that she required urgent specialised examination and treatment, but none was forthcoming. In a marginal

[19] Statements of Andrei Marius, Segarceanu Aurelia Lavinia, exhibits 88, 90.
[20] Medical record, 5 July 1996 – 20 January 2004, exhibit 9.
[21] Idem.
[22] Idem.
[23] Idem.

note, a doctor recommended that the medication allocated to a different patient be transferred to her, without mentioning the type of medication[24].

32. Beştea died on 17 January 2004 at 4.00 am. She was cachectic at the time of her death. In light of the subsequent discovery that Beştea died from a violent cranial traumatism, the circumstances of her death merit closer inspection. Grigorescu Ioana, the psychiatrist who was the head of pavilion where Beştea was hospitalised, and who was supposed to be on night duty, was on leave on 17 January 2004[25]. Therefore an unidentified member of staff informed Calina Viorica, the psychiatrist running a different pavilion, about Beştea's death, and she made the requisite note in the applicant's medical record as follows:

> *17.01, 4.00 hours: I was informed that the patient died. Under examination, the body did not display traces of violence*[26].

33. The final note in the applicant's medical record stating the cause of death and which was required by the law ("*epicriza*") was entered by Lidia Ghitulescu, another psychiatrist, three days after Beştea died, on 20 January 2004[27]. The death certificate was completed by yet another psychiatrist, Prodan Gheorghita, on 19 January 2004, and stated that Beştea died from a cardio-respiratory failure, caused by an ischaemic cardiopathy[28].

34. According to information submitted by the Hospital during the official investigation, Calina Viorica was the only psychiatrist on duty in the night of 16/17 January 2004[29]. Considering her note concerning Beştea's death, there are serious doubts she actually examined the body. In any case, the statement she gave during the investigation does not include anything about the circumstances in which Beştea died[30]. Instead, Prodan Gheorghita, who was not on duty that night claims in her statement that she examined Beştea's body personally and did not notice any signs of violence![31] The prosecuting authorities did not pay attention to these incongruities.

35. The Dolj Prosecutor's Office ordered for a forensic examination to be carried out concerning the circumstances in which Bestea died and which concluded as follows:

1. *The death of Maria Bestea aged 66 was not violent (pathologic).*
2. *We consider that the diagnosis and the entries in the medical record and the cause of death mentioned in the death certificate are concordant, the syndrome of malnutrition being due to the oesophageal stenosis which could have lead to a cardiac insufficiency.*

[24] Idem.
[25] Statement Ghitulescu Lidia, 14 September 2004, exhibit 92-93.
[26] Medical record, 5 July 1996 – 20 January 2004, exhibit 9.
[27] Idem.
[28] Death certificate, 20 January 2004, exhibit 10.
[29] Letter of the Hospital, 12 October 2004, exhibit 50.
[30] Statement Calina Viorica, 16 September 2005, exhibit 105.
[31] Statement Prodan Gheorghita, 14 September 2004, exhibit 99.

3. *The treatment administered to the above mentioned during hospitalisation, was adequate for the psychiatric condition, and for the other ailments it was palliative; as a result of the impossibility of undertaking an investigation it was impossible to establish a therapeutic approach (medical and/or surgical).*
4. *The symptomatic treatment [applied in response to Beştea's symptoms] (vitamins, glucose) was recommended too late.*[32]

36. Subsequently the Dolj Prosecutor's Office ordered that an autopsy be carried out. The autopsy took place on 16 April 2004, three months after Beştea's death. The conclusions from the autopsy were the following:

1. *The death of the said Maria Bestea aged 66 was violent.*
2. *It was due to a cardio-respiratory failure, the consequence of a diffuse meningaeal haemorrhage, the consequence of a cranial-cerebral traumatism.*
3. *The violent lesions could have been caused by a hit with or by solid objects (most probably a fall*[33]*) on an organism with multiple ailments.*
4. *Between the violent lesions and the death there is direct and unconditional relationship.*
5. *There are no traces of medical or surgical treatment on the body.*[34]

37. The reasons why the Dolj Prosecutor's Office singled out Maria Bestea for an autopsy are unclear, given that the conclusions of the forensic report in her case did not differ fundamentally from those in the reports concerning the other applicants. It is however significant that one of the only two autopsies undertaken by the investigating authorities in the case at hand dramatically altered the original cause of death, as entered on Bestea's death certificate.

38. Despite the findings from the autopsy, on 7 June 2004 the Dolj Prosecutor's Office issued a decision of non-indictment[35]. The Prosecutor's Office sought to explain the violent traumatism as follows:

> *Thus, [witness statements] show that the patient Bestea Maria was generally peaceful, but during fits she became aggressive, getting hurt when she fell down.*
>
> *The witness statements are supported by her medical record, and the forensic evidence collected scientifically proves the possibility that the lesion may be the result of a fall.*
>
> *Furthermore, considering the degree of deterioration of the victim's body, in the context of inadequate food intake – as shown by the evidence collected – the victim could not practically keep her balance anymore which directly caused*

[32] Forensic report, 26 March 2004, exhibit 12.
[33] This hypothesis was endorsed subsequently by the National Forensic Institute, Forensic report, National Forensic Institute, 17 October 2004, exhibit 15.
[34] Forensic report on exhumation and annexes, 4 June 2004, exhibit 14.
[35] Resolution of non indictment, Dolj Prosecutor's Office, 7 June 2004, exhibit 40.

her to fall. Furthermore, even the medical record contains entries referring to the fact that the victim could not feed herself and therefore the body had no possibility to recover either.

Given the above, we consider that the lesions found were caused by a fall, possibly during a fit.

39. The resolution of the High Court Prosecutor's Office dated 31 August 2004[36] highlighted a number of shortcomings in the official investigation concerning the death of Maria Bestea, both in relation to the treatment she received before she died, as well as in relation to the circumstances in which she died:

- the investigators failed to clarify fully who was responsible for treating a cardiac condition with delay, insufficiently, and with palliatives;
- the investigators failed to clarify the reasons why Beştea's somatic health problems had not been investigated despite the fact that symptoms had been apparent for years;
- the investigators failed to identify those responsible for the failure to order Beştea's transfer to a specialised external medical establishment which could have provided adequate treatment for her ailments;
- members of staff should have been questioned in order to clarify the circumstances in which Bestea died, "especially since the patient did not suffer from epilepsy".

(iii) Dumitru Ticu

40. Dumitru Ticu[37] died on 28 January 2004, at the age of 62, after a hospitalisation of approximately eight years (from 23 December 1996 until he died) for paranoid schizophrenia.

41. After his hospitalisation, and until 8 July 2003, Ticu continuously received only psychiatric medication, despite the fact that the entries in his medical record consistently showed that he was "peaceful, cooperative"[38]. Starting from 10 July 2003, Ticu's health state started to become more problematic. On 21 July 2003 he had "a generally mediocre state, he was afebrile, he lacked appetite, he had pale teguments, he experienced loss of weight, parkinson-type tremor in limbs"[39]. Despite these findings, the treatment with psychiatric medication continued unmodified.

42. Starting from 23 July 2003, Ticu started having diarrhoea with abdominal cramps, lacked appetite, and was losing weight[40]. The doctor interpreted these symptoms as signalling gastric problems, and started administering specific medication. Before he died, Ticu also had pediculosis. On 22 January, he was referred to the Calafat Hospital in

[36] Resolution of the High Court Prosecutor's Office, 31 August 2004/Maria Bestea, exhibit 45.
[37] The description of Ticu's health state during his hospitalisation is based on indirect accounts – his medical records were not collected in the investigation file and therefore the CLR did not have access to them (see below §44).
[38] Resolution of cancellation, High Court Prosecutor's Office/Dumitru Ticu, exhibit 66.
[39] Idem.
[40] Idem.

order to remove an infected lipoma diagnosed as early as 9 January 2004. On 26 January 2004 Ticu's general state deteriorated markedly. Consequently the psychiatric treatment was stopped while the treatment for his perceived gastric problems continued. Dumitru Ticu was pronounced dead on 28 January 2004. The cause of death mentioned in the death certificate was a myocardial infarction which led to a fatal cardio-respiratory failure. The certificate also mentioned paranoid schizophrenia, secondary anaemia, and cachexia as associated conditions at death.

43. The forensic report issued in relation Dumitru Ticu's death concluded as follows:

- *between the digestive symptoms, the unfavourable evolution mentioned in the medical record, and the cause of death there is no concordance;*
- *the diagnosis of myocardial infarction is not supported from a clinical and laboratory point of view;*
- *A multidisciplinary consult would have been necessary including full investigations in order to establish with certainty the causes of the existing symptoms.*
- *The treatment applied to the patient was palliative, based solely on external symptoms and insufficient for the digestive symptoms,*
- *An exhumation would not bring new information allowing the case to be elucidated*[41].

44. Prosecutors from the High Court Prosecutor's Office highlighted a series of gaps in the official investigation on two occasions[42]. They averted to the fact that at least some of the applicant's problems might have been the side effect of unrestrained use of neuroleptics. The Prosecutor's Office stated squarely that the Hospital doctors interpreted erroneously the symptoms displayed by the applicant, and consequently administered treatment for supposed gastric problems instead of what proved to be cardiac problems. Finally, the Prosecutor's Office highlighted the lack of hygiene at the Hospital, as demonstrated by the lipoma and the pediculosis the applicant suffered from and the fact that the applicant's medical records were actually missing from the investigation file.

(iv) Ioana Istrate

45. Ioana Istrate died on 2 February 2004 at the age of 68 after multiple periods of hospitalisation at the Hospital[43]. The latest uninterrupted stretch of hospitalisation lasted for approximately ten years since 29 June 1994 until she died.

46. Istrate's psychiatric symptoms at hospitalisation were "psychomotor agitation, behavioural problems, delirious ideas" ("*agitatie psihomotorie, tulburari de comportament, idei delirante*") corresponding to a diagnosis of "old age depression"

[41] Idem.
[42] Resolution of the High Court Prosecutor's Office, 31 August 2004/Dumitru Ticu, exhibit 47; Resolution of cancellation, High Court Prosecutor's Office/Dumitru Ticu, exhibit 66.

[43] Medical record, 29 June 1994 - 2 February 2004, exhibit 16.

("*depresie de involutie*") which she kept until she died[44]. Throughout her hospitalisation, Istrate's medical file typically recorded her mental state as being "calm and uncooperative" ("*linistita, slab cooperanta*"). However, a note dated 11 March 1998 indicated that she was "calm, cooperative" and went on to state the possibility of "release from hospital possible, but family opposes it"[45].

47. Very few of the entries in Istrate's medical file were made by GPs (as opposed to those made by psychiatrists), and most of them refer to dental problems, up until her death[46]. However, she was never referred to a specialised unit, being typically treated with painkillers. Istrate's medical file did not record any significant deterioration of her health condition in the run-up to her death - only diarrhoea, lack of appetite and headaches, for which she received vitamins or anti-diarrheal medication. According to the entry dated 14 January 2004 Istrate was supplied with the medication prescribed to another patient, without mentioning the type of medication and the reasons for this prescription. On 2 February 2004 Istrate displayed a weak arrhythmic heartbeat, she was cooperative, she did not respond to verbal and painful stimuli, her tegument was pale, and her limbs cold. Later in the evening of the same day she was pronounced dead. The death certificate briefly mentioned that the death was due to a cardio-respiratory failure, itself the result of an acute myocardial infarction and old age depression[47].

48. A forensic report dated 12 March 2004, elaborated at the request of the Dolj Prosecutor's Office, concluded briefly as follows:

> *The death of Istrate Ioana aged 68 was not violent (pathologic).*
> *Considering the evolution and symptoms displayed it is possible that the above mentioned could have suffered from a myocardial infarction (insufficiently investigated), for which we are of the opinion that the treatment administered had been inadequate.*
> *For the dental condition (dental abscess), the treatment was adequate but insufficient, in the absence of a dental consult.*
> *For the mental condition the treatment was correctly prescribed.*
> *We consider that an exhumation is not necessary.*[48]

49. The Prosecutor's Office highlighted a series of gaps in the official investigation on two occasions[49]. Thus, it noted that the digestive problems which Istrate experienced in December 2003 were a side effect of long term treatment with neuroleptics. Hospital staff failed to recognise Istrate's cardiac problems, and instead treated her for what they perceived as digestive problems. Eventually, in the absence of treatment, the heart condition proved to be fatal. The investigation did not identify those responsible for the

[44] Idem.
[45] Idem.
[46] Idem.
[47] Death certificate, 4 February 2004, exhibit 18.
[48] Forensic report, National Forensic Institute, 17 November 2004, exhibit 20.
[49] Resolution of the High Court Prosecutor's Office, 31 August 2004, exhibit 46, Resolution, High Court Prosecutor's Office, 11 February 2005, exhibit 68.

failure to transfer Istrate to a specialised external medical establishment, for setting a mistaken diagnosis and prescribing inadequate medication.

(v) Miorița Malacu

50. Miorița Malacu died on 7 February 2004, at the age of 32[50], from a myocardial infarction/cardio respiratory failure sequence, after having spent all her life in institutions for people with disabilities. At the time of her hospitalisation, Malacu was "integrated in the [Hospital] community, friendly"[51]. A witness questioned during the investigation stage confirmed that "although she was a mental patient, she [did not] trouble anybody and did not enter into conflict with anybody"[52].

51. Malacu grew up in a social care institution for children ("*Căminul de copii Corlate*"). She was transferred to the Hospital after she turned 18, on 27 March 1990. Her diagnosis at the time was "severe retardation, epilepsy, congenital strabismus" ("*oligofrenie gr. III, epilepsie, strabism congenital*"[53]).

52. Immediately after entering the Hospital, Malacu became pregnant. Her medical record noted that she was referred to an external establishment where she underwent an abortion during the 6th month of pregnancy[54].

53. During hospitalisation she suffered from numerous health problems. One recurring problem was that of cuts on her body, the origin of which was never examined[55]. On one such occasion she was referred to the Hospital No. 1 in Craiova, where she was hospitalised for more than three months, between 19 September 2001 and 27 December 2001[56]. There she received treatment for extensive slashes on her arms and buttocks. She received anaesthetics and her cuts were cleaned and stitched. More serious cuts were treated with skin grafts. At the same time medical staff discovered that she was infected with syphilis.

54. The entries in Malacu's medical record invariably record throughout her hospitalisation that she was "peaceful" and/or "cooperative"[57]. From 14 January 2004, her medical record noted that Malacu refused to leave the bed and lacked appetite. On 21 January 2004 the doctor on watch discovered that she had pediculosis, and ordered that she be isolated, disinfected and washed. After this time and until she died on 7 February 2004, Malacu's state of health deteriorated constantly, such that she stopped responding

[50] There is no information in the investigation file concerning Malacu's date of birth, only her age.
[51] Medical record (27 March 1990-7 February 2004), p. 3, exhibit 23.
[52] Resolution of non indictment, Dolj Prosecutor's Office, 7 June 2004/Miorita Malacu,p.3, exhibit 39.
[53] Medical record (27 March 1990-7 February 2004), exhibit 23.
[54] Idem; after the abortion, Malacu's medical record noted with devotion every menstruation period until she died.
[55] See for example 22 February 1995, 6 July 1995, 25 January 1995, 16 March 1995, 24 January 1997, 14 September 2001, 16 May 2003, Idem.
[56] Discharge note, 27 December 2001, exhibit 25.

[57] Medical record (27 March 1990-7 February 2004), exhibit 23.

to any external stimuli. It appears that the applicant did not receive any medication other than tranquilizers until she died.

55. The forensic report dated 23 March 2004 by the Craiova Forensic Medicine Institute concluded as follows:

> *" The death of Malacu Miorita, aged, 32, was not violent (pathologic).*
> *We consider that the cause of death mentioned in the death certificate is not supported by the symptoms and the evolution of the patient's state of health; the notes made in the medical record point towards a probable diagnosis of septicaemia with multiple starting points, in a body with marked low immunity.*
> *On this basis, we consider that it is necessary to undertake the exhumation in order to establish the cause of death.*
> *We consider that the treatment for the psychiatric condition was correct and adequate, while the treatment for the respiratory symptoms was correct but insufficient."*[58]

56. The Dolj Prosecutor's Office ordered that an exhumation be undertaken, and asked the forensic experts to elucidate the following questions:

- *the medical cause of death*
- *any signs of violence and explanations as to their origin, and the possible relationship of causality with the death;*
- *traces of medical treatment, and if this was adequate from a medical and therapeutic point of view;*
- *if considered necessary, an analysis of tissue and organs to be undertaken with a view to establishing the cause of death on the basis of laboratory tests.*[59]

57. The exhumation took place on 30 March 2004, almost three months after Malacu's death. Since she didn't have any relatives, she was buried in the hospital cemetery. At exhumation she was found undressed in the coffin, and only covered with a skirt and a t-shirt. The forensic report concluded very briefly and without further explanations that she died a non-violent death and that this was due to an "acute cardio-respiratory insufficiency which was the result of a pulmonary oedema on a body with multiple organic ailments"[60].

58. At a later stage of the proceedings Malacu's medical records including the forensic reports were submitted to the "Mina Minovici" National Institute of Forensic Medicine ("*the National Forensic Institute*"). Besides reiterating the conclusions made in relation to the other applicants' deaths, the Institute briefly and cryptically stated that "we do not agree with the forensic exhumation report" undertaken in relation to Miorita Malacu's death[61].

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[58] Forensic report, 23 March 2004, exhibit 28.
[59] Letter of request, Dolj High Prosecutor's Office, 26 March 2004, exhibit 29.
[60] Forensic report on exhumation, 3 June 2004 exhibit 30.
[61] Forensic report, National Forensic Institute, 17 November 2004, exhibit 32.

59. The High Court Prosecutor's Office highlighted a series of gaps in the official investigation on two occasions[62]. Thus, the investigation failed to clarify fully who was responsible for the failure to provide adequate treatment for Malacu's pulmonary disease and who was responsible for the precarious hygiene at the Hospital, as a result of which the applicant suffered from repeated infections and pediculosis. The investigation also failed to identify those responsible for the failure to order Malacu's timely transfer to a specialised external medical establishment which could have provided adequate treatment for her ailments.

The Poiana Mare Psychiatric Hospital

60. The following account is based on three CPT reports on visits to the Hospital in 1995, 1999 and 2004[63], the report published by the CLR after its visit to the hospital on 20 February 2004[64], a number of reports elaborated by state authorities with monitoring attributions which visited the Hospital before or after the period when the applicants died[65] as well as witness statements collected during the official investigation[66].

61. The Hospital is situated in the south-western part of Romania, in a very isolated rural location, in close proximity to the Bulgarian border. The towns closest to the hospital are Calafat (a minor town, 10 kilometres away) and Craiova (a more important regional centre, 89 kilometres away). The complex currently hosting the Hospital opened in 1952 as a military barracks[67]. In 1960 a sanatorium for people suffering from tuberculosis opened on the site, with a capacity of 700 beds. The Hospital started admitting 'voluntary' psychiatric patients in 1973, and patients committed in the context of criminal proceedings on the basis of a court order ("*forensic patients*") in 1987. During the Communist regime the Hospital was also used as a place of detention for political prisoners[68]. As a result of international pressure, particularly from the CPT, patients suffering from tuberculosis were transferred in 2002 to an external section of the Calafat Municipal Hospital located in the nearby Poiana Mare village.

62. In 2004, the Poiana Mare "Hospital of Psychiatry and for Maximum Security Measures" was an establishment of "national public interest" subordinated directly to the Ministry of Health[69]. The Hospital is in fact a very large complex of 10 pavilions for hospitalisation and approximately 50 other buildings, occupying a total surface of 26

[62] Resolution of the High Court Prosecution Office, 31 August 2004, exhibit 44; Resolution of cancellation, High Court Prosecutor's Office, exhibit 69.
[63] "The 1995 CPT Report", "the 1999 CPT Report", and "the 2004 CPT report", exhibits 175-177.
[64] Criminal complaint by CLR, exhibit 33.
[65] Exhibits 168-174.
[66] Exhibits 87-144.
[67] "*Spitalul de Psihiatrie Poiana Mare, Istoric*", Exhibit 181.
[68] See Vianu, Ion, *Persecutia psihiatrica a opozantilor si dizidentilor*, Revista 22, available at http://www.revista22.ro/persecutia-psihiatrica-a-opozantilor-si-disidentilor-2769.html
[69] Governmental Decision no. 743/2003 concerning the organisation and functioning of the Ministry of Health, exhibit 190.

hectares[70]. Due to a large extent to its isolation, the Hospital developed as a self-sufficient, self-administered unit, with autonomous heating, water, sanitation and sewage systems.

63. In reaction to international and domestic criticism concerning the abuses taking place at the Hospital, the Government has repeatedly committed to closing it down and moving the patients to other locations. Thus, in its response to the observations made by the CPT after its first visit to the Hospital in 1995, the Romanian Government stated that:

> *The Poiana Mare Hospital shall be gradually eliminated as a hospital, as it no longer brings together acceptable circumstances (neither from the medical, from the penal or humanitarian point of view).*[71]

64. Although the Government has publicly reiterated the commitment to close down the Hospital in 1999[72] and 2005[73], the institution remains open; it has the same capacity, and is accepting new patients.

The Hospital's Patient Population

65. On 29 February 2004 the Hospital had a total capacity of 510 beds of which 438 were occupied[74]. Due to the lack of clear criteria for admission, the population of the hospital was heterogeneous[75].

66. A sizable group (239 out of 440 patients according to the Hospital manager at the time[76]) was made up of patients admitted as a result of compulsory hospitalisation orders made by criminal courts on the basis of Article 114 of the Criminal Code[77]. In addition, some patients were hospitalised as a result of compulsory treatment orders in conformity with Article 113 of the Criminal Code. These patients were admitted to the Hospital by default, in the absence of adequate community-based facilities[78].

[70] The 1995 CPT Report, §§ 167-168, exhibit 175.
[71] Further measures taken by the Ministry of Health following a new on site inspection at Poiana Mare Hospital (November 1995), exhibit 175.
[72] The 1999 CPT Report, §195, exhibit 176.
[73] Ministry of Health press release, 6 November 2005, exhibit 182.
[74] Letter of the Hospital, 12 October 2004, exhibit 50.
[75] The 1999 CPT report, §§192-193 and the response of the Romanian Government, exhibit 176.
[76] The CLR report, exhibit 33.
[77] The Hospital was one of the six 'maximum security" psychiatric establishments in Romania receiving such patients, its catchment area being made up of 12 counties situated in the South of Romania and the capital city, Bucharest.
[78] The 1999 CPT Report, §192. According to findings from a visit at the Hospital on 14-15 November 2005, 19 "Article 113 patients" were held at the Hospital because "they represented social cases, without next of kin, and thus it would have been impossible to undertake obligatory treatment [if left to their own devices]", Response of the Ministry of Health, 5 December 2005, p. 6, exhibit 174.

67. The second group of patients were nominally admitted on a 'voluntary' basis[79] but the reasons for their hospitalisation and their mental condition were in fact varied. Some patients had genuine mental health problems, in acute and chronic forms, of various degrees of severity. Some (such as Maricica Barbu and Miorita Malacu) had intellectual disabilities of various degrees. Many patients had been hospitalised at the Hospital for very lengthy periods of time, while some of them, such as Maricica Barbu and Miorita Malacu, had spent all their lives in social care institutions[80]. Many patients belonging to this group were so-called "social cases", who were hospitalised primarily on the basis of their marginal social status and their heightened vulnerability, and not strictly in consideration of their mental condition. "Social cases" are subject to a more detailed analysis below (§§71-75).

68. The legal basis for the continued hospitalisation of patients who were not subject to criminal proceedings was unclear or, in some instances, non-existent[81]. Most 'voluntary' patients, including all applicants, had been hospitalised under Communist legislation formerly in force which entrusted the role of ordering the involuntary commitment in a psychiatric hospital to a commission composed of psychiatrists, upon request from the family of the person concerned or from a civil or medical authority. However, this legislation stopped being used in practice after 1989 which meant that individuals brought by their family or by the police could be hospitalised against their will with limited or no safeguards.

69. Even after a new, more modern law was adopted – Law no. 487/2002 on the mental health and the protection of persons suffering from mental problems ("*the Mental Health Law*") – the Hospital failed to apply the safeguards provided therein in the context of involuntary hospitalisation, either to new admissions, or to people who had already been admitted[82]. As a result, as also noted by the CPT, a considerable number of patients were held at the hospital against their will, and the legal basis for doing this has always been unclear[83]. This is apparent from the applicants' files, which do not contain any indication of the legal basis for holding them at the Hospital or their consent thereto.

70. Patients resided in six pavilions, of which four were male-only and two mixed[84]. There was no formal separation between areas allocated to 'forensic' patients and those occupied by 'voluntary' patients, all being subject by extension to the same 'maximum security regime'[85].

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[79] Andrei Marius, a nurse at the Hospital, stated that all patients at the pavilion where he worked and which accommodated "social cases" were persons hospitalized "voluntarily", generally brought by their next of kin [sic!], exhibit 113.

[80] According to an admission by the Hospital manager, more than 70 patients in this situation were hospitalised at the Hospital in February 2004, CLR report, exhibit 33.

[81] Decree no. 133/1980; the 1995 CPT Report, §§168, 196, exhibit 175; the 1999 CPT Report, § 193, exhibit 176.

[82] According to the admission of the Hospital manager, cited in the CLR report, exhibit 33. Also the 2004 CPT Report, §32, exhibit 174.

[83] The 1999 CPT report, §193, the 2004 report, §32.

[84] See for example the Ministry of Health report, 24 March 2004, pp. 2-4, exhibit 171.

[85] One of the six pavilions of the Hospital was shared between the two categories of patients. A Ministry of Health report dating from November 2005, discovered that "the patients hospitalized on the basis of

The social cases

71. A sizable part of the non-forensic patients were made-up of the so-called 'social cases'. According to a doctor working at the Hospital, social cases "without a family" amounted to 50% of all 'voluntary patients' at the Hospital[86]. A Ministry of Health report dated 25 November 2004 cited the following statement made by the Hospital management:

> *The psychiatric patients hospitalised are divided in two categories:*
> - *the patients whose legal status means that their discharge is dependent on the decision of courts;*
> - *the chronic patients, social cases, without any next-of-kin, and who cannot be discharged*[87].

72. Rodica Pesea, the Hospital manager at the time, accurately defined "social cases" as patients "who are marginalised by their family and by society"[88]. The defining characteristic of a "social case" is not necessarily their mental health problem, but rather it is their social vulnerability, which is frequently due to the absence of family or other relatives. Mitroaica Daniela, a doctor at the Hospital, declared that most social cases are "abandoned by their families"[89]. Ioana Istrate, who was suffering from depression, could have been discharged according to notes made by doctors in her medical file, but for her family opposing it (see above, §46)[90]. According to Florina Pesea, even if they had a family before, many patients were abandoned after they were hospitalised[91].

73. The absence of next of kin is frequently combined with other sources of exclusion, including lack of income, lack of a place of abode, and substance abuse problems. Grigorescu Ioana, a psychiatrist at the Hospital described "social cases" as follows:

> *"The pavilions for chronic patients accommodate patients with mental problems, as well as numerous so-called "social cases", namely patients without a family, without a home, without a pension, but who are referred [to the Hospital] by [other medical authorities] and who cannot therefore be turned down."*[92]

Articles 113 and 114 Criminal Code were held in the same place as the chronic patients!", response of the Ministry of Health, 5 December 2005, p. 6, exhibit 174.

[86] Prodan Gheorghita, 14 September 2004, exhibit 99.

[87] Ministry of Health report, 25 November 2004, p. 11, exhibit 172.

[88] Pesea Rodica, 14 September 2004, exhibit 97-98.

[89] Mitroaica Daniela, 10 November 2004, exhibit 114.

[90] Similar situations have been reported in relation to other patients at the Hospital. Neferu Virgil was hospitalised at the Hospital with tuberculosis. His medical record states that "after his treatment was undertaken between 7 August 2002 and 25 October 2003, the patient was discharged and re-committed on 26 October 2003, being considered a social case, and the family refusing to take him back". Information note, 19 March 2004, p. 2, exhibit 38.

[91] Pesea Rodica, 14 September 2004, exhibits 97-98.

[92] Grigorescu Ioana, 14 September 2004, exhibit 96.

74. Although the situation of "social cases" is the object of significant attention by all doctors at the Hospital as well as in many official commentaries, this contrasts with the complete lack of legal regulation of the situation. This practice developed completely outside any legal framework, and is premised on the tacit non-observance by all actors in the system (the Hospital, the medical authorities doing the referral, the Police, the Prosecutor's Office) of legal provisions such as the Mental Health Law that are supposed to protect the rights of people with disabilities in such circumstances.

75. Despite the fact that the category of "social cases" is an informal classification and therefore the issue of membership to this group may be the subject of debate, it is certain that all applicants belong to this group. They do meet all the typical characteristics of social cases: they either had no family or were abandoned by their families. All lived all their life or very long periods in institutions. All originate from rural areas, which lack any community-based support facilities at all. Their mental health does not appear to be such as to justify prolonged commitment at the Hospital. One doctor at the Hospital does in fact identify the four applicants who were in her care as "social cases": Barbu, Istrate, Bestea and Malacu[93]. It is submitted that the authorities' treatment of "social cases" profoundly shaped the course of the applicants' life and contributed to their untimely demise.

Living conditions at the Hospital

76. During the height of the scandal surrounding the high mortality rate at the Hospital, a group of patients sent a letter to a local newspaper appealing to the outside world for help and exposing the dreadful conditions at the Hospital[94]. This letter provides an accurate and poignant picture of life at the Hospital, both in term of the helplessness felt by the patients as well as the hardship they had to face:

> *Esteemed journalists!*
> *A few miserable and desperate patients from the Poiana Mare Psychiatric Hospital are writing to you on behalf of all our colleagues in misery.*
> *We hope that somebody will listen to us. Maybe the press at least will pay some attention, as we are tired of how many letters we sent to the Ministry of Health without getting any replies. We suspect that our letters, in which we asked for justice, were sent by Madam Doctor Jugravu Viorica from the Ministry back to the hospital manager Pesea Florina, who is our day-to-day terror.*
> *Sirs, we urge you to help us, to cry out for help as we cry out, as maybe you will be taken into account and thus we will be saved. All patients in this hospital […] live in indescribable grime, they die of hunger, the cold breaks their bones and the lice eat them alive.*

[93] Grigorescu Ioana, 11 November 2004, exhibit 131.
[94] The letter is dated 19 February 2004, was sent by an anonymous group of patients from the Hospital to a local newspaper, *Gazeta de Sud*, and was forwarded by the CLR to the High Court Prosecutor's Office together with their initial criminal complaint, exhibit 33.

We don't know what to choose - the lice which left open sores on our bodies or the poisons […], which the orderlies are spray on us in order to rid us of lice. […]
Dozens of us die of pneumonia, dysentery (they give us cabbage for the first meal and milk for the second; oil, lard, meat, sugar in morning tea are missing, there are maggots in food and the bread is mouldy). […] We cover with tattered duvets, we have ragged bed sheets, and mattresses full of lice and tuberculosis microbes, as they were brought from the former tuberculosis ward of the hospital. We don't have clothes, pyjamas, shoes or warm robes.
We kept hoping that after so many monitoring visits took place, somebody will notice and take measures, but nothing happened […]. The dead are lying at the morgue as long as three weeks at a time, even during summertime, at 40° Celsius, although the morgue does not have a refrigerator, until the maggots come out all the way out on the alley. The cemetery looks like hell, without crosses, with graves which are caving in. It is located near the hospital's garbage dump, where the garbage is scattered on the field, and from where our ill fellow patients eat. […] if anybody says anything we are drugged and we receive injections and our mouths are kept shut with fists and legs.
What kind of manager is she when one of our woman fellow patients was eaten by [stray] dogs at the hospital (her head was eaten) and nobody is firing her.
We are threatened with beatings and drugs and we are locked up like animals, and the employees who take our side are transferred from one pavilion to another and threatened with dismissal. […]
Sirs, we will stop writing as we are frightened, and, if we are caught, we will have to face hell on earth.
Please publish this letter in a newspaper, so that the whole world sees it, and something changes at the Poiana Mare Hospital!
We beg you not to let us finish our days on Earth here!

77. Most Hospital buildings and facilities had not been renovated since they were built in 1952. A ministerial commission which visited the Hospital in July found conditions to be so deplorable that it decided to make an ultimatum to senior staff to bring about improvements and threatened with dismissing certain staff if this did not take place:

Taking into account the deficiencies found concerning the management and maintenance of the Hospital's installations and facilities (sanitary, electrical, heating installations etc.), the Commission called all auxiliary personnel in charge with the maintenance and management of pavilions (doctors, heads and deputy heads of pavilions), as well as the manager of the establishment and gave them an ultimatum in relation to the responsibilities they have to solve such problems. In addition it was decided that in case the negative aspects persist, legal administrative sanctions should be applied, including the dismissal of members of staff concerned. [95]

[95] Ministry of Health/Ministry of Justice Report, 18 July 2003, exhibit 168.

78. Another commission which visited the Hospital in September 2003 noted that the pavilion with the worst living conditions was that managed by Dr. Calina Viorica, and had "damaged walls, broken doors, dirty and inadequate toilets". The commission went on to point out that "the head of pavilion at this Hospital does not wish to also fulfil their administrative and managerial duties"[96].

79. A letter dated 15 September 2003 addressed by the Hospital management to the authorities contained a list of urgent repair work that had to be carried out:

> *a) the heating system dates from 1952 is corroded, petrified and heat transmission is very inefficient. At the same time the fuel used […] is very expensive and large amounts of it is necessary during winter (approx. 600 tons);*
> *b) the system of illumination is fifty years old (from 1952) and necessitates replacement, both inside the ten pavilions of hospitalisation as well as the external tracts;*
> *c) almost all pavilions of hospitalisation necessitate current repairs of the bathrooms, specifically with regard to the drinking and current water provision, repairs of the sewage system, tiling the walls and floors etc;[…]*
> *e) the kitchen and the laundry room face difficulties in preparing food and washing the laundry because of the antiquated machinery and the buildings where they are located necessitate works of repair and modernisation;*
> *f) the sewage system is old and clogged-up.*[97]

80. Patients in many wards were faced with overcrowding problems[98]. When the CLR visited the hospital on 20 February 2004, it found two or even four patients sleeping in the same bed, either for lack of space or in order to get warm. Some patients were without clothes or were dressed in pyjamas[99]. Many patients lacked shoes or socks, and consequently they developed bruises on their feet[100]. Furthermore, patients generally lacked any private belongings[101] or any private space.

81. Hospital wards were generally in a very poor shape. The following is the description of an average pavilion, included in a official report dating from September 2003 concerning the situation at the Hospital:

> *Pavilion no. 5 (Psychiatry VI – Dr. Ionete Dorina – GP, Dr. Mitroaica Adriana – GP), with 70 beds, located in 12 wards with 75 patients, therefore the phenomenon of overcrowding, since each patient did not have their own bed,*

[96] Ministry of Health report, 2 September 2003, exhibit 169.
[97] Letter of the Hospital, 15 September 2003, exhibit 159.
[98] See for example the detailed descriptions of the situation in each individual ward in the CLR report, exhibit 33, and in the Ministry of Health report, 23 March 2004, exhibit 171.
[99] The CLR report, exhibit 33; also the 1999 CPT Report, §207, exhibit 176. The CPT noted on this occasion that only certain patients received personal clothes as a compensation for good behaviour.
[100] The 1999 CPT Report noted that the hospital had difficulties providing shoes and socks to all patients, §207, exhibit 176.
[101] The CLR report, exhibit 33.

We noticed that the toilet on the ground floor was semi-demolished, it does not have a sink while serving the needs of both floors, as on the second floor the toilet and the showers are not in use and the door is blocked. In addition, we noticed that walls were destroyed so badly that bricks were visible, on the ground floor, as well as the second floor. In the wards we noticed the absence of pillows (ward no.12 did not have any pillows). [102]

82. Many wards lacked windows and/or doors. The furniture was frequently in an advanced state of deterioration or lacking altogether. An official monitoring commission from the Ministry of Health which visited the hospital on 23 March 2004 noted that many bed mattresses were 'tattered', that some beds had child-sized mattresses despite being occupied by adult patients and that pillows were lacking in some wards[103]. Most reports highlight the state of toilets and bathrooms which were in an advanced state of disrepair, dysfunctional and/or lacking tiling.

83. Water and sanitation systems were old and inefficient. Hot water for use by the patients was provided sporadically. The CPT noted in its 2004 report that each pavilion received hot water only one day weekly and therefore patients were allowed a single weekly shower[104]. The CLR noted in their report that "[patients didn't] get soap, shampoo, toilet paper or tooth brushes, brushes or towels. When taking a shower, two patients have had to enter the shower at the same time…in order to save hot water"[105].

84. One of the most serious consequences of the unhygienic conditions at the Hospital was the recurring outbreaks of pediculosis, particularly throughout 2003 and the beginning of 2004[106]. At least two applicants were infected with it – Dumitru Ticu and Miorita Malacu. The problem was highlighted in reports issued by the State Sanitary Inspectorate (the '*Inspectorate'*), which undertook a number of monitoring visits to the hospital during 2003 and 2004. On one occasion, the Inspectorate noted that the Hospital was cleaned only very rarely and that disinfectant products were rarely used. The Hospital manager Florina Pesea and other members of staff were fined in February 2004, on the basis of a failure to prevent and contain the outbreaks of pediculosis. It appears that the outbreak of pediculosis peaked at the same time as the mortality rate in January-February 2004.

85. Living conditions became even worse during the winter of 2003/2004. This was due to some extent to the fact that in the autumn of 2003 the Hospital had accumulated a large amount of unpaid debts to its food and fuel suppliers which had a detrimental

[102] Ministry of Health report, 2 September 2003, exhibit 169.
[103] Ministry of Health report, 23 March 2004, exhibit 171.
[104] The 2004 CPT Report, §30, exhibit 177.
[105] The CLR Report, exhibit 33. Also noted in the 2004 CPT Report, §30, exhibit 177.
[106] Similar problems were noted in the 1994 and 1999 CPT Reports, exhibits 176-177. Also see generally "*Peste o suta de pacienti au fost rasi in cap si izolati*", Gazeta de Sud, 17 February 2004, and"*Foamea si paduchii, paravan pentru jocurile de interese ale clanurilor PSD*", Gazeta de Sud, 27 February 2004, exhibit 185.

impact on its ability to secure winter supplies[107]. Thus, in a letter dated 8 May 2003, the Hospital informed the Dolj Public Health Department that:

> *Given that the sums received for the first four months were only approximately sufficient to cover salaries, we were placed in impossibility to pay the providers to whom we incurred debts, so that presently they refuse to continue supplying food, fuel etc.* [108]

86. Four months later, on 15 September 2003, another letter noted that:

> *Securing the food, medication is being undertaken at a much lower pace than what is necessary because of financial shortages. At this time with the money due to be received from Dolj Public Health Department for the rest of 2003 it is impossible to secure the supplies for the winter at the required level.*[109]

87. As a result of financial shortages, the food ratio for every patient in January 2004 was only 33,084 ROL (approx. 0.82 Euro/day), which represented circa 60% of the sum set by the law[110]. Most witness statements collected during the official criminal investigation agree in stating that the diet of patients during the winter of 2003/2004 was extremely poor.

88. The CLR report described their findings from the visit to the Hospital on 20 February 2004 as follows:

> *"The food given to patients consists for more than a month of canned vegetables (according to the statement of a patient). At the time of our visit the hospital's storage room contained only 108 jars of vegetable hotchpotch and 15 kilos of rice (the dinner that day). For the next day (Saturday) all they had left was 500 grams of bread/patient and a few boxes of margarine. Even though the time for serving dinner was 7 pm, at 7.30 pm there was nobody in the dining room or on their way there".*[111]

89. In its 2004 report, the CPT focused on the alimentation of patients and heating, which they placed in direct relation to the high mortality rate registered that winter. Thus, the CPT noted that the medical records of deceased patients revealed that 10% were cachectic at the time of their death or during the weeks before they died[112]. In this

[107] On 15 September 2009, the Hospital owed 5.797.187.000 ROL to its providers, Letter of the Hospital, 15 September 2003. In a letter dated 8 May 2003, the Hospital informed authorities that given the low level of budgetary allocations for the first four months of 2003, the hospital was only able to pay the salaries, "and were placed in the impossibility of paying the providers to whom we are indebted, who as a result have ceased deliveries of food, fuel, etc." Letter of the Hospital, 8 May 2003, exhibit 157.
[108] Letter of the Hospital, 8 May 2003, exhibit 157.
[109] Letter of the Hospital, 15 September 2003, exhibit 159.
[110] Ministry of Health report, 23 March 2004, exhibit 171.
[111] The CLR Report, exhibit 33.
[112] The 2004 CPT Report, §18, exhibit 177.

context, the CPT delegation weighed all 62 patients residing in the pavilion for male chronic patients, discovering that one in four was underweight.

90. In both its 1999 and 2004 reports the CPT highlighted the low calorie contents of the food served to patients. In 2004 the CPT found an underestimate of around 40% for certain days during the period of February to June 2004 and concluded that "the budget allocated to alimentation was not always fully spent to that end"[113]. The CPT also noted that "the protein and vitamin contents of food were insufficient, thus generating a weakening of bodily defences, notably in the context of infectious diseases and weather changes"[114].

91. In addition to lack of food, patients suffered from lack of heating, a situation aggravated by cold winter weather. The CPT made the following comments in that regard:

> *La centrale thermique était dans un état de délabrement avancé, seule la moitié de ses brûleurs étant encore en état de marche. De l'avis des responsables de la centrale, la situation en ce domaine était même critique, la centrale thermique ne pouvant en aucun cas, et ce même utilisée à plein régime 24 heures sur 24, assurer en hiver une température dans les pavillons supérieure à 15 degrés Celsius.*
> *En outre, la délégation a cru comprendre qu'au fonctionnement défectueux de la centrale s'ajoutait une limitation volontaire, pour raisons budgétaires, de l'utilisation de celle-ci. Les responsables précédemment mentionnés ont en effet clairement laissé entendre à la délégation que, l'hiver dernier, la direction leur avait donné des instructions pour limiter tant les horaires de chauffage à huit heures par jour - diminuant de ce fait la température ambiante déjà basse à l'intérieur des pavillons - que la production d'eau chaude. En pratique, la température serait considérablement descendue dans les pavillons pendant l'hiver 2003/ 2004.* [115]

92. The lack of heating in patients' wards was also highlighted by certain doctors in medical records (i.e. in Maricica Barbu's record, above §23). Hospital personnel tried to compensate for the lack of heating by distributing improvised heating devices, duvets, and hospital robes, which however were not sufficient.

Medical Treatment Available at the Hospital

93. The Hospital had very limited medical equipment. It had a laboratory of medical equipment where very basic investigations could be carried out (tests of blood, urine, water)[116]. Other more complex laboratory investigations could not be undertaken at the Hospital, due to old equipment and/or lack of specialised personnel. Laboratory and

[113] Idem.
[114] Idem.
[115] The 2004 CPT Report, §19, exhibit 177.
[116] Letter of the Hospital, 21 October 2004, exhibit 50, the 2004 CPT Report, §16, exhibit 177.

multidisciplinary investigations were carried out at hospitals in Calafat or, more frequently, in Craiova[117].

94. The CPT, in its 2004 report, emphasised the alarming absence of basic prevention and first-aid equipment for cardiac problems, officially the main cause of mortality at the Hospital:

> *Le matériel de première urgence était pour ainsi dire inexistant : il n'y avait ni défibrillateur, ni même électrocardiographe, et cela en dépit de la fréquence élevée des cardiopathies mentionnées dans le cadre des certificats de décès. (§16)*

95. It appears that the Hospital generally disposed of sufficient psychiatric medication, especially "classic" neuroleptics which were administered liberally to patients. However, the Hospital was confronted with a shortage of medicine for somatic conditions. One generalist doctor stated that "the Hospital's medicine supplies were very poor and the only medication for somatic ailments available occasionally was glucose drips, vitamins, and some antibiotics"[118]. This observation is supported by the applicants' medical records, which confirm that when their health state worsened they invariably received vitamins, antibiotics and/or glucose drips.

96. The CPT also noted the absence of "a centralised structure for the clinical supervision of patients with serious somatic problems or necessitating specific consolidated supervision"[119]. A Ministry of Health report noted dryly that at the Hospital "the patients are rarely prescribed laboratory investigations and the medication prescribed is inadequate most of the times"[120].

97. Although in theory patients could be referred to external medical establishments for specialised treatment or investigation this happened rarely[121]. This is apparent from the applicants' files. Between the five of them, they were referred only five times to external establishments, twice for abortions (Maricica Barbu and Miorita Malacu), and three for emergency treatment (Maria Bestea, Dumitru Ticu and Miorita Malacu). The reluctance shown by the Hospital to refer patients to external establishments was due to financial considerations, in the context of major budgetary shortages as well as the opposition manifested by non-psychiatric establishments in relation to treating psychiatric patients, perceived as particularly problematic[122]. Even when referrals took

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[117] See for example the resolutions of non-indictment issued by the High Court Prosecutor's Office, 11 February 2005, exhibits 55-59.

[118] Paul Mitroaica, 14 September 2004, exhibit 94; Prodan Gheorghita, 14 September 2004, exhibit 91.

[119] The 2004 CPT Report, §16, exhibit 177.

[120] Ministry of Health report, 2 September 2003, exhibit 169..

[121] Some doctors at Poiana Mare were even resisting the idea of referring patients to external establishments: "a mental patient may not be hospitalised in medical establishments for mentally healthy patients, for reasons which are easy to understand". Prodan Gheorghita, 14 September 2004, exhibit 99.

[122] "Mental patients "are accepted by other hospitals for treatment with great difficulty", Oprescu Viorel, 14 September 2004, exhibit 95. External establishments "respond with great difficulty to our requests, because the somatic ailment is accompanied by a mental problem which everybody is trying to avoid dealing with." Pesea Florina, 14 September 2004, Exhibit 97-98.

place, patients came back with prescriptions for treatment which could not be covered by the pharmacy of the Hospital[123].

98. Medical records were not generally kept in an adequate manner. An audit report dated 16 January 2004 noted a number of shortcomings in this regard, with a number of records that had to be kept according to the law missing altogether[124]. Furthermore, entries in medical records were extremely brief and repetitive to the point of being useless as an indicator of how a patient's health evolved in time. Based on the frequency of notes made in the applicants' medical records, it becomes apparent that as a rule each patient was seen once a week by a psychiatrist and much more infrequently by a GP.

99. The only general examination of a patient's health state took place upon hospitalisation. For the rest of their stay at the hospital, medical examinations were essentially reactive in the sense that patients were seen and prescribed treatment only after developing symptoms of an illness.

100. Patients did not have an individualised therapeutic plan aimed at alleviating their mental health or rehabilitation plans. The entries in the applicants file were formulaic and repetitive and did not register progress towards some therapeutic goal. Hospitalisation at the Hospital was very remote from any therapeutic purpose, and instead was aimed at controlling some individuals perceived as problematic by authorities. All CPT reports consistently noted the almost complete absence of any rehabilitative or therapeutic activities at the Hospital, and found that the treatment provided to patients consisted essentially of pharmacotherapy. In its 2004 report, the CPT noted that although it had been nine years since its first visit, its observations in this regard had remained "dead letter" and suggested that the situation was "intolerable" and that "it had to stop"[125].

101. Most patients, including all applicants, were treated indiscriminately with neuroleptic medication, tranquilisers and sedatives. As is apparent from their medical records, this practice lacked any logical connection to the applicants' actual health state, as it was administered equally to persons who were "peaceful and cooperative" as well as to those who were "restless and uncooperative". A monitoring report issued by the Ministry of Health in 2003 made very pointed remarks in relation to the practice of administering neuroleptics at the Hospital:

> *At the Poiana Mare Hospital Dolj County, the heads of pavilion Prodan Gheorghita, Grigorescu Ioana and Calina Viorica prescribe [neuroleptic] medication without there being any connection between the psychiatric conditions and the medicine administered.*[126]

[123] Prodan Gheorghita, 14 September 2004, p. 4, exhibit 99.
[124] Internal public audit report, 16 January 2004, exhibit 170.
[125] The 2004 CPT Report, §28, exhibit 177.
[126] Ministry of Health report, 2 September 2003, p. 2, exhibit 169.

Hospital Staff

102. The three reports published by the CPT consistently show that the Hospital had been continuously understaffed and that staff generally lacked the skills required for working with mental health patients[127]. In its 2005 report, the CPT summarised the state of affairs found at the Hospital as follows:

> *Le CPT est tout particulièrement préoccupé par la pauvreté des moyens, tant humains que matériels, mis à la disposition de l'hôpital de psychiatrie de Poiana Mare pour assurer la gestion des urgences médicales et un suivi somatique des patients digne de ce nom.*[128]

103. At the beginning of 2004, the Hospital only employed 299 staff, as opposed to 492 required by the law[129] - psychiatrists, general practitioners, nurses, and other auxiliary personnel, but no psychologists, social workers, psychotherapists, occupational therapists or other specific personnel specialised in providing treatment and care to psychiatric patients[130].

104. Only 11 doctors worked at the Hospital - five psychiatrists and six general practitioners ("*GPs*")[131]. Thus, the doctor/patient ratio was of one psychiatrist for 88 patients and one GP for 73 patients[132]. All psychiatrists also performed managerial duties as heads of pavilion, which left one pavilion without a manager. One psychiatrist, Rodica Pesea, also acted as hospital manager, in addition to her duties as psychiatrist and head of pavilion.

105. GPs worked only for five hours daily[133]. In addition to widespread indiscipline (see below §108), this meant that GPs had very little time to spend with individual patients. This is obvious from the scarcity of entries made by GPs in the applicants' medical records, which were sometimes separated by months. A ministerial commission which visited the Hospital between 14 July and 19 July 2003 expressed doubts about the adequacy of employing GPs at the Hospital:

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[127] The 1995 CPT Report, §170, the 1999 CPT Report, §201, exhibits 175-176
[128] The 2004 CPT Report, §16, exhibit 177.
[129] The 2004 CPT Report, §25, exhibit 177. The norms of personnel for medical services were regulated at the relevant time on the basis of the *Order no. 208/17 March 2003 on the approval of norms of personnel*, exhibit 190.
[130] Another major problem faced by the Hospital was the lack of a dentist. Many patients (as many as 90%) suffered from dental problems during their stay at the Hospital, including most applicants - see the CLR report, exhibit 33. Despite the absence of specialised personnel, patients were very rarely referred to external specialists, being treated instead with palliatives or antibiotics (this was the case with Ioana Istrate who was frequently confronted with dental problems, only to be treated with painkillers).
[131] Letter by the Hospital, 12 October 2004, exhibit 50.
[132] For example, the *Order no. 208/17 March 2003 on the approval of norms of personnel* required a doctor for every 10-14 patients and a nurse for every 8-12 patients, exhibit 190.
[133] Opening hours at the Hospital, exhibit 146.

[S]omatic consults are undertaken by [GPs] whose presence at the Hospital is not justified. […] The Commission recommends that the other doctors besides psychiatrists should be specialists in internal medicine, and for [more complicated] cases the multidisciplinary consult should be undertaken at the Calafat Municipal Hospital.[134]

106. The Hospital employed only 82 nurses[135], below the numbers required by the law, as well as other auxiliary personnel. The great majority of nurses and auxiliary personnel were recruited from the nearby Poiana Mare village, and lacked specialised training in working with psychiatric patients[136]. The difficulties in recruiting qualified personnel or accessing various services are related to some extent to the Hospital's geographic isolation[137].

107. The problem of staff shortage was aggravated at night. Following a conflict between psychiatrists and GPs, only the former were entitled to night shifts. This practice was particularly problematic in case a medical emergency occurred during night time (as exemplified by the circumstances in which Maria Bestea died, see above §§32-34). The CPT made the following comment in this context:

Le manque de personnel était particulièrement criant l'après-midi et la nuit. Ainsi, par exemple, dans le pavillon chronique des femmes d'une capacité de 67 lits, le personnel paramédical se limitait, outre la présence d'un agent des services hospitaliers, à 1 (exceptionnellement 2) infirmier et 1 aide-soignant l'après-midi, et à 1 seul (parfois 2) infirmier la nuit.[138]

108. Discipline was generally lax among staff employed at the Hospital, including doctors[139]. Many doctors arrived late at work, having to commute from Craiova, 80 kilometres away[140]. Despite the challenges posed by their main job, GPs placed

[134] Ministry of Health/Ministry of Justice report, 18 July 2003, exhibit 168.
[135] Includes 6 head nurses, CLR report, exhibit 33; letter by the Hospital, 12 October 2004, exhibit 50.
[136] The 1995 CPT Report, §170, exhibit 175.
[137] The 1999 CPT Report, §195, exhibit 177.
[138] The 2004 CPT Report, §25, exhibit 178.
[139] "During the time I managed the establishment I noticed improper attitudes from their side, concerning work attendance, the way in which they made notes in the medical records in relation to the various stages of the disease or the absence of any notes, as well as the lack of interest from their part with regard to evident modifications in the patients' health state, concerning rapid weight loss, fever, apathy, lack of appetite, lack of movement", Pesea Florina, 14 September 2004, exhibit 97-98.
[140] The Hospital manager stated that the Hospital hires 5 psychiatrists, but only two of them come to work daily (of which one is the manager herself). The other three psychiatrists, stated the director "come to the hospital, they chat for an hour, and then they go back to Craiova, to attend their private practice duties", the CLR report, exhibit 33. An official audit report noted that: "the program of activity is not respected by the doctors during the normal working days", internal public audit report, 16 January 2004, exhibit 170. Another commission sanctioned a few psychiatrists at the Hospital due to the "serious aspects connected to the lack of abeyance to professional and management duties"; the same report noted that the said doctors asked the monitoring commission from the Ministry of Health to approve a few days off during the week, when they should be present at the PMH, in order to undertake consultations at their private practices in Craiova. At the same time they requested that during those days they be mentioned as present at the PMH, a request with which the commission did not agree", Ministry of Health report, 2 September 2003, exhibit

considerable pressure on authorities to allow them to operate parallel private practices in a building of the hospital, along with their other duties[141].

The treatment of patients after death

109. The patients' predicament did not end when they died. After they died, their bodies were stored in the hospital's morgue sometimes for many days, until relatives came to recover them, or, in the absence of relatives, until sufficient funds were identified to carry out a burial. However, the morgue lacked adequate equipment for preserving the bodies, a particularly gruesome problem, especially during summer time.

110. If the person who died did not have any relatives, they would be buried in the Hospital's cemetery. The piece of land designated as the cemetery was not clearly marked out from the surrounding fields, and doubled as a site for discharging sewage from the hospital[142]. At least two of the applicants (Maria Beştea and Ioana Istrate) were buried in the Hospital's cemetery[143]. Given that Maria Beştea's grave lacked a cross, the forensic experts who carried out her exhumation were guided to her grave by a 'cemetery keeper' who knew the location of all graves in the cemetery "by heart"[144].

111. According to legislation in force at the relevant time[145], it was mandatory to carry out an autopsy in cases where the person concerned died in a psychiatric hospital. This placed a duty in practice on medical personnel at psychiatric hospitals to inform prosecuting authorities whenever a patient died so that an autopsy could be carried out. Despite the fact this piece of legislation entered into force as early as 2000, the Hospital management and medical personnel complied with their obligation only insofar as forensic patients were concerned, omitting to inform authorities of 'voluntary' patients' deaths. The Hospital manager, Rodica Pesea, sought to justify this omission on the basis of an erroneous understanding of the law – namely, they wrongly considered that their legal duty was limited to informing the authorities solely in relation to deaths thought to have occurred in violent circumstances[146]. At least two doctors from the Hospital denied

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169; Prodescu Claudia, a nurse, stated that doctors are often late as they commute from Craiova, 9 November 2004, exhibit 110; Oprescu Viorel, the manager of the Hospital after March 2004 stated that "the activity of management was almost non-existent due to quarrels between the former manager and most heads of pavilion", 14 September 2004, exhibit 95. Finally, criminal proceedings were started against a number of nurses for falsely declaring they had worked on weekends in order to receive double pay, see below 150.

[141] Ministry of Health report, 2 September 2003, p. 5, exhibit 169.

[142] "*Mortii de la Poiana Mare sunt ingropati pe campul de imprastiere a apelor reziduale*", Gazeta de Sud, 8 March 2004, exhibit 185.

[143] Forensic report on exhumation and annexes, 4 June 2004, exhibit 14, and forensic report on exhumation and annexes, 3 June 2004, exhibit 30.

[144] Padureanu Marin, 16 April 2004, exhibit 87.

[145] *Order no. 1.134/C of 25 May 2000 on the approval of the procedural norms concerning [forensic work]*, Art. 34§2(d) of the norms, exhibit 190.

[146] Rodica Pesea, 14 September 2004, exhibits 97-98.

however that this was the case, and instead stated that the management pressured them not to report the deaths to authorities[147].

112. Authorities did not investigate at any length the reasons for the failure to report deaths and took the justification advanced by the Hospital management at face value. The decision of non-indictment dated 8 October 2007 stated simply that the omission to inform did not meet the requirements of any crime in the Criminal Code, and therefore no criminal responsibility could be discerned[148].

Financing issues

113. Throughout the official investigation, the Hospital management constantly complained about budgetary shortages and the high costs the Hospital needed in order to operate, as well as the overall underfunding of the mental health system. The sums allocated to the Hospital in 2003 and 2004 were however significant. In 2003, the budget allocated to the Hospital was 41,300,000,000 ROL (approx. 1,100,000 Euro)[149] and in 2004, the budget allocated initially was 47,632,781,000 ROL (approx. 1,175,189 Euro)[150].

114. The largest single cost in the hospital's budget is represented by salaries - 60% of the initial budget for 2004. For the rest, the cost of food represented approx.12% of the initial budget for 2004, the cost of medical supplies was approx. 4%, maintenance costs (heating, water, electricity etc) were approx. 15%, and the cost of ongoing repairs was approx. 8%. There was no allocation in the budget for capital renovation.

115. The hospital constantly ran into arrears with its main suppliers and was constantly cutting costs. Since costs associated with salaries were fixed, these cuts came mainly from the budget allocated to food, maintenance and ongoing repairs[151]. Although the management of the Hospital tried to blame the poor diet of the patients on financial shortages, it appears that during both 2003 and 2004 the hospital reduced its spending on food: in 2003 the total spending on food was 8,943,210,000, which represented a saving of 3,565,895,010. A saving in spending on food also took place in 2004[152].

Domestic proceedings

116. The conduct of domestic proceedings in this case was extremely complex and complicated, in large part due to contradictory decisions issued by the High Court Prosecutor's Service at key moments during the investigation. Due to the lack of

[147] Paul Mitroiaca, 14 September 2004, exhibit 94, Grigorescu Ioana, 14 September 2004, exhibit 96.
[148] Resolution of non-indictment, High Court Prosecutor's Office, 8 October 2007, exhibit 80.
[149] Ministry of Health report, 25 November 2004, p. 12, exhibit 172.
[150] Figures presented are based on historic conversion rates provided on the website of the National Bank of Romania, http://www.bnr.ro/Cursuri-medii-3544.aspx .
[151] Letter of the Hospital, 26 February 2003, exhibit 155: the Hospital management noted that savings would be made on electricity, heating, fuel and lubricants etc.
[152] Resolution of non-indictment, High Court Prosecutor's Office, 8 October 2007, exhibit 80.

transparency that characterised the investigation phase, as well as the reluctance of the Prosecutor's Office to provide the applicants' representatives with copies from relevant documents, many details of the investigation remain unknown to them. The Court is therefore respectfully requested to ask the Government to submit to the Court file copies of all documents relevant to the applicants.

117. On 20 February 2004 the CLR carried out a monitoring visit at the Hospital. A public statement and a report were released shortly afterwards setting out the findings from the visit[153]. On 1 March 2004 the CLR submitted the report to the General Prosecutor of Romania ('*the General Prosecutor*') asking for a criminal investigation to be initiated in relation to the tragic situation found at the Hospital. At the same time the CLR asked for the immediate closure of the Hospital, and the transfer of patients to more appropriate establishments where they could benefit from satisfactory living conditions and receive proper treatment. Confronted with what they perceived as the inaction of the General Prosecutor, the CLR reiterated their request in writing on 24 August 2004. Amnesty International[154] and the National Association of Patients and Social Health Insurance Holders ("*A.N.A.P.A.S.S.*") filed criminal complaints in parallel with the CLR[155].

118. Apparently as a result of the complaints filed by the three organisations, the Dolj Prosecutor's Office initiated, on 12 March 2004, an investigation into the circumstances in which 13 patients at the Hospital, including the applicants, died during the period of January-February 2004. The object of the investigation was to establish whether the crimes of genocide (Article 357 of the Criminal Code), inhuman treatment (Article 358), homicide by negligence (Article 178) and negligence at service (Article 249) had been committed. The investigation was limited to determining the culpability of the doctors (both psychiatrists and GPs) working at the Hospital under the aforementioned articles of the Criminal Code.

119. Also on 12 March 2004 the Dolj Prosecutor's Office ordered the Craiova Institute of Forensic Medicine to carry out forensic examinations in relation to the cause of deaths of the applicants, allowing one week for their completion. The experts were asked to elucidate the following questions:

- *the nature of death;*
- *the concordance between the diagnosis and the entries in the medical record of [the patient] and the cause of death from the death certificate issued by the [Hospital];*
- *if the treatment received by [the patient] had been adequate medically and therapeutically for the condition which was being treated at the Hospital;*
- *if an exhumation is recommended for identifying the true cause of death.* [156]

[153] See exhibits and 33 183; also the Amnesty International materials, exhibit 184.
[154] AI also initiated an international letter-writing campaign targeting the General Prosecutor and other important Romanian officials.
[155] Criminal complaints by Amnesty International and A.N.A.P.A.S.S, exhibit 34.
[156] See for example ordinance, Dolj Prosecutor's Office, 12 March 2004, exhibit 37.

120. The reports were based solely on the applicants' medical records from the Hospital and did not include an autopsy of the body[157]. Nevertheless, significant shortcomings were found to exist in relation to the treatment received by the applicants. Each applicant's individual conclusions are included above (see above §§ 25, 36, 43, 48, 55).

121. During the period of June to August 2004, the Dolj Prosecutor's Office issued decisions of non-indictment in relation to the investigation[158]. With the exception of Maria Bestea and Miorita Malacu, all decisions relied solely on the applicants' individual medical records and the forensic reports issued by the Craiova Institute for Forensic Medicine. The decisions of non-indictment inexplicably failed to have regard to the findings in the aforementioned forensic reports and were entirely devoid of reasoning. No witnesses had been questions by this time, other than those few who "confirmed" that Maria Bestea's head traumatism was the result of a fall.

122. On 31 August 2004 Gabriela Voicu, a prosecutor-inspector with the High Court Prosecutor's Office "ex officio" struck down the decisions of non-indictment and ordered that the investigation be continued (hereinafter referred to as "*the Voicu decisions*")[159]. In particular, Gabriela Voicu highlighted the fact that instances of medical malpractice evidenced in the forensic reports, as well as the impact of sub-standard living conditions were overlooked. It further instructed the investigating authorities to collect certain evidence in order to identify the individuals responsible for these shortcomings.

123. On 11 and 16 February 2005 the High Court Prosecutor's Office issued a new series of decisions of non-indictment[160]. This marked the end of any effective investigation in the case at hand. The most significant pieces of evidence collected during this stage of the proceedings were the reports from the the National Forensic Institute - the highest authority in Romania entitled to pass expert judgment on forensic matters. The questions addressed by the High Court Prosecutor's Office were formulated however in a very narrow and suggestive manner. Thus, in Miorita Malacu's case the National Forensic Institute was asked solely to "approve" the conclusions of the forensic reports undertaken so far in the investigation[161]. In Istrate Ioana's case, the questions were qualified and suggestive of the answer expected. Thus, the National Forensic Institute was asked to determine "what the adequate treatment [for a myocardial infarction] should have been and who should have been responsible to apply it, considering that the Hospital only employed psychiatrists and GPs"[162]

124. Insofar as relevant for the case at hand, the reports issued by the National Forensic Institute concluded as follows:

[157] Forensic reports, exhibits 6, 12, 20, 28.
[158] Resolutions of non indictment, exhibits 39-42.
[159] Resolutions of the High Court Prosecutor's Office, 31 August 2004, exhibits 44-47.
[160] Resolutions of the High Court Prosecutor's Office, 11 February 2005, exhibits 55-59.
[161] Letter of request, High Court Prosecutor's Office, 12 October 2004, exhibit 27.
[162] Letter of request, High Court Prosecutor's Office, 12 October 2004, exhibit 21.

- *Gaps in medical records as well as the failure to conduct an autopsy mean that it is impossible to elaborate on the cause of the victims' deaths;*
- *"Available information shows major administrative deficiencies (lack of heating in the wards, insufficient food, insufficient staff involved in the patients' care, the absence of medication, extremely reduced possibilities of para clinical investigation), which contributed to the deaths, without the possibility of quantifying (in the absence of autopsy) the exact contribution. These conditions favoured the inception of infectious ailments as well as their lethal evolution, significantly reducing the chances of success of any therapeutic scheme, no matter how advanced, due to the marked decrease of the patient's body ability to defend and its reactivity."*
- *"An adequate therapeutic scheme […] could have influenced favourably the evolution of infectious ailments which led to death, but, taking into account the above, this evolution would have been uncertain.*[163]

125. The National Forensic Institute concluded that "it was impossible to establish in an objective manner a certain relationship of causality between the medical treatment applied and the patient's death"[164].

126. In addition to the opinions from the National Forensic Institute, between September 2004 and February 2005 the High Court Prosecutor's Office questioned a few members of staff from the Hospital as well as some patients[165].

127. In the decisions dated 11 and 16 February 2005[166], the High Court Prosecutor's Office acknowledged that basic medical facilities were lacking in the Hospital as well as that it was confronted with severe budgetary shortages. However, no direct relationship of causality between the living conditions at the Hospital and the deaths could be established. The High Court Prosecutor's Office also stated that living conditions were circumstances which merely influenced the outcome but did not determine it. At the same time, the High Court Prosecutor's Office stated that budgetary shortages "could influence the quality of health care, as well as other administrative activities, but could not directly determine the deaths of some patients".

128. The High Court Prosecutor's Office concluded that in the absence of an expert opinion showing with certainty the deaths were the direct result of medical malpractice, it was impossible to establish the criminal liability of medical personnel at the Hospital. Furthermore, the High Court Prosecutor's Office stated that in the absence of a legislative framework specifying the conditions for medical malpractice it was impossible to hold the Hospital staff liable for the applicants' deaths. Finally, it stated that although the

[163] Forensic reports, National Forensic Institute, 17 November 2004, exhibits 8, 22, 32; the reports for Istrate Malacu and Barbu were very similar; the report on Bestea merely endorsed earlier findings according to which her cranial traumatism might have been caused by a fall, exhibit 15.
[164] Idem.
[165] Exhibits 87-144.
[166] Resolutions, High Court Prosecutor's Office, 11 February 2005, exhibits 55-59.

Hospital did indeed experience severe budgetary shortages, these could not be blamed on the medical/administrative personnel.

129. On 16 March 2005 the High Court Prosecutor's Office informed the Ministry of Health in a letter of the results of its investigation as follows:

> *[The investigation revealed a number of] deficiencies of administrative nature concerning: the lack of heating in the patients' wards, food lacking in calories, personnel insufficient in numbers and lacking qualifications to work with psychiatric patients, absence of advanced medication, extremely reduced possibilities for laboratory investigations, inefficiency of multidisciplinary screening for somatic ailments, highlighting the fact that all these circumstances favoured the occurrence of infectious diseases, as well as their lethal evolution, reducing significantly the chances of success of any therapeutic scheme, no matter how advanced that might have been, due to the decrease in the bodily defence mechanisms and reactivity."* [167]

Consequently, the Prosecutor's Office suggested that "necessary measures be taken".

130. The CLR challenged the decisions of non-indictment before the Head Prosecutor of the High Court Prosecutor's Office in relation to nine out of eleven decisions, including those regarding the applicants. On dates between 4 and 9 May 2005, the Head Prosecutor rejected these complaints.

131. At this stage three sets of proceedings, arising out of the decisions of non-indictment issued by the High Court Prosecutor's Office, developed as follows:

(i) The first set of proceedings

132. The CLR appealed the decisions of non-indictment of February 2005 to the Calafat County Court[168]. The appeal was grounded on procedural shortcomings as well as substantive grounds. Thus, the CLR emphasized that the investigating authorities failed to collect crucial evidence altogether, or in a timely manner (*inter alia* witness statements, documentary evidence, forensic examinations). At the same time, the focus of the investigation was too narrow, being limited to the immediate causes of death and not including issues such as the impact of substandard living conditions on the applicants' health, the evolution in time of the applicants' health after their hospitalisation, the exact scope of the duties incumbent on medical and other categories of personnel to provide proper and appropriate care and treatment to the applicants and the extent of their compliance with those duties.

133. The Calafat County Court referred the files to the Craiova Court of Appeal on jurisdictional grounds. Between March and June 2006 the Craiova Court of Appeal

[167] Information notes, High Court Prosecutor's Office, 16 March 2005, exhibit 60.
[168] Complaint by the CLR, exhibits 33.

dismissed all the complaints filed by the CLR as inadmissible[169], relying on the decisions of 20 July 2005 by the Head Prosecutor of the High Court Prosecutor's Office *ex officio*, which triggered the second set of proceedings, described below. The decisions of 20 July 2005 cancelled all decisions of non-indictment issued by High Court Prosecutor's Office dated between 4 and 9 May 2005, declaring them illegal. The reason was that in accordance with Article 275 of the Criminal Procedure Code the CLR did not have standing to challenge the decisions of the Prosecutor's Office, and therefore a decision on the substance of the complaint was illegal.

134. The CLR filed appeals against the judgments issued by the Craiova Court of Appeal which the High Court of Cassation and Justice rejected as ill-founded.

(ii) The second set of proceedings

135. The CLR appealed against most of the decisions of 20 July 2005, including the decisions relating to the applicants, but chose only one file – that concerning Costea Parjol, a patient who died in similar circumstances to the applicants – as a test case which it took all the way to the High Court of Cassation and Justice.

136. In the case concerning Costea Parjol the CLR complained against the decision of 20 July 2005 with the Calafat County Court. On 17 November 2005 the Calafat County Court referred the file to the Craiova Court of Appeal on jurisdictional grounds. On 28 February 2006 the Craiova Court of Appeal rejected the complaint. The CLR appealed against this decision with the High Court of Cassation and Justice.

137. On 15 June 2006 the High Court of Cassation and Justice allowed the appeal, recognized that CLR had standing to pursue criminal proceedings on behalf of the victim and returned the file to the Craiova Court of Appeal for a rehearing (also see below §216-218)[170]. The Craiova Court of Appeal ordered that a new investigation be undertaken and returned the file to the Dolj Prosecutor's Office. The CLR has yet to receive any information concerning the result of those proceedings.

(iii) The third set of proceedings

138. On a unknown date, Marcel Sampetru the Deputy Prosecutor of the High Court Prosecutor's Office *ex officio* struck down the decisions of non-indictment issued in February 2005 for the second time (hereinafter referred to as "*the Sampetru decisions*"), joined all eleven files, including the files of all the applicants, and ordered that a fresh investigation be undertaken[171]. The decisions basically reiterated the reasons included in the Voicu decisions (see above §122).

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[169] Decision in file no. 106/P/2006, Craiova Court of Appeal, 16 March 2006, exhibit 71, Decision in file no. 6969/54/2006, Craiova Court of Appeal, 6 June 2006, exhibit 72, Decision in file no. 18114/54/2005, Craiova Court of Appeal, 8 June 2006, exhibit 73.

[170] Decision in file no. 4948/1/2006, High Court of Cassation and Justice, 15 June 2006, exhibit 74.

[171] These decisions do not mention the date on which they were delivered. Resolutions of cancellation, High Court Prosecutor's Office, exhibits 66-69.

139. On 10 October 2006 the Prosecutor's Office attached to the Craiova Court of Appeal decided to separate the parts of the complaint concerning crimes against humanity and genocide (Articles 357, 358 of the Criminal Code) from the rest of the complaint concerning Articles 249 and 178[172]. A decision of non-indictment was issued in relation to the former part. For the latter the Prosecutor's Office attached to the Craiova Court of Appeal proposed that the investigation be taken over by the Prosecutor's Office attached to the Calafat First Instance Court.

140. On 21 May 2007, the Prosecutor's Office of the Calafat First Instance Court proposed to the High Court Prosecutor's Office to take over the investigation, due to its high degree of complexity. By a decision dated 21 May 2007 the High Court Prosecutor's Office accepted the request and took over the investigation[173].

141. On an unknown date in July 2007 the General Prosecutor of the High Court Prosecutor's Office cancelled the Sampetru decisions as illegal[174]. The General Prosecutor also ordered that all files be returned to the Criminal Investigation Department of the High Court Prosecutor's Office so that a decision may be made. It appears that subsequent to this date these decisions were tacitly disregarded and replaced with the decision of non-indictment dated 8 October 2007.

142. At this stage, the prosecutor from the High Court Prosecutor's Office, placed in charge of the files joined as a result of the Sampetru decisions, wrote an informative note detailing the progress in the investigation[175]. Thus, he indicated that in his opinion the aforementioned decisions of cancellation were illegal, but since they had been communicated to the CLR, they could not be withdrawn and the investigation had to be continued even if it was based on manifestly illegal decisions.

143. On 8 October 2007 the High Court Prosecutor's Office issued another decision of non-indictment[176], reiterating the arguments included in the decisions of non-indictment of February 2005. The CLR challenged this decision before the Head Prosecutor of the High Court Prosecutor's Office[177]. On 11 December 2007 the Head Prosecutor rejected the appeal and upheld the decision of non-indictment[178].

144. On 10 April 2008 the Craiova Court of Appeal rejected[179] the appeal[180] filed by the CLR against the decision of 8 October 2007. The CLR filed a last appeal against this

[172] Ordinance, Prosecutor's Office attached to the Craiova Court of Appeal, 10 October 2006, exhibit 76.
[173] Resolution, High Court Prosecutor's Office, 21 May 2007, exhibit 77.
[174] Ordinance of cancellation, High Court Prosecutor's Office, July 2007, exhibit 78.
[175] Information note, High Court Prosecutor's Office, 5 July 2007, exhibit 79.
[176] Resolution of non-indictment, High Court Prosecutor's Office, 8 October 2007, exhibit 80.
[177] Complaint by the CLR, 19 November 2007, exhibit 33.
[178] Resolution, High Court Prosecutor's Office, 11 December 2007, exhibit 82.
[179] Decision in file 472/54/2008, Craiova Court of Appeal, 10 April 2008, exhibit 84.
[180] Appeal brief by the CLR, exhibit 83.

judgment, which was rejected by the High Court of Cassation and Justice on 7 November 2008[181].

Other proceedings

145. The situation at the Poiana Mare Hospital generated significant public outrage, both in Romania and abroad. Thus placed under pressure to act, the authorities engaged in a number of proceedings as follows.

Criminal proceedings initiated by the CLR in relation to other deaths which occurred in January-February 2004

146. In addition to the applicants, the official investigation initiated by the CLR concerned six other people who also died in January-February 2004 in very similar conditions to the applicants[182]. Of these six people four were committed at the Hospital in the context of criminal proceedings, on the basis of Article 114 of the Romanian Criminal Code in force at that time (Cristinel Viorel Tranca, Ion Radu, Ovidiu Falcan, Costea Parjol), one died at the phtisiology ward of the Calafat Municipal Hospital located in Poiana Mare village, after having been hospitalised at the Hospital (Iulian Florescu Nanuti), and one (Dumitru Ion) died only after a short period of hospitalisation.. The proceedings relating to these people followed a very similar trajectory as above and also resulted in decisions of non-indictment.

The criminal proceedings concerning Valentin Campeanu

147. Campeanu Valentin was a teenager of Roma ethnicity, HIV-positive, with a severe intellectual disability, and with a history of suffering from other associated conditions such as tuberculosis and hepatitis. Campeanu was abandoned at birth and grew up in a social institution for children. When he turned 18, Campeanu was discharged from the children's home and on transferred to a medico-social care establishment. He only stayed there for a week, until he was transferred to the Hospital. The CLR found Campeanu alone in a separate cell at the Hospital during their monitoring visit on 20 February 2004. He had been left to die by medical personnel who refused to touch him for fearing of getting infected with the HIV virus and he died later that day, after a stay of only one week at the Hospital. The proceedings initiated by the CLR in relation to his death resulted in a decision of non-indictment. This case forms the object of a separate complaint to the Court[183].

Criminal proceedings concerning 129 deaths which occurred at the Hospital in 2002-2004

[181] The operative part of the Decision no. 3617 in file 472/54/2008 of the High Court of Cassation and Justice, exhibit 85 .
[182] These proceedings are summarised in the resolution of non-indictment of the High Court Prosecutor's Office, 8 October 2007, exhibit 80.
[183] *Campeanu v. Romania*, Application no. 47848/08.

148. In 2004 the Dolj Prosecutor's Office opened individual criminal investigations in relation to the deaths of 129 patients during 2002-2004, in response to an order issued by the High Court Prosecutor's Office[184]. In 65 of these files the Prosecutor's Office ordered the Craiova Institute of Forensic Medicine to undertake a forensic examination of the patients' medical files. On 10 February 2005 the Institute submitted 30 forensic reports of the 65 requested. In 20 of those cases the Institute concluded that shortcomings existed in the treatment received by the patients. The subsequent development in these files is not known, although it appears that all were closed on the basis of decisions of non-indictment.

Criminal proceedings concerning the financial management of the Hospital during 2002-2004

149. In 2004 the Dolj Prosecutor's Office opened a criminal investigation concerning the way in which the Hospital management spent the budget allocated to the hospital for the years 2002, 2003 and 2004[185]. The investigation looked at aspects such as whether the bids for supplies published by the hospital complied with existing law, the patient's food ratios, and the allocation of funds between various items in the budget, and their effective disbursement. The investigation did not yield any findings of criminal responsibility, and the file was closed on the basis of a decision of non-indictment.

Criminal proceedings concerning some nurses from the Hospital

150. In 2004 the Dolj Prosecutor's Office initiated four criminal proceedings concerning allegations that four nurses from the Hospital, including the head nurse, Veronica Tomescu, falsely declared that they had worked during Saturdays and Sundays receiving double pay[186]. The Prosecutor's Office pressed criminal charges against the four nurses. The subsequent development in these files is not known.

Measures taken by the Ministry of Health and conditions at the Hospital after February 2004

151. Immediately after the CLR exposed the dreadful conditions at the Hospital, Ovidiu Branzan the Minister of Health at the time, made a visit to the Hospital. On this occasion the Minister made the following statement:

> *I visited today the establishment at Poiana Mare and I can say that the statements according to which here people died of cold and hunger are unsubstantiated, and based on the visit carried out today I noticed acceptable conditions in relation to food, facilities and accommodation.*[187]

[184] Information note, Dolj Prosecutor's Office, 10 February 2005, exhibit 54.
[185] These proceedings are summarised in the resolution of non-indictment of the High Court Prosecutor's Office, 8 October 2007, exhibit 80.
[186] Information note, Dolj Prosecutor's Office, 10 February 2005, exhibit 54.
[187] Ministry of Health press release, 26 February 2004, exhibit 182.

152. Also on this occasion, the Minister of Health decided to suspend Rodica Pesea from her position as manager of the Hospital for "problems related to administration and substandard management"[188]. However, she kept her positions as psychiatrist and head of pavilion. In addition, the Minister blamed local authorities for passivity and decided to dismiss the director of the Dolj Public Health Department and the Director of the Romanian Railways Company's Hospital.

153. Over the following months, the Ministry took a number of measures[189] aimed at improving conditions at the Hospital, namely:

- It increased food ratios from 53,000 ROL to 70,000 ROL a day;
- It supplemented the budget allocated for urgent repair work of buildings belonging to the Hospital with 5.7 billion ROL;
- It increased the pay of personnel working in psychiatric hospitals by 50-100%.

154. In November 2005 the Ministry of Health announced its decision to close down the Hospital[190]. Faced with angry opposition from hospital staff who went on strike, the Ministry backed down and decided solely to transfer the patients hospitalised in the context of criminal proceedings to other establishments in the country. At the same time the Ministry committed not to decrease the number of patients hospitalised at the Hospital or to dismiss any members of staff[191].

155. On 1 June 2006 the Ministry of Health decided to reappoint Doctor Rodica Plesea as Director of the Hospital despite protests from the part of staff and civil society[192]. The Ministry noted that the criminal investigations into the deaths which took place in 2003-2004 were ended with decisions of non-indictment, and which held that the deaths had not been violent and were due to "pulmonary, cardiac or infectious diseases". As demonstrated above at the time when Pesea was reappointed proceedings concerning her criminal liability were ongoing.

156. The forensic patients were only moved from the Hospital on 30 January 2006[193].

157. After February 2004, abuses at the Poiana Mare Hospital came periodically to the attention of the public[194]. The Romanian mental health system remains largely unreformed to this day, despite promises by the Government after the national and

[188] Idem.
[189] See Ministry of Health press release, 2 March 2004 et seq., exhibit 182.
[190] Ministry of Health press release, 6 November 2005, exhibit 182.
[191] Ministry of Health press release, 3 December 2005, exhibit 182
[192] Ministry of Health press release, 1 June 2006, exhibit 182
[193] "*Nebunie la Poiana Mare, balamuc la Ojasca*", 31 January 2006, www.9am.ro, exhibit 187.
[194] See for example "*Dezvaluiri Accidentale: Festin la ghena, tolerat de medici*", www.editie.ro, 7 October 2009, "*Mizerie si tacere la Poiana Mare*", www,editie.ro, 31 May 2007, "*Inca doi bolnavi au murit la Poiana Mare*", www.editie.ro, 1 September 2005, "*Jampier, sanse minime de supravietuire*", www.editie.ro, 1 July 2005, ""*Decese in serie la Poiana Mare*", www.editie.ro, 21 April 2005, exhibit 186.

international outcry relating to the deaths of 2002-2003 to initiate a root and branch reform of the system[195].

III. RELEVANT DOMESTIC AND INTERNATIONAL LAW

A. Domestic law

158. A compilation of relevant legislation in the original language is attached to this application as exhibit 190.

B. International law

The United Nations Convention on the Rights of Persons with Disabilities

159. The United Nations Convention on the Rights of Persons with Disabilities ("*the UN Disability Convention*") 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 UN Disability Convention came into force on 3 May 2008. As of 8 December 2009, 143 States have signed it, including Romania on 26 September 2007 as well as the European Community, and 75 ratified it[196].

160. The fundamental purpose of the UN Disability Convention 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)*

161. The guiding values or principles of the UN Disability Convention 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 UN Disability Convention 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" which tends to view persons with

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[195] "*Raport privind respectarea drepturilor si libertatilor persoanelor aflate in institutii medico-sociale pentru persoane cu dizabilitati mintale*", Bucuresti, Editura Didactica si Pedagogica, .2008, available at http://www.crj.ro/Uploads/CRJAdmin/Raport_pacienti_dizabilitati_minatale.pdf; "*Monitorizarea drepturilor copiilor si tinerilor cu dizabilitati din institutiile publice*", UNICEF, Centrul pentru Resurse Juridice, Marlink, Bucuresti, 2007, available at http://www.crj.ro/Uploads/CRJAdmin/RaportCopii%20si%20Tineri%20cu%20Dizabilitati_UNICEF2006.pdf; "*Mecanismele de protectie pentru persoanele cu dizabilitati din institutiile medico-sociale: de la iluzie la realitate*", Centrul pentru Resurse Juridice, 2007, available at http://www.crj.ro/Uploads/CRJAdmin/RaportCRJ6Iulie2007.pdf; "*Hidden Suffering: Romania's Segregation and Abuse of Infants and Children with Disabilities*", Mental Disability Rights International, available at http://www.mdri.org/PDFs/reports/romania-May%209%20final_with%20photos.pdf .

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

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 UN Disability Convention when examining the issues raised by the case at hand.

The Committee for the Prevention of Torture

162. The Committee for the Prevention of Torture ("*the CPT*") visited the Hospital three times: in 1995, 1999 and 2004.

163. In 1995 the living conditions at the 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[197]. 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 the Hospital. 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.

164. In 1999 the CPT returned to the Hospital[198]. 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.

165. In June 2004 the CPT visited the Hospital for the third time, this time in response to reports concerning the increase in the mortality rate among patients[199]. 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.

[197] The 1995 CPT Report, exhibit 175.
[198] The 1999 CPT Report, exhibit 176.
[199] The 2004 CPT Report, exhibit 177.

The CPT Standards

166. The CPT Standards include detailed guidance in relation to the care and treatment that have to be available in detention facilities[200]. The CPT has emphasized that these standards are *mutatis mutandis* also applicable to psychiatric establishments[201].

- Prisoners should be able to have access to a doctor at any time (§34);
- A prison's health care service should at least be able to provide regular outpatient consultations and emergency treatment; prison doctors should be able to call upon the services of all specialists;(§35)
- A doctor should always be on call for emergency treatment; (§35)
- The direct support of a fully-equipped hospital service should be available (§36);
- A prison health care service should be able to provide medical treatment and nursing care, as well as appropriate diets, physiotherapy, rehabilitation or any other necessary special facility […]. Provision in terms of medical, nursing and technical staff, as well as premises, installations and equipment, should be geared accordingly (§38)
- A medical file should be compiled for each patient, containing diagnostic information as well as an ongoing record of the patient's evolution and of any special examinations he has undergone. In the event of a transfer, the file should be forwarded to the doctors in the receiving establishment. (§39)

167. The CPT Standards also include one section dedicated to psychiatric establishments, which includes references to patients' living conditions, treatment, staff and safeguards in the context of involuntary treatment[202].

IV. STATEMENT RELATIVE TO ARTICLE 34 OF THE CONVENTION

168. It is submitted that Article 34 of the Convention should be read so as to permit standing to the CLR to submit this application to the Court on the applicants' behalf. In particular it is submitted that this is justified on the basis of the general interest in examining this case, the applicants' special circumstances, the lack of alternative sources of representation and the recognition by local courts of standing to the CLR to pursue proceedings domestically on the applicants' behalf. The Court is invited to consider this submission in light of recent developments in European and international law, and in particular the adoption of the U.N. Disability Convention, calling for an end to exceptional legal regimes applied to persons with disabilities and to impunity for abuses against their human rights (see *Glor v. Switzerland*, §53).

[200] The CPT Standards, Section II.
[201] The CPT Standards, Section V, §26.
[202] The CPT Standards, Section V.

General principles

169. The victim status requirement 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). Consequently, the position of principle is 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 any other individual who does not comply with this basic requirement.

170. However, the Court has applied this rule with significant flexibility, allowing applications from persons other than those directly affected, in consideration of special circumstances in each individual case. The Court justified this approach on the basis that 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). At the same time, although the existence of a victim is indispensable, "this criterion is not to be applied in a rigid, mechanical and inflexible way throughout the proceedings" (*Karner v. Austria*, §25) 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).

171. The following is a general review of the case law on standing and victim status where the Court applied the aforementioned 'direct victim' rule with some flexibility, followed by an examination of the factors which were held to justify such an approach. As will be demonstrated, a significant consideration driving the Court's approach in this context has been the general interest of human rights.

Persons with standing to bring/continue proceedings before the Court

172. According to the Court' case-law three categories of persons have standing to bring a complaint to the Court. A fourth category may be discerned where the Court may decide to continue with the examination of a duly introduced application *ex officio*, even after the applicant has died.

173. 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 victims if they had to prove that they had been the direct target of such measures.

174. 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).

175. In principle, non-governmental organizations may not be able to claim to be a victim of measures which affect the rights of their 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.

176. 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 party to (*Ada Rossi v. Italy*, n$^{o.}$ 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*).

177. 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 situation 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" (*Fairfield 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. (Soering v United Kingdom, (A/161): (1989) 11 EHRR 439, §88)

178. 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.

179. 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)); and the husband of a woman subjected to a forced medical examination (*Y.F. v. Turkey*, no. 24209/94, 22 July 2003*)*, etc.

180. Where the direct victim dies before bringing their complaint to the Court, the situation is more complex. Initially the relevant test applied in order to decide whether a next of kin qualified as a victim for the purposes of bringing an application on behalf of their dead relative was whether the right is transferable or whether it is so eminently personal that it cannot be transferred (*Sanles Sanles v. Spain*). More recently, the Grand Chamber of the Court appears to have departed from this approach in the case of *Micaleff v. Malta* (also see *Marie-Louise Loyen and Bruneel v. France*, §29), where the Court recognized standing to the initial victim's brother to initiate proceedings before the Court on her behalf on the basis of the public interest of the issues raised by the case.

181. 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 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 noted that the case has a wider significance transcending the interests of the applicant and his heirs.

182. The fourth situation is when the applicant dies and there is no next of kin to continue the application. Even in such circumstances, the Court may choose to continue examining the application of its own motion, 'in the interest of human rights' (*Karner v. Austria*, no. 40016/98, § 28, 24 July 2003; *Gagiu v. Romania*, no 63258/00, 24 February 2009). These judgments are analyzed in further detail below.

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

183. 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 relationship between the representative and the victim and the existence of alternative sources of representation.

184. The vulnerability of the victim, due for example to their age, sex or disability is a relevant consideration in this context. The Court has emphasized the vulnerability of persons with disabilities in institutions in the case of *Herczegfalvy v. Austria*:

> *[The] position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with.(§82)*

185. The case of *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.

186. 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.

187. 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).

188. 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 a 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".

189. In the aforementioned *S.P., D.P., and A.T. v. UK* case, 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.

190. 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). Crucially, the applicant had not shown that the patients could not lodge an application in their own names, or with their guardians' support.

191. 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.

192. 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 neither "inappropriate nor unnecessary".

193. The problem of identifying the person who is most suitable to represent a victim was raised in cases concerning conflict between a natural parent and the person appointed by the authorities to act as the child's guardian. The Court stated that the relevant consideration here 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 to which the state appointed representative does not provide the requisite protection to the child and the state fails to appoint another guardian ad 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*).

194. A similar consideration informed the judgment of the Court in the case of *Stagno v. Belgium*, where the applicants' mother had squandered the indemnity paid by an insurance company to their benefit after their father's death. By the time they reached majority age and were able to complain in court in this regard, the statute of limitations had already expired. The applicants complained under Article 6 that the application of the statute of limitations in this instance represented a breach of their right to access to court. The Court held that the standing rules in force represented an absolute bar on their right to access to courts and held in their favour. The Court highlighted the State's failure to appoint an alternative curator to safeguard their rights before the statute of limitations expired:

> *Etant mineures, les requérantes ne pouvaient pas saisir le juge compétent, en raison de l'absence de désignation d'un curateur spécial qui est nécessaire pour représenter les enfants lorsqu'il y a conflit, comme en l'espèce, entre les enfants et leur représentant légal, en l'occurrence leur mère. Personne n'a pris l'initiative de demander la désignation d'un curateur spécial, en application de l'article 321 du code civil italien, et, vu l'âge des requérantes à l'époque, on ne saurait leur reprocher de ne pas avoir fait elles-mêmes cette démarche.(§30)*

195. Another significant factor taken into consideration by the Court is whether the leading issue(s) raised by the case go beyond 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.[203] This may arise in particular where an application concerns legislation or a legal system or practice in the defendant State (*Altun v. Germany*, Decisions and Reports no. 36, §32).

196. A striking application of the general interest principle took place in the *Micaleff v. Malta* case. Domestic proceedings in that case were initiated by Mrs. M, who died before lodging a complaint with the Court. Her brother complained before the Court on his sister's behalf that she had been denied a fair hearing, in particular because of her lack of opportunity to make submissions before an impartial tribunal contrary to Article 6 of the Convention. The Grand Chamber, like the Chamber before it, decided that the general interest, arising out of the issues raised by the case, justified extending the concept of victim status to include the victim's brother, even in the absence of any interest on his part in the application before the Court (*Micaleff*, §49-50). It should be remembered that although the issue that came to be decided by the Grand Chamber was of indisputable importance, the dispute that occasioned it was an argument between neighbours concerning the precise place in an apartment block where laundry could be hung to dry (see in this context the dissenting opinion of Judges Costa, Jungwiert, Kovler and Fura).

197. A similar approach has been adopted by the Court where the original applicant died during Court proceedings and 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 applicant had complained of his inability to succeed to the tenancy of his homosexual partner when a heterosexual partner would be able to do so in analogous circumstances. When the original applicant in the proceedings before the Court died, his heir waived the right to succeed to his estate, including in relation to any right regarding those proceedings. Nevertheless, 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 purpose 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.

[203] 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."

The Court has recently stated that the applicant's particular circumstances may justify the decision to continue the examination of an application after the applicant died, even in the absence of a person willing to continue the proceedings on their behalf, and in the absence of manifest public interest. 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).

198. 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*, § 35). However, the Court has on many occasions 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, *Micaleff v. Malta*, §49).

Application of the principles to the case at hand

The following arguments are submitted to the attention of the Court to support a more flexible approach to the requirements of standing and victim status in the case at hand.

(a) Considerations relating to the applicants

199. The applicants' vulnerability to abuse derives from both their actual and perceived mental health problems as well as from their long-term isolation at the Hospital.

200. As for the first factor, three applicants were diagnosed with paranoid schizophrenia, two had serious forms of intellectual disabilities, and one was suffering from depression of involution. For at least four applicants their vulnerability was enhanced by their relatively advanced age – Maria Bestea was 66, Dumitru Ticu 62 and Ioana Istrate 68. Although no examination has been undertaken in order to assess each applicant's functional capacity, it may be presumed based on their disability and prolonged institutionalisation that this was impaired to various degrees.

201. The applicants' vulnerability was compounded by their isolation in a psychiatric hospital over a long period of time – two applicants spent most of their lives in social care institutions and three applicants spent 8 to 10 years at the Hospital. Long-term hospitalisation and associated stigma increases the individuals' feelings of helplessness and powerlessness and is associated with a loss of social skills. For those who had never lived outside an institution in particular, these feelings are accentuated while at the same time they are lacking any understanding of the possibility of appealing to assistance from the outside. Furthermore, the controlling and coercive environment at the Hospital further increased their isolation and feelings of powerlessness, with a negative effect on their capacity to complain about the abuses they suffered during their lifetime.

202. The applicants' feelings of helplessness and vulnerability are highlighted in the letter they sent to the *Gazeta de Sud* newspaper and which is reproduced in part at the beginning of the current complaint. The letter is an appeal addressed to the outside world by a group of patients attempting to highlight to the blatant catastrophic abuses of human rights which took place at the Hospital. The letter also reveals the complete failure of the state apparatus to defend some of its most vulnerable citizens.

(b) Lack of alternative sources of representation

203. No alternative source of representation, either by a next of kin or in the shape of an adequate institutional arrangement, existed at the relevant time which could assist in vindicating the applicants' rights, either before or after their deaths, including before this Court.

204. The applicants in this case may be divided in two groups – those who demonstrably had no known relatives and those who had some relatives. It is submitted that in the particular circumstances of this case having known relatives does not represent a material difference as far as the standing requirement is concerned. This is because even where a family existed, they may have been instrumental in the initial placement and continued stay of the person concerned at the Hospital (see the case of Ioana Istrate whose family opposed taking her back home despite the recommendation of the doctors to do so).

205. The absence of any mention of the applicants' family members in the medical records and the investigation files is conspicuous. If some applicants clearly lacked any relatives, for others the only time when relatives were mentioned was usually in the context of their initial commitment to the Hospital. The Prosecutor's Office did not question any of the applicants' relatives during the official investigation. Furthermore, there is no evidence to show that the Hospital informed the applicants' relatives of their death or whether any of the relatives even came to claim the deceased's body. It is certain that only those who lacked relatives were buried in the hospital's cemetery, which is the case for at least two applicants (those in respect of whom autopsies were carried out – Maria Bestea and Miorita Malacu). Finally, the lack of relatives or the lack of support from a family is the main ingredient of what constituted a "social case", a category to which, it is submitted, all applicants belonged (see above §71-75).

206. The following is an account of the family situation of each individual applicant.

207. Maricica Barbu spent almost her entire life in social care institutions. This, in addition to the fact that there is no record of any relatives in contact with her, means that it is unlikely she had any relatives in a position to offer care and assistance.

208. Maria Bestea's medical file does not mention any relatives, while the circumstances in which she was hospitalised at the Hospital are unclear. Bestea was

buried in the Hospital's cemetery which indicates with certainty that if she had any relatives, they had abandoned her altogether.

209. No mention of relatives exists in Dumitru Ticu's investigation file. The CLR actually managed to identify and meet with his parents and tried to persuade them to get involved in the proceedings concerning their son's death. However, they refused to be involved, given their relationship of friendship with certain members of staff at the Hospital and considering that it was their decision to place the applicant at the Hospital[204].

210. The circumstances in which Ioana Istrate was hospitalised at the Hospital are unclear. Her medical records only make one brief reference to her relatives. On that occasion the doctor noted that the patient's mental state was such that justified release from the hospital, but the family did not agree with this measure. Consequently, Istrate, who only suffered from a type of depression, spent the following six years at the Hospital up until she died.

211. Miorita Malacu spent all her life in social care institutions which means in all likelihood that she had no known relatives. A witness questioned during the investigation stated that Malacu came from a nursery home for children and that "she did not have any relatives"[205]. The fact that she was buried in the hospital's cemetery suggests this to be the case.

212. Romanian legislation has in place a system of guardianship as an imperfect means of safeguarding the rights of persons with disabilities. However, at no point in time was the applicants' capacity assessed with a view to placement under guardianship. Even if this system is not compliant with the Convention, it would have provided a modicum of protection and potentially an avenue for pursuing proceedings related to the applicants' deaths. There is no other institutional arrangement at the domestic level whereby independent representation could be provided to the applicants in domestic and international proceedings.

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

213. The CLR has extensive expertise on the rights of people with mental disabilities placed in institutions and has represented the applicants throughout the duration of domestic proceedings. Furthermore, its standing to act on the applicants' behalf has been recognised by the highest court in Romania.

[204] It should be noted that next of kin are not recognised standing automatically by the Court – they must demonstrate interest in the application, which may be demonstrated by having complied with the exhaustion of domestic remedies criteria.
[205] Resolution of non indictment, Dolj Prosecutor's Office, 7 June 2004/Miorita Malacu, exhibit 39

214. 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[206]. The CLR has received 'public utility' status in 2004.

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

216. The criminal proceedings concerning the circumstances in which the applicants died were initiated as a result of a visit to the Hospital undertaken by the CLR. During the visit, the CLR witnessed the plight of the patients at the Hospital and decided to act on their behalf. They were at the origin of an international campaign spearheaded by Amnesty International aiming to pressure the Romanian Government into remedying the situation. As a result of the campaign, the Prosecutor's Office initiated investigations in relation to the hundreds of deaths which took place at the Hospital during 2002-2004, whereas before the CLR visit these deaths passed largely unnoticed. In the intervening years, and until now, the CLR conducted litigation on the applicants' behalf as well as entering into voluminous correspondence with various state agencies trying to secure a full investigation into the applicants' death.

217. The CLR has acted as a party in domestic criminal proceedings. Its standing to do so has been the object of extensive litigation as a result of a challenge brought by the Deputy Prosecutor of the High Court Prosecutor's Office. In an appeal brought by the CLR, the High Court of Cassation and Justice recognized the CLR had standing to pursue criminal proceedings on the applicants' behalf[207] (see above §71-75). 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.

[206] The CLR Statute, exhibit 189; more information about the CLR is available on their website, www.crj.ro .

[207] Decision in file no. 4948/1/2006, High Court of Cassation and Justice, 15 June 2006, exhibit 74.

Furthermore, the High Court noted that Article 13 of the Convention afforded victims the right 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 thereafter. Furthermore, the CLR was a non-profit organization with public utility status and their object of activity included activities aimed 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.

218. 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 specific individuals.

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

219. 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 in substance. Beyond providing justice to the applicants which would otherwise be denied, the case at hand raises important public policy issues the clarification of which could contribute to improved standards of protection for an extremely vulnerable class of individuals.

220. 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[208]. 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".

221. According to a comprehensive report published recently, 1.2 million persons with disabilities live in long-stay residential institutions[209]. The CPT identified numerous

[208] *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 .

[209] 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 .

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, and lack of legal assistance. 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.

222. Romania in particular continues to have in place a largely unreformed system of mental health care relying heavily on large-scale institutions, and which has been the object of continuous international and national concern[210]. There are very few safeguards to prevent abuse in the context of institutionalisation of people with disabilities. Once they are committed to institutions people have to face unspeakable abuses of their most basic human rights on a daily basis and which are perpetrated with impunity. Shedding light on this dark area is imperative and goes to the heart of the Court's purpose which includes providing protection to vulnerable minority groups.

223. The CLR therefore submits that this case would assist in clarifying standards in an important area of human rights law on which, to date, there has not been a great deal of jurisprudence. 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.

224. 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 group of persons to bring claims on their behalf. Otherwise this very vulnerable group 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.

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[210] *Raport privind respectarea drepturilor si libertatilor persoanelor aflate in institutii medico-sociale pentru persoane cu dizabilitati mintale*", Bucuresti, Editura Didactica si Pedagogica, .2008, available at http://www.crj.ro/Uploads/CRJAdmin/Raport_pacienti_dizabilitati_minatale.pdf; "*Monitorizarea drepturilor copiilor si tinerilor cu dizabilitati din institutiile publice*", UNICEF, Centrul pentru Resurse Juridice, Marlink, Bucuresti, 2007, available at http://www.crj.ro/Uploads/CRJAdmin/RaportCopii%20si%20Tineri%20cu%20Dizabilitati_UNICEF2006.pdf; "*Mecanismele de protectie pentru persoanele cu dizabilitati din institutiile medico-sociale: de la iluzie la realitate*", Centrul pentru Resurse Juridice, 2007, available at http://www.crj.ro/Uploads/CRJAdmin/RaportCRJ6Iulie2007.pdf; "*Hidden Suffering: Romania's Segregation and Abuse of Infants and Children with Disabilities*", Mental Disability Rights International, available at http://www.mdri.org/PDFs/reports/romania-May%209%20final_with%20photos.pdf .

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

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

VIOLATION OF ARTICLE 2

225. It is submitted that inadequate care and treatment, as well as inappropriate living conditions directly contributed to the applicants' untimely deaths, thus amounting to a breach of their right to life contrary to Article 2 of the Convention. The State further failed in its obligations under Article 2 to carry out an effective investigation into the applicants' deaths.

226. In particular, medical authorities responsible for the applicants' care and treatment repeatedly failed to take into account their extreme vulnerability as persons who suffered from significant physical and mental afflictions. In particular the illnesses which ultimately caused the applicants' deaths were either caused or exacerbated by their stay in Hospital. There was a complete failure to provide the applicants with adequate and appropriate treatment. Specific failings which resulted ultimately in their deaths included delays in treatment, inappropriate and insufficient medication and failure to transfer to an appropriate specialist establishment.

227. The applicants' submission under Article 2 should be considered in the context of the extremely high mortality rate at the Hospital after 1989, but in particular between 2002 and 2004. Thus 68 patients died in 2002, of which 27 died during the winter months (November-February)[211]. In 2003, 87 patients died, of which 42 during the winter months[212]. In the first two months of 2004, 17 patients died, including the applicants[213]. According to available death certificates, the vast majority of deaths were caused by cardiac problems[214]. Under pressure from public opinion, at the beginning of 2004, the authorities opened criminal investigations in relation to every death which occurred during the aforementioned periods (see above §146). To our knowledge, none of these investigations resulted in a finding of criminal liability.

A. With respect to the substantive failures to safeguard the applicants' lives

As to the law

228. The Court has repeatedly emphasized in its jurisprudence that the State must not only 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], 17 January 2002, 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).

[211] List of patients who died at the Hospital in 2002 and 2003, exhibit 178.
[212] *Idem*.
[213] List of patients who died at the Hospital between January 2004-May 2005, exhibit 179.
[214] List of patients who died at the Hospital in 2002 and 2003, exhibit 178.

229. Where death has been caused through negligence, the applicability of Article 2 will depend on whether there was a direct causal link between the applicant's death and the impugned negligence (*Dodov v. Bulgaria*, no. 59548/00 (Sect. 5), ECHR 2008, 17 January 2008, §69).The sphere of application of Article 2 cannot be interpreted as being limited to the time and direct cause of death – a chain of events triggered by a negligent act and leading to a loss of life may also fall to be examined under Article 2 (*Öneryıldız v. Turkey* [GC], no. 48939/99, ECHR 2004-XII, 30 November 2004, § 94-95, Dodov v. Bulgaria, §70).

The Court has repeatedly held that lack of resources cannot in principle justify prison conditions which are so poor as to reach the threshold of treatment contrary to Article 3 of the Convention (*Dankevich v. Ukraine*, no. 40679/98 (Sect. 4), 29 April 2003, § 144).

States' Article 2 obligations in the public health sphere

230. 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 (Sect. 4), ECHR 2004-II, 9 March 2004, § 71; *Tarariyeva v. Russia*, no. 4353/03 (Sect. 5), ECHR 2006-XV, 14 December 2006, § 74). Furthermore, it cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under Article 2 (see *Powell v. the United Kingdom* (dec.), no. 45305/99, ECHR 2000-V, 4 May 2000, § 1). 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, ECHR 2001-IV, 10 May 2001, § 219 and *Nitecki v Poland* (dec.), no. 65653/01 § 1, 21 March 2002; *Pentiacova & Ors v Moldova* no. 14462/03, 4 January 2005).

231. In the public health sphere States have a positive obligation 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, ECHR 2004-VIII, 8 July 2004, § 89; *Calvelli and Ciglio v. Italy, §49*; and *Powell v. the United Kingdom*). Moreover, States have an obligation to secure high professional standards among health professionals (*Dodov v. Bulgaria*, §82). The obligation to adopt appropriate regulations refers to medical doctors' errors (*Calvelli and Ciglio*), but also extends to other categories of staff such as medical orderlies or technical auxiliary staff, in so far as their acts may also put the patients' life at risk and/or where patients' capacity to look after themselves is limited (*Dodov v. Bulgaria*, §81). The relevant regulations must also provide for appropriate procedures, taking into account the technical aspects of the activity in question, for identifying shortcomings in the processes concerned and any errors committed by those responsible at different levels (*Oneryildiz v. Bulgaria*, §90).

States' Article 2 obligations with regard to persons in detention

232. 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 refer to both those detained under the criminal law and those detained on medical grounds where medical professionals have complete and effective control over care and movement (*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). 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).

233. 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*, §§ 80 and 87-89).

234. 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.

235. 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, 13 June 2002, §110). 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*). In particular, 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).

236. 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 those injuries and any death occurring during 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 July 2004, § 27).

As to the facts

237. It is submitted that by failing to provide the applicants with appropriate medical care and treatment, combined with the conditions under which they were hospitalised, resulting in their untimely death, the Respondent State violated their right to life as guaranteed by Article 2 of the Convention.

238. The multiple failures at the Hospital have been consistently exposed by the CPT in its three reports published in 1995, 1999 and 2004. In its 2004 report, the CPT has concluded that the deaths at the Hospital were caused by a combination of poor living conditions and insufficient care and treatment:

Au vu des constatations précédentes, on ne peut exclure que la conjugaison des conditions de vie difficiles - en particulier les carences alimentaires et les difficultés de chauffage - ait contribué à la dégradation progressive de l'état général de certains des patients les plus faibles, et que la pauvreté des moyens sanitaires alloués à l'hôpital n'ait pu éviter l'issue fatale dans plusieurs cas. (§20)

239. The National Forensic Institute reached similar conclusions, emphasizing the preponderant contribution of substandard living conditions to the deaths which occurred at the Hospital (see above §124-125)[215].

(i) Inadequate care and treatment

240. All patients experienced a steep deterioration in their health during the winter of 2003/2004. Poor living conditions at the Hospital are likely to have contributed to and exacerbated these problems. For four applicants aggravated physical ailments proved fatal, while the fifth applicant, Maria Bestea, died from a cranial traumatism in circumstances which are yet to be clarified (see above §32-39). Far from alleviating their health problems, the substandard care and treatment available at the Hospital contributed greatly to the applicants' demise. Poorly maintained and out of date facilities and equipment, lack of preventative and therapeutic treatment, inadequate keeping of medical records, delays in appropriate treatment including administration of required medication, severe staff shortages, and inadequate regulation of medical processes all combined to have a cumulative negative impact on the applicants' health.

241. Domestic legislation in force at the time set out a number of guiding principles on the provision of medical care and treatment in hospitals. Thus, Article 4 of *Law no. 270/2003 on hospitals* provides that hospitals have an obligation to "ensure conditions of accommodation, alimentation, prevention of infections"[216]. Article 3 of *Law 46/2003 concerning patients' rights*, provides that "the patient has to benefit from respect as a human being, without discrimination"[217]. Article 35 provides that the patient has "the right to continuous medical care until the amelioration of his health state or until they are

[215] Forensic report, National Forensic Institute, 17 November 2004, exhibits 8, 22, 32.
[216] Exhibit 190.
[217] Idem.

cured". Furthermore, "the patient has the right to terminal care in order to be able to die in dignity"[218]. Domestic social insurance legislation is premised on the "fair and non-discriminatory provision of a package of basic medical services to all holders of social insurance"[219]. This package comprises "medical services, service of health care, medicine, sanitary materials, and medical equipment"[220]. Medical services covered included preventive treatment as well as treatment "to cure the disease, to prevent further complications, and for the recovery or at least the amelioration of the suffering as may be the case"[221].

242. The Hospital was massively understaffed, the majority of existing staff were not qualified to work with psychiatric patients, and essential categories of staff were missing altogether (see above §102-108). At the same time, the Hospital lacked the most basic medical installations and equipment. The scarcity of staff had a significant negative impact on the quality of care and treatment offered to patients. Thus, for example, according to their job description GPs were obliged to examine each patient at least once a day. However, as is apparent from the applicants' medical records, individual examinations by GPs were weeks or even months apart.

243. The activity of record keeping was very poor. A governmental audit commission which visited the Hospital in 2003 found a number of shortcomings in that regard and imposed a number of sanctions[222]. The main record kept for each applicant was a "clinical observation log" ("*foaie de observatie clinica*", referred to as "medical records" throughout the brief) which was supposed to include data concerning the patients' health and the treatment applied. In practice, patients were consulted weekly by a psychiatrist and much less frequently by GPs. It should be noted that medical records did not include any information regarding treatment or the patient's state of health for months on end. At the same time, medical records did not include any information concerning the patients' diet, although entering this data was a task formally entrusted to GPs[223]. Some applicants, but not all, also had temperature logs ("*foaie de temperatura*") which were supposed to include information concerning the patient's state of health on a daily basis, but which in practice were completed infrequently and contained major gaps. The Hospital does not appear to have kept any other records on their patients.

244. The psychiatrists working at the Hospital took on extensive management, treatment and care duties, in addition to their normal duties (see above §102-108). Most entries in the applicants' records as well as in most death certificates were made by psychiatrists, In addition psychiatrists were the only ones entitled to undertake night shifts, which was quite problematic especially if medical emergencies occurred. In practice only one psychiatrist would be on duty for the whole Hospital during any given night, thus being responsible for its nominal capacity of 500 beds. The difficulties

[218] Exhibit 190
[219] Art. 1 (f) of the *Emergency Ordinance 150/31 October 2002, concerning the organisation and operation of the social health insurance system*, exhibit 190.
[220] *Idem*, Article 10.
[221] *Idem*, Articles 16 and 19.
[222] Internal public audit report, 16 January 2004, exhibit 170.
[223] GP's job descriptions, exhibit 145.

associated with this situation are reflected in the circumstances in which Maria Bestea died (see above §32-39). The practice prevalent at the Hospital of assigning extensive supervision, diagnosis and treatment duties in relation to somatic health conditions to psychiatrists is in potential breach of domestic legislation and good medical practice.

245. The treatment offered to patients at the Hospital was essentially reactive, seeking to address problems as they became apparent. It is the case that, for all applicants in the case at hand, doctors observed, recorded and attempted to treat the abrupt deterioration in patients' health at a very late stage, weeks or even days before they died. In those circumstances the chances of success for any treatment would have been reduced significantly.

246. The Hospital offered virtually no ongoing, preventative treatment. Patients, including the applicants, were subject to only one multidisciplinary consultation at the time when they were admitted to the Hospital, whereas the law provided that all social insurance holders had the right to "at least one preventative control every year, depending on the sex and the age group"[224], "aimed at tracing diseases which could have major consequences for morbidity and mortality"[225].

247. Despite lacking the specialist skills and equipment, the Hospital rarely referred patients for external treatment due to budgetary constraints, its isolated geographic position, as well as the reluctance shown by external establishments to deal with psychiatric patients (see below §419). Between them the applicants were referred to a specialised establishment for treatment only three times throughout their hospitalisation (see above §121), despite the fact that all of them experienced a rapid deterioration in health prior to death and the Hospital was clearly unable to address those problems. The Prosecutor's Office identified the refusal to transfer the applicants to an external establishment as a consistent failing in the events leading up to their deaths.

248. Medication was in short supply (with the possible exception of classic neuroleptics). According to one of the doctors, at the relevant time, the Hospital's pharmacy only held vitamins, intravenous glucose and antibiotics[226]. This is confirmed by the medical records of some applicants (Maricica Barbu and Maria Bestea), who invariably received vitamins, antibiotics and glucose drips as their health deteriorated before they died. Physiotherapy, rehabilitation or other special facilities were also absent from the Hospital.

249. One of the major areas of the noncompliance by the State with Article 2 is the lack of adequate regulation of medical processes, aimed at safeguarding the patients' right to life.

[224] Art. 11 (e) of the *Emergency Ordinance 150/31 October 2002, concerning the organisation and operation of the social health insurance system*, exhibit 190.
[225] *Idem*, Article 16 (c).
[226] Paul Mitroaica, 14 September 2004, exhibit 94; Prodan Gheorghita, 14 September 2004, exhibit 91.

250. The only documents included in the investigation file were the Rules of Internal Order ("*the Internal Rules*")[227] and the GP's job descriptions[228]. Both were woefully inadequate and outdated. The Internal Rules in force at the relevant time dated from 2002, and mostly included job descriptions for all categories of personnel. The 2002 Internal Rules included provisions referring to the care of patients with tuberculosis (which had been transferred from the Hospital in 2002) as well as staff positions which did not exist in practice such as the psychologist. Job descriptions were too general considering the absence of other specific provisions regulating medical processes.

251. The main piece of legislation concerning standards for the provision of medical services in State hospitals was concerned mostly with the financing of medical activities, and much less on setting applicable standards of quality[229]. Furthermore, the provisions of the Framework Contract were not adapted to the specificity of services provided in psychiatric hospitals and working with psychiatric patients and they were not correlated with other specific legislation such as the Mental Health Law. This in fact is reflected in the Contract of Provision of Medical Services for 2004 concluded between the Hospital and the Dolj Health Insurance Department and which was the basis on which the Hospital could operate during 2004. The Contract is a standardised document, and does not reflect the specific nature of the services provided by the Hospital.

252. Essential processes such as hospitalisation, emergency treatment, record-keeping, institutional relationships with external specialist establishments, hygiene standards, dealing with infectious outbreaks, disciplinary procedures, and obligations incurred by staff after a patient's death, were all either insufficiently regulated or completely unregulated. At the same time no adequate procedures were in place regulating the use of certain medicines with problematic side effects such as neuroleptics.

253. The failure of the authorities to ensure there was an adequate programme of care and treatment, and the complete absence of any appropriate framework within which the Hospital should have been expected to function, had a catastrophic effect on the applicants.

254. Maricica Barbu was only 34 when she died on 15 January 2004 (see above §19-26). The first indication in the medical record that her health was worsening is dated only on 12 January 2004. The doctor on duty did not however make any judgment about the nature of the ailment and prescribed generic medication: antibiotics, vitamins and a glucose drip, in addition to usual psychiatric treatment composed of neuroleptics and sedatives. On that day the doctor noted pointedly that there was no heating in the applicant's ward when outside the temperature was -10° Celsius.

255. Based on the evidence gathered during the investigation phase, it appears that Barbu's bronchopneumonia was facilitated by poor living conditions. Medical professionals failed to identify the bronchopneumonia in a timely fashion, or otherwise

[227] Exhibits 147, 148.
[228] Exhibit 145.
[229] The 2003 Framework Contract concerning the conditions for the provision of medical assistance in the system of medical social insurance, ("*the Framework contract*") exhibit 190.

refer Barbu to a specialist establishment so that full clinical and laboratory tests could be carried out. By the time medical personnel noticed there was something wrong with Barbu and applied some treatment it was already too late. Alternatively, medical personnel failed to transfer the applicant to an external establishment for adequate treatment. The Prosecutor's Office also noted that her medical records were incomplete and irregular and that discrepancies existed between the data entered in the medical record and the data included in the death certificate[230]. Finally, on one occasion, the Prosecutor's Office alluded to the fact that unrestrained treatment with neuroleptics might have led to Barbu's health problems (see above §26).

256. Maria Bestea died on 17 January 2004 at the age of 66 from a cranial traumatism (see above §27-39). Prior to her violent death, she suffered from a similar pattern of deteriorating health and inadequate treatment as the other applicants. At the time of death Bestea suffered from malnutrition.

257. As became apparent after her death, Bestea suffered from an oesophageal stenosis as a result of ingesting toxic substances when she was 25 years old. This early incident may explain the frequent instances of pain related to deglutition throughout her stay at the Hospital reported in her medical record. This problem worsened considerably towards the end of 2003, such that Bestea stopped being able to ingest any food approximately two months before she died. One criticism directed against medical staff referred to the fact that although they had been aware of the applicant's digestion problems, they failed to take adequate and timely precautionary measures to avert a deterioration of her health state[231].

258. The doctors attempted to address her digestion problems by providing her with vitamins and glucose drips, however this proved insufficient. Bestea's condition resulted in malnourishment, a state severe enough to entail damage of internal organs ("degenerative cardiac, hepatic and renal lesions"[232]). Medical professionals at the Hospital failed to stop, let alone reverse, this trend. By the time they took the decision to transfer Bestea to an external establishment her physical condition was such that she was, by that stage, terminally ill.

259. The external specialists who examined Bestea failed to treat her problem and returned her to the Hospital without any suggestions for treatment, which resulted effectively in a situation of therapeutic abandonment. A note in her medical record dated 14 January 2004 indicated in fact that she required urgent specialised examination and treatment, but none was forthcoming. The aforementioned failures were noted in fact during the official investigation, both by forensic experts as well as, at certain stages, by prosecutors (see above §26-39).

260. The discovery that Maria Bestea's death was violent was made to some extent by chance, since this was not mentioned in her death certificate or in the initial forensic

[230] Resolution of cancellation, High Court Prosecutor's Office/Maricica Barbu, exhibit 67.
[231] Resolution of the High Court Prosecutor's Office, 31 August 2004/Maria Bestea, exhibit 45.
[232] Idem.

examination. The exhumation led to the conclusion that death was due to a "violent cranial traumatism". It is submitted that the investigation failed to provide an adequate explanation as to the origin of this traumatism. This is a particularly serious failure on the part of authorities, given that the incident took place in a psychiatric hospital, where there were frequent ongoing incidents of violence and aggression.

261. The explanation advanced by authorities was that the traumatism was due to a fall. This explanation is not corroborated by the evidence gathered in the file. First, the report on the forensic examination of the body concluded that the traumatism could have been caused by a blow or an impact with or by a hard object. Second, the witness statements collected by the Prosecutor's Office are contradictory and inconclusive. The Prosecutor's Office interviewed three nurses who worked in the ward where Bestea was hospitalised[233]. All mentioned that Bestea was a very "peaceful" patient. At the same time they all stated that they heard from colleagues "that she suffered from very violent crises, during which she could fall from her bed". This statement is hearsay evidence, is potentially contradictory, and raises the question of the veracity of the alleged "crises" given that nurses working in the same ward had never seen this happening. At the same time, this information is not corroborated by Bestea's medical records, which do not contain any mention of crises and falls. Third, serious question marks surround the failure by the doctor on duty in Bestea's ward to enter her true cause of death in the death certificate. Additional questions persist in relation to the identity of the doctor on night duty when Bestea died and whether anybody examined her body after she died at all (see above §32-34). This incident is particularly problematic since it may leave potential violent incidents in a psychiatric hospital unnoticed and unreported.

262. Even assuming that Bestea used to fall off her feet and fall off the bed, the Hospital would have been under a duty to take effective precautionary measures to prevent her from hurting herself. As is apparent from the medical record, no such measures had ever been taken.

263. Dumitru Ticu died on 28 January 2004, aged 62 (see above §40-44). According to his death certificate he died from a myocardial infarction which led to a fatal cardio-respiratory failure. He was also cachectic at the time of his death and had secondary anaemia.

264. The forensic experts and the prosecutors at some stages during the official investigation highlighted major problems with the treatment and care afforded to Dumitru Ticu. Thus, concerns were expressed in relation to the long-term use of neuroleptics on a "peaceful and cooperative" patient, and the possibility that this might have led to other health problems as a side effect. All evidence in the file state squarely that the medical professionals at the Hospital misinterpreted Ticu's symptoms and administered treatment for gastric problems instead of cardiac problems. Medical professionals at the Hospital failed to refer Ticu to a specialist establishment in order to adequately diagnose his

[233] Statements of Andrei Marius, 16 April 2004, Picu Lelia, 16 April 2004, Segarceanu Aurelia Lavinia, 16 April 2004, exhibits 88-90.

problems. Ticu's lipoma and pediculosis revealed the precarious state of hygiene at the Hospital. Even when Ticu had been referred to specialised treatment this was done with much delay – his over infected lipoma was observed on 9 January and he was only transferred to an external medical service to have it removed almost two weeks later, on 21 January. Finally, Ticu's medical records had never been collected in the investigation file, and therefore it appears all decisions taken by the Prosecutor's Office were based on indirect statements of what actually happened to him.

265. Ioana Istrate died on 2 February 2004 at the age of 68 (see above §45-49). Both the forensic experts as well as some prosecutors at certain stages of the investigation stated squarely that Istrate had been misdiagnosed, that medical professionals at the Hospital interpreted her symptoms as signalling a gastric problem, when in fact she was suffering from cardiac problems which eventually proved fatal. As a result of the misdiagnosis, Istrate had not received any adequate treatment whatsoever, and was simply left to die in the Hospital. Her health problems may have been the result of long term use of neuroleptics. Istrate had not been transferred in a timely fashion to a specialised establishment for comprehensive examination, diagnosis and treatment.

266. Miorita Malacu died on 7 February 2004, aged only 32 (see above §50-59). She was another case of misdiagnosis and mistaken treatment. As is apparent from forensic reports as well as certain Prosecutor's Office decisions, Malacu died from pulmonary problems which were left untreated, and not from cardiac problems as mentioned in her death certificate. It appears that Malacu had not received any medication other than tranquilisers until she died. Malacu had not been referred to an appropriate medical establishment which could adequately examine, diagnose and treat her. In the run up to her death she suffered from pediculosis and other infections, further evidence of the precarious hygiene at the Hospital and which are likely to have contributed to lowering her bodily defence mechanism.

(ii) Poor living conditions

267. It is submitted that in addition to the multiple shortcomings in their treatment and care, the horrendous living conditions they experienced at the Hospital also directly contributed to the applicants' deaths.

268. The appalling conditions at the Hospital were a constant source of concern for the CPT after their three successive visits in 1995, 1999 and 2004. The 2004 report in particular singled out the problems with heating and nutrition as circumstances which contributed to the high mortality rate at the Hospital. In addition, the CPT condemned the Hospital for overcrowding, the poor state of wards and medical equipment, old and inefficient water and sanitation, lack of nutritious food, lack of heating and recurring outbreaks of pediculosis. The CPT account is corroborated by the report issued by the CLR pursuant to their visit to the Hospital on 20 February 2004[234]. In addition a number of state agencies with monitoring attributions that visited the Hospital before and after the period when the applicants died confirmed to a large extent the deficiencies extant at the

[234] The CLR Report, exhibit 33.

Hospital[235]. Most statements by the doctors at the Hospital, as well as those of other personnel and of patients, made during the official investigation confirm the conditions at the Hospital during the winter of 2003/2004 were extremely difficult. Prosecuting authorities generally accepted that such deficiencies existed but qualified them merely as administrative problems without criminal significance (see above §129). Consequently they failed to investigate the causes of such deficiencies or establish who was liable for them.

269. We would like to refer you to the factual section for a more detailed account of the living conditions at the Hospital, and in particular paragraphs §76-92). For this part only a few selected aspects will be analyzed.

270. It is a fact that in the absence of capital repairs, living conditions at the Hospital deteriorated continuously after 1989. Problems were aggravated by its isolated location as well as the large costs the Hospital needed to expend in order to operate. Winter time exposed these basic flaws. During winter outside temperatures fell frequently below -10° Celsius and consequently the costs of providing electricity, heating, hot water and other life essentials grew exponentially. As a result the Hospital was faced every winter with a spike in the mortality rate, a phenomenon which was known to authorities for a long time (see below §380-385).

271. The situation in the winter of 2003/2004 was particularly serious in view of the Hospital's failure to secure sufficient supplies in advance (see above §85-86). Three problems were singled out as having contributed significantly to the increase in the mortality rate: food, heating, and infectious diseases.

272. It appears that during the winter 2003/2004 the food offered to patients was neither appropriate nor adequate to ensure they received adequate sustenance. The daily food allocation for every patient during this period was only of 33,084 ROL, or 60% of the allocation provided by law (see above §87). During this period food had very little calorific content, a phenomenon measured and reported by the CPT. The patients' diet lacked any meat for months on end and was made up of very basic staple foods such as vegetable hotchpotch or rice. As a result many patients who died at the Hospital during this time displayed cachexia, an extreme form of malnutrition – including at least two applicants, Maria Bestea and Dumitru Ticu.

273. During the winter of 2003/2004 heating in the patients' wards was provided only for two hours a day. This was particularly problematic considering the cold weather, and was highlighted by medical professionals at the Hospital in Maricica Barbu's medical records. The problem of lack of heating was exacerbated by the fact that patients often lacked warm clothes and even shoes, and that in many wards windows and doors were damaged or altogether missing.

[235] Ministry of Health/Ministry of Justice report, 18 July 2003, exhibit 168, Ministry of Health report, 2 September 2003, exhibit 169, Ministry of Health report, 23 March 2004, exhibit 171

274. Hygiene standards were particularly poor at the Hospital, both in terms of cleanliness as well as the patients' personal hygiene. Reports suggest that during the winter of 2003/2004 restrictions on hot water meant that patients were only allowed to shower once a week. Pediculosis outbreaks were a significant challenge throughout 2003 and the first half of 2004, most likely aggravated by overcrowding problems in many Hospital wards. In addition to ailments such as furuncles and lipoma, and pediculosis outbreaks were a sure indicator of the unhygienic conditions at the Hospital.

275. All these factors combined – lack of food, lack of heating, infectious outbreaks – generated in all likelihood a weakening of the bodily defences and increased vulnerability to diseases. In the absence of adequate treatment, the effects of the applicants' illnesses were exacerbated.

B. With respect to the failures to carry out an effective investigation into the applicants' deaths

276. It is submitted that by failing to carry out an effective investigation into their deaths and the surrounding circumstances, the Respondent State violated its procedural obligations under Article 2 of the Convention.

As to the law

277. 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 its responsibility (*Oneryildiz v. Turkey,* §92). 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 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).

278. The necessity of carrying out an official investigation in accordance with the requirements of Article 2 in relation to public health related incidents is justified by the public interest that possible errors committed in the health care sphere should be established promptly, to allow the dissemination of information and thereby prevent the repetition of similar errors and contribute to the safety of health service users (*Dodov v. Bulgaria,* §89). Therefore not only the persons concerned but also society at large has a vested interest in seeing that an investigation is successful. In that regard, an investigation has a double purpose – to remedy past wrongs, but also correct systemic failures and thus prevent future similar incidents.

279. 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).

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

281. 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 those circumstances are largely 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).

282. 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*)*

283. 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. 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*)*

284. 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*).

285. 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).

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

287. 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).

288. 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).

289. 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).

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

As to the facts

291. It is submitted that nothing short of a criminal investigation and subsequent prosecution for any alleged wrongdoing is capable of satisfying the procedural requirements of Article 2 in the case at hand. Firstly, this case is a part of wider allegations that hundreds of patients died as a result of inadequate care and treatment as well as lack of food and heating. Secondly, many individuals and State agencies share responsibility for the applicants' demise. In that sense only an official investigation is capable of shedding light on the circumstances surrounding the applicants' deaths, which were largely within the knowledge of the State authorities. Thirdly, the responsibility of state officials and institutions in relation to the applicants' death goes beyond mere errors of judgment or carelessness. The relevant authorities consistently failed or omitted to take positive steps to secure appropriate protection for the applicants' right to life. Their awareness of the applicants' conditions and circumstances makes those authorities complicit in causing the applicants' deaths.

292. It is submitted that the official investigation was defective in a number of major respects: it was superficial and perfunctory, limited in scope, lacking in the requisite diligence to properly examine a case of this size, scope and complexity, extraordinarily complicated due to the competing and contradictory decisions from the High Court Prosecutor's Office, lacking in transparency and failed to have regard to the overall context within which the applicants' deaths occurred. More crucially, throughout the official investigation, prosecuting authorities ignored extensive evidence of criminal wrongdoing.

293. Although authorities had been aware for some time about the high mortality rate at the Hospital, no official investigation had been undertaken into the circumstances in which these deaths occurred, either by the Ministry of Health, the Prosecutor's Office or other authorities. The Prosecutor's Office initiated an investigation only after the CLR publicised the findings from its visit to the Hospital on 20 February 2004 and filed a formal criminal complaint, which in turn brought the situation at the Hospital into the public spotlight. The passivity of the Prosecutor's Office appears all the more striking as this is the institution entrusted with protecting the interests of vulnerable people, such as the applicants, with disabilities and without any family.

294. Throughout its course, the investigation was extremely limited in scope, despite the exhortations received from the CLR. Thus, the investigation only focused on the individual responsibility of the doctors involved in the applicants' treatment (both GPs and psychiatrists) and did not examine the responsibility of other individuals and authorities such as other categories of staff at the Hospital (nurses, other auxiliary personnel, individuals with managerial duties), the Ministry of Health (in its capacity as supervisor of the Hospital), other authorities with monitoring attributions and ultimately the Government. The prosecuting authorities lacked the expertise required to deal with,

and failed to recognize the complexity of events leading to the applicants' deaths, and the fact that responsibility for their deaths went beyond individual malpractice and extended to a systemic failure to provide adequate conditions for treatment and care of mental health patients.

295. The prosecuting authorities only focused on the immediate causes of the applicants' death and did not attempt to investigate the role played by relevant critical factors such as living conditions, medical mistreatment and the absence of essential medicines, installations and equipment. This is evident from the questions that the forensic experts were asked to examine during the investigation (see above §123). Despite the Prosecutor's Office's ability to undertake and define the extent of any criminal enquiry, the investigation in the case at hand was, for its duration, confined to the limits set in the introductory complaints (see above §118). Furthermore, the scope of the official investigation was also restricted temporally, focusing on the events in the run up to the applicants' death, instead of looking to how the applicants' health evolved over a period of time during their hospitalisation at the Hospital.

296. Despite the shortcomings of the official investigation, plenty of evidence was collected in the file establishing prima facie evidence of serious misconduct. The forensic reports established for instance that medical professionals failed in their duty to provide adequate treatment to the applicants in many critical respects, including instances of misdiagnosis, the failure to refer certain applicants to specialist treatment, and poor record keeping. Plenty of evidence in the file established that living conditions at the Hospital during the winter of 2003/2004 were inhuman and degrading and that hygiene standards were very poor.

297. The prosecutors employed various tactics in order to dismiss these findings.

298. The investigation led to an extensive list of findings that deficiencies concerning the treatment, care and living conditions existed at the Hospital during the relevant period. Likewise, the Prosecutors admitted that these deficiencies contributed to the applicants' death, but not in a decisive manner. Consequently, these deficiencies were qualified as administrative matters, and referred to the Ministry of Health for consideration. The finding that living conditions merely contributed to the lethal outcome but did not determine it points out to a systemic flaw in the practice of criminal prosecution in Romania.

299. Given that the investigation was limited to determining the liability of the doctors, factors such as living conditions or budgetary issues were dismissed since they could not be imputed to the doctors[236]. The Prosecutor's Office failed to investigate and determine the causes for these shortcomings and prosecute those responsible.

300. The prosecuting authorities ignored some problematic findings altogether. For example, the prosecutors ignored certain statements by medical staff claiming that the Hospital manager pressured doctors not to report patients' deaths to the Prosecutor's

[236] Resolutions, High Court Prosecutor's Office, 11 February 2005, exhibits 55-59.

Office. Instead, the Prosecutor's Office accepted the justification advanced by the Hospital's management that they were not aware of their legal duties in that regard.

301. Prosecutors relied on the absence of adequate regulations on malpractice in order to absolve medical personnel at the Hospital from criminal responsibility[237]. While this is not a valid justification in itself, the Prosecutor's Office ignored clear responsibilities where they existed, such as for example as part of job descriptions or where there was a legal duty on doctors to report deaths so that autopsies could be carried out in accordance with existing laws.

302. The investigation was exceedingly complex and complicated, due to a large extent to contradictory decisions by prosecutors within the same office - the High Court Prosecutor's Office. In the end the investigation was subject to excessive delays and included lengthy periods of inactivity. Considering the circumstances of the case there was no public accountability or transparency. The CLR provided the only element of public scrutiny throughout the investigation. The Prosecutor's Office did in fact continuously attempt to undermine any CLR involvement in the proceedings by submitting challenges based on standing.

303. The prosecuting authorities failed to collect critical items of evidence. This included documentary evidence (such as individual medical records, other documentary evidence concerning medical processes at the Hospital, the CPT reports etc), the failure to question important witnesses such as the CLR staff regarding their visit to the Hospital on 20 February 2004, and staff from State authorities with monitoring attributions. Even where witnesses were questioned, this was done in a non-inquisitive manner. The prosecuting authorities failed to examine properly and in detail the assertion by witnesses that living conditions as well as the treatment and care available at the Hospital were acceptable, as well as major factual contradictions between various statements by members of Hospital staff. Furthermore, in cases of medical malpractice, the prosecuting authorities failed to undertake autopsies immediately after the applicants' deaths.

304. The investigation was extremely superficial considering the size, scope and complexity of the case. Thus, the investigation was confined to a period of six months – between September 2004 and February 2005, when most witnesses were questioned and documentary evidence collected for the file. The first decisions of non-indictment were based solely on forensic reports and did not contain any reasoned analysis[238].

305. The Prosecutor's Office was very slow in gathering evidence, a crucial factor in hampering investigations concerning medical malpractice. In many crucial respects the investigation only started in earnest in September 2004, when doctors from the Hospital were questioned for the first time. In addition the usefulness of the only two autopsies carried out in case at hand was significantly reduced given that they were undertaken three months after the applicants' deaths.

[237] *Idem*.
[238] Resolutions of non indictment, Dolj Prosecutor's Office, June 2004, exhibits 39-42.

306. The circumstances in which Maria Bestea died set her aside from the other applicants. As previously stated the discovery that she died as a result of a cranial traumatism came to some extent by chance. Furthermore, despite the gravity of the findings of the forensic experts, the prosecuting authorities treated the investigation with extreme superficiality. The prosecutors readily accepted that the trauma she suffered was caused by a fall from her bed despite very serious doubts. They failed to clarify major inconsistencies in the versions of events supplied by medical professionals involved in Bestea's care before she died (see above §32-34).

307. On at least two occasions, prosecutors working for the High Prosecutor's Office issued decisions cancelling previous decisions of non-indictment where they highlighted the numerous shortcomings of the official investigation and made concrete recommendations concerning investigatory steps that needed to be taken[239]. These decisions were however thoroughly ignored, under the pretext they were issued in breach of procedural rules.

308. The domestic courts failed to carry out a proper and thorough examination of the decisions of non-indictment issued by the Prosecutor's Office. In particular the domestic courts failed to address in substance the matters raised by the CLR in their appeals against those decisions.

VIOLATION OF ARTICLE 3

309. During their hospitalisation at the Poiana Mare Hospital the applicants were subjected to inhuman and degrading treatment which went well beyond the threshold of gravity required in order to find a violation of Article 3. It is submitted that the following aspects taken together or separately amounted to inhuman and degrading treatment.

310. First, the applicants' placement and continuing detention in a psychiatric hospital lacking in any legal basis, inadequate and insufficient mental health treatment, the mentality based on control and coercion prevalent at the Hospital, the absence of measures aimed at increasing the capacity of the person concerned to return to community, and the deprivation of measures of support and safeguards normally available to persons with disabilities outside the Hospital, are all circumstances which amounted to inhuman and degrading treatment. All these matters were informed by extensive discrimination and the stigma attached to the applicants' disability and social status. Indeed, it is submitted that the treatment by the authorities of persons informally designated as "social cases" is at the origin of the applicants' predicament and ultimately their death.

311. Second, the applicants were subjected to extremely poor living conditions, a situation which was aggravated during the winter of 2003/2004. In addition to lack of heating and poor diets, the applicants suffered from inter alia overcrowding, poor facilities, lack of private space, and lack of adequate clothing.

[239] The Voicu and Sampetru decisions, see above §122, 138.

312. Third, the Hospital failed to provide the applicants with the most basic care and treatment facilities throughout their hospitalisation.

As to the law

313. 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).

314. 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 psychological suffering (*Moldovan v. Romania* (no. 2), nos. 41138/98 and 64320/01, § 113, ECHR 2005-VII).

315. 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). 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).

316. In relation to injuries sustained by people within the custody of the state the Court applies the standard of proof "beyond reasonable doubt" in its assessment of evidence at its disposal (*Ireland v. the United Kingdom* REF § 161). Such proof may follow from the coexistence of sufficiently strong, clear and concordant inferences or of similar unrebutted presumptions of fact. Where the events in issue lie wholly, or in a large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in custody, strong presumptions of fact will arise in respect of injuries occurring during such detention. In such cases it is up to the authorities to provide a satisfactory and convincing explanation (see *Salman v. Turkey* [GC], no. 21986/93, § 100, ECHR 2000-VII). In the absence of such explanation the Court can draw inferences which may be

unfavorable for the respondent Government (see *Orhan v. Turkey*, no. 25656/94, § 274, 18 June 2002).

317. One of the factors taken into consideration by the Court when assessing claims of ill treatment is whether any discriminatory animus has played a role in the infliction of inhuman and/or degrading treatment or torture. So far the Court has found this to be the case only in cases of racial discrimination. However, it is submitted that the same principles apply, mutatis mutandis to cases where ill treatment was informed by discriminatory attitudes towards people with disabilities. Thus, in the East Africans case, the Commission noted that racial discrimination may amount in itself to degrading treatment within the meaning of Article 3 (*East African Asians v. United Kingdom*, Commission Report, 14 December 1973, DR 78, p. 5, §62). In *Moldovan v. Romania*, the Court, after reiterating the Commission's dicta in the East Africans case, has held that racially discriminatory remarks of the authorities have been taken into account as "an aggravating factor in the examination of the applicants' complaint under Article 3 of the Convention" (*Moldovan and others v. Romania*, (No. 2)).

Mental health treatment

As to the law

318. Although the Court's case-law on care, treatment and living conditions in social care institutions is relatively underdeveloped, standards developed in cases concerning prison conditions may be applicable mutatis mutandis to the psychiatric context. In addition, the CPT offers useful guidance in relation to the specific standards applicable to social care institutions.

319. 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 whenever possible 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.

320. The Court has stated that the assessment of whether the particular conditions into which persons who suffer from mental health problems are placed are incompatible with the standards of Article 3 must 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).

321. 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).

322. In this respect, while it is for the authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used to preserve the physical and mental health of patients who are incapable of deciding for themselves, and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3 (*Slawomir Musial v Poland*, Application no. 28300/06, § 96, 20 Jan 09).

323. 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).

As to the facts

324. The nature and extent of the mental health problems suffered by each of the applicants were not significant factors in the Hospital's decision to commit or to continue holding them. Indeed, a person may be healthy before commitment, or become healthy during hospitalisation, and yet this does not have an impact on the decision to discharge/not to admit the person. The main consideration for taking and maintaining the measure of hospitalisation was to be found in the marginal social status of the person concerned. The prevailing ethos of the Hospital was to control the patients, rather than provide them with therapeutic treatment aimed at returning them to the community. Because they were labelled as psychiatric patients, the applicants did not benefit from the measures of support normally available to persons with mental disabilities outside the Hospital.

325. The treatment thus imposed on the applicants was arbitrary and lacked any support in law. At the same time a significant disconnect existed between the practice of hospitalisation and its portrayal as a therapeutic measure by the authorities. Finally the measure of indefinite hospitalisation was disproportionate and excessive in view of the applicants' mental condition. It is submitted that these circumstances taken together amounted to inhuman and degrading treatment in breach of Article 3.

326. Based on the available medical evidence from the Hospital's own records, it can be concluded that none of the applicants had such serious mental health problems, either in type or degree, justifying their admission followed by prolonged commitment at the Hospital. There is not one available diagnosis, or other evidence, to suggest the applicants

were in any way a danger to themselves or others and their condition in no way warranted this type of treatment and effective abandonment. This is reinforced by the fact that one of the doctors at the Hospital identified the four applicants in her care, Barbu, Istrate, Bestea and Malacu, as "social cases", which implies their placement at the Hospital was due more to their social status rather than the seriousness of their mental condition (see above §71-75).

327. As already stated, the legal basis for placement of "voluntary patients" at the Hospital is unclear (see above §67-69)[240]. As a rule, Hospital staff chose to ignore the provisions of the Mental Health Law setting out the procedural safeguards for involuntary commitment in a psychiatric hospital. The commitment process was very informal, being based on a request formulated by external medical authorities, the Police or the family of the person concerned and the informal agreement of a psychiatrist from the Hospital. No assessment of whether the person concerned represented a danger to himself or to others was made. The consent of the person concerned was likewise considered irrelevant.

328. The applicants' right to liberty was restricted much more than what was strictly necessary[241]. Indeed, it is submitted that placement at the Hospital amounted to a "deprivation of liberty" in the sense of Article 5 of the Convention. This is due to the "high security" regime of the Hospital and to the fact that patients were not free to leave, regardless of whether they belonged to the group of forensic patients or to the so-called "voluntary" patients[242]. The applicants' detention remained at all times under the exclusive control of the Hospital.

329. Once inside, the length of each applicant's detention was open ended, and not subject to review other than by psychiatrists at the Hospital. As demonstrated by this case, patients designated as "social cases" would spend many years at the Hospital, possibly their whole life. No written documents setting out the circumstances in which the person concerned was hospitalised, or reviewing the necessity for ongoing detention, exist.

330. An important consideration in the decision-making process concerning the hospitalisation and ongoing detention of any particular patient was the presence or otherwise of that patient's family. Frequently a person was committed to the Hospital on their families' initiative (this for example was the case with Ioana Istrate). Unless the family agreed, the person concerned would not be discharged, regardless of the fact that they might be perfectly healthy, as exemplified by Ioana Istrate's case. As for persons who spent their whole lives in social care institutions and who lacked any known relatives – such as Maricica Barbu and Miorita Malacu – the possibility of discharge was almost non-existent, regardless of their state of health.

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[240] Andrei Marius, a nurse at the Hospital, stated that all patients at the pavilion where he worked and which accommodated "social cases" were persons hospitalized "voluntarily", generally brought by their next of kin [sic!], exhibit 113.

[241] This is potentially at odds with Article 26§2 of the Mental Health Law: "The care provided to persons with mental health problems is delivered in the least restrictive environment."

[242] Article 41 of the Hospital's 2004 Rules of Internal Order provides that patients are obliged "not to leave the hospital without written permission", exhibit 148.

331. Considering that in addition to "voluntary" persons, the Hospital held patients who had been placed there in the context of criminal proceedings for having committed a crime, the "high security regime" was applied, by default, to all. There was no formal separation between the areas allocated to the two groups, who were sharing all facilities of the Hospital in common. In fact the two groups even shared one of the Hospital's pavilions. One ministerial commission which visited the Hospital in 2003 made the comment that the Hospital looked like "a penitentiary", and recommended that security should be achieved through other "modern means" such as "medication, individual supervision, increased observation and discipline"[243].

332. The Hospital cultivated a mentality based on disproportionate control and supervision of the 'patient' supported by the overuse of sedative medication rather than an approach aimed at alleviating the patients' mental health problems and returning them to community life. This may have been due to the confusion between "forensic" and "voluntary" patients but also to the stigma associated with disability. That this is so is demonstrated by the content of notes entered in the applicants' medical records, which were mostly limited to describing their state of spirit on the day as "peaceful", "cooperative", "restless", "uncooperative" in seemingly random combinations. In addition, as also confirmed by the CPT, most treatment administered to patients was made up of psychiatric medication, respectively classic neuroleptics, sedatives and tranquilisers (see above §95, 101). Given the lack of apparent connection with the applicants' actual state of health it may be surmised that the psychiatric medication was used primarily or, in some instances exclusively, as a means of controlling patients.

333. Patients at the hospital were not diagnosed in accordance with accepted medical practice and legislation and the treatment prescribed was not individualised according to the patient's mental health.

334. The applicants were not diagnosed in accordance with accepted standards such as the World Health Organisation International Statistical Classification of Diseases and Related Health Problems (ICD-10), as also required by Article 15§1 of the Mental Health Law. The diagnosis was not subject to review, and remained unchanged throughout the applicants' hospitalisation. According to Article 28 of the Mental Health Law, "the treatment and the care delivered to the person with mental health problems are based on an individualised therapeutic plan, discussed with the patient, revised periodically". None of the applicants benefited from such a plan[244].

335. The quality of entries made in the applicants' medical records is very poor, such that it is impossible to use those records as an adequate indicator of the mental health of the person concerned or of the evolution towards some (unidentified) therapeutic goal. The applicants' medical record would include the same weekly note – for example "peaceful and cooperative" - unchanged for years on end. The diagnosis set at the

[243] Ministry of Health/Ministry of Justice report, 18 July 2003, exhibit 168.
[244] Exhibit 190.

beginning of hospitalisation and the symptoms observed were expressed in very concise terms and often bore no logical connection.

336. As mentioned already, treatment was based exclusively on pharmacotherapy – particularly classical neuroleptics, sedatives and tranquilisers (see above §95, 101). Medical staff would enter in patients' medical records that psychiatric medication had been administered well in advance of it being actually administered – for example although Maricica Barbu died on 15 January 2004, her medical record attests that she continuously received psychiatric medication until 20 January[245]. For some applicants the therapeutic necessity of administering neuroleptics is in serious doubt – for example although Dumitru Ticu's medical record constantly recorded that he was "peaceful and cooperative" he continued being prescribed neuroleptics for years on end. This aspect was confirmed by a commission which visited the Hospital and which noted that there was no relationship between the patients' mental state and the psychiatric treatment actually administered (see above §95, 101).

337. Furthermore, during the investigation phase, certain prosecutors from the High Court Prosecutor's Office expressed strong doubts in relation to the possibility that the unrestrained use of psychiatric medication over a long period of time might have been at the origin of some medical problems faced by the applicants and which eventually led to their deaths (see for example the case of Dumitru Ticu, §264-265). This aspect had been totally ignored during the official investigation. To the contrary, at certain stages and with regard to certain patients, the Prosecutor's Office and some doctors from the Hospital sought to justify the cachexia of some patients as a side effect of prolonged neuroleptics use, rather than the result of substandard living conditions as the CLR claimed[246]. The attitude of authorities in relation to cachexia is a damning indictment of the manner on which the approached the provision of treatment to the applicants. To this end an opinion was sought from the National Forensic Institute, which noted that this scenario was very unlikely[247]. It is clear that both the Prosecutor's Office and these doctors regarded the unrestrained and indiscriminate use of neuroleptics as an essential part of psychiatric treatment, even if this should ultimately lead to malnutrition and possibly death.

338. The CPT standards require that psychiatric treatment involve "a wide range of rehabilitative and therapeutic activities, including access to occupational group therapy, group therapy, individual psychotherapy, art, drama, music and sports". Furthermore, "patients should have regular access to suitably-equipped recreation rooms" and they should be "offered education and suitable work"[248]. None of these components were present at the Hospital.

[245] Same situation for Ioana Istrate.
[246] See for example Grigorescu Ioana's statement, 11 November 2004, exhibit 131.
[247] Opinion of National Forensic Institute on side-effects of neuroleptics, 13 January 2005, exhibit 53.
[248] The CPT Standards, §37.

339. The stated purpose of mental health care according to the Mental Health Law is to "defend and strengthen personal autonomy"[249]. Social assistance legislation is also premised firmly on the objective of enhancing the "autonomy" of vulnerable individuals, including persons with disabilities, and "preventing social marginalisation and exclusion and promotion of social inclusion"[250]. To this end, Romanian legislation provides persons with disabilities with certain types of support, including social benefits, aiming at supporting their "professional and social integration"[251]. A number of procedures are put in place in order to achieve these objectives: defining the "handicap group" of the person concerned, preparing an "individual program of recovery, re-adaptation and social integration", undertaking the process of "complex evaluation"[252] among other types of support. The provisions of the Family Code providing for the possibility of incapacitating a person and placing them under guardianship are also framed as a measure of support for people with disabilities to exercise their rights[253].

340. The applicants did not benefit from any of these provisions during their hospitalisation. This is another example of how, once they were labelled as mental patients and hospitalised in a psychiatric hospital, all their other rights were basically suspended *sine die*.

341. It is submitted that institutionalisation of "social cases" might have been easily avoided by providing adequate support for community living, tailored according to the individual needs of the person concerned. Furthermore, this case illustrates the significant difficulties associated with providing mental health care and treatment in large institutional settings, something which was also noted by the CPT:

It is now widely accepted that large psychiatric establishments pose a significant risk of institutionalisation for both patients and staff, the more so if they are situated in isolated locations. This can have a detrimental effect on patient treatment. [254]

Living conditions in detention

As to the law

342. 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

[249] Article 28 of the Mental Health Law, exhibit 190.
[250] Article 1§1 of the Ordinance no. 68 of 28 August 2003 on social services, exhibit 190.
[251] Emergency Ordinance no. 102/1999 concerning the special protection and employment of persons with handicap, exhibit 190.
[252] According to Article 33§1 of Ordinance no. 68, "the process of complex of social evaluation aims at elaborating a strategy of support containing the package of measures and services adequate and individualised according to the identified social needs", exhibit 190.
[253] Exhibit 190
[254] The CPT Standards, §58.

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).

343. 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).

344. The extreme lack of space weighs heavily as an aspect to be taken into account for the purpose of establishing whether the impugned detention conditions were "degrading" from the point of view of Article 3 (see *Karalevičius v. Lithuania*, no. 53254/99, 7 April 2005).

345. Beyond overcrowding, the Court has noted other aspects of physical conditions of detention as being relevant for its assessment of compliance with Article 3 (*Orchowski v Poland*, no. 17885/04, § 22, 22 October 2009). Such elements include, in particular, the availability of ventilation, access to natural light or air, adequacy of heating arrangements, compliance with basic sanitary requirements and the possibility of using the toilet in private (*Babushkin v. Russia*, no. 67253/01, § 44, 18 October 2007; *Ostrovar v. Moldova*, no. 35207/03, § 89, 13 September 2005, and *Peers v. Greece*, no. 28524/95, §§ 70-72, ECHR 2001-III). Lack of basic privacy in a detainee's everyday life may also breach Article 3 (see, *mutatis mutandis*, *Belevitskiy v. Russia*, no. 72967/01, §§ 73-79, 1 March 2007; *Valašinas*, cited above, § 104; *Khudoyorov*, cited above, §§ 106 and 107; *Novoselov v. Russia*, no. 66460/01, §§ 32, 40-43, 2 June 2005).

346. It has also been held that 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 REF).

347. Furthermore 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).

As to the facts

348. The applicants submit that the conditions in which they were kept at Hospital amounted to inhuman and degrading treatment. As reported by the CPT and the CLR overcrowding, poor hygiene and sanitation, inadequate food, clothing and heating, lack of

private space and possessions both separately and cumulatively combined to create great physical and mental hardship and suffering for all applicants. A series of reports issued by State authorities with monitoring attributions during 2003 and 2004 highlighted the overall poor repair of most of the buildings and facilities including lighting, bathrooms, kitchens, laundry, water and sewerage[255]. Poor hygiene was identified as the cause of opportunistic illnesses in a number of applicants as well as of recurring outbreaks of pediculosis.

349. A prolonged stay in such conditions and the realisation of the high mortality rate among fellow patients must have a caused the applicants great suffering and despair, in addition to causing deterioration in their mental health as well as a loss of social skills and a sense of isolation.

350. These conditions deteriorated rapidly during the winter of 2003-2004, when temperatures frequently dropped below 0°Celsius, due in large part to a failure by the authorities to provide adequate resources for food, clothing and heating. Given the frail condition of all the applicants, it can only be concluded that the worsening living conditions must have contributed greatly and rapidly to their declining health.

Inadequate medical care and treatment

As to the law

351. 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). In addition, 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 of 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).

352. 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).

[255] Ministry of Health/Ministry of Justice report, 18 July 2003, exhibit 168, Ministry of Health report, 2 September 2003, exhibit 169, Ministry of Health report, 23 March 2004, exhibit 171

353. Furthermore, where the authorities decide to place and maintain in detention a person who is seriously ill, they should demonstrate special care in guaranteeing such conditions as correspond to his special needs resulting from his disability (see *Price v. the United Kingdom*, no. 33394/96, § 30, ECHR 2001-VII, and *Farbtuhs v. Latvia*, cited above, § 56; *Malenko v Ukraine*, no. 18660/03, § 53, 19 Feb 2009).

354. The Court has not ruled out the possibility that in particularly serious cases situations may arise where the proper administration of criminal justice requires remedies to be taken in the form of humanitarian measures (*Enea v Italy*, no. 749201/01 § 58, 17 January 2009; *Matencio v. France*, no. 58749/00, § 76, 15 January 2004, and *Sakkopoulos v. Greece*, no. 61828/00, § 38, 15 January 2004).

355. In this respect the Court has observed that there are three particular elements to be considered in relation to the compatibility of a patient'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).

356. It has been found that where an individual suffers from multiple illnesses this can increase the risk associated with any illness they suffer during their detention and thus add further to their hardship. 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, creates a strong feeling of insecurity which, combined with physical suffering, can amount to degrading treatment (*Khudobin v Russia* no. 59696/00, §95-96, 26 October 2006).

357. Where the lack of assistance gives rise to a medical emergency or otherwise exposes the victim to 'severe or prolonged pain', the breach of Article 3 may amount to inhuman treatment (*McGlinchey v UK* (2003) 37 EHRR 821). However, even where this is not the case a finding of degrading treatment may still be made if the humiliation caused to the victim by the stress and anxiety that he suffers due to the lack of assistance is severe enough (*Sarban v Moldova* (Appln No. 3456/05, 4 Oct 2005). For example, this was the case where the lack of medical treatment for the applicant's various illnesses, including TB contracted in prison, caused him considerable mental suffering thereby diminishing his human dignity (*Hummatov v Azerbaijan* (Applications nos. 9852/03 and 13413/04, 29 November 2007).

358. The mere fact that a detainee was seen by a doctor and prescribed a certain form of treatment cannot automatically lead to the conclusion that the medical assistance was adequate (see *Hummatov v. Azerbaijan*, nos. 9852/03 and 13413/04, § 116, 29 November 2007; *Malenko v Ukraine*, no. 18660/03, § 54, 19 Feb 2009).

359. The authorities must also ensure that a comprehensive record is kept concerning the detainee's state of health and the treatment he underwent while in detention (*Khudobin v. Russia* § 83), and that the diagnoses and care are prompt and accurate (*Hummatov v. Azerbaijan* § 115; *Melnik v. Ukraine*, no. 72286/01, §§ 104-106, 28 March 2006; and, *mutatis mutandis*, *Holomiov v. Moldova*, no. 30649/05, § 121, 7 November 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, and how the applicant's state of health was monitored. In the absence of such information, the Court may draw appropriate inferences (*Aleksanyan*, §147). Contradictions in medical records have been held to amount to a breach of Article 3 (*Radu v Romania*, no 34022/05, § 52, 21 July 2009).

360. The Court has found a breach of Article 3 where the authorities fail to provide sufficient details of the kind of treatment administered, when it was given and by whom (*Isayev v Ukraine*, *no. 28827/02*, § *62*, 28 May 2009; mutatis mutandis, *Ostrovar v. Moldova*, no. 35207/03, § 86, 13 September 2005) and consequently a plausible account of whether they have complied with their obligation to provide the applicant with adequate medical treatment while in detention (see, mutatis mutandis, *Khudobin v. Russia* § 88).

361. The authorities should also ensure that where necessitated by the nature of a medical condition, supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at curing the detainee's diseases or preventing their aggravation, rather than addressing them on a symptomatic basis (*Hummatov* §§ 109, 114; *Sarban v. Moldova*, no. 3456/05, § 79, 4 October 2005; and *Popov v. Russia*, no. 26853/04, § 211, 13 July 2006). The authorities must also show that the necessary conditions were created for the prescribed treatment to be actually followed through (see *Hummatov*, § 116, and *Holomiov* REF § 117).

362. The Court has found a violation of Article 3 where a detainee (with mental health problems) was not given specialist treatment in an external establishment (*Kucheruk v Ukraine*, no. 2570/04, § 151 and 152).

363. Forced medical treatment can amount to a breach of Article 3 where it is not of therapeutic necessity in the interests of the person's physical or mental health (*Jalloh v Germany*, 44 EHRR 667 § 69).

As to the facts

364. The applicants submit that they all received inadequate medical care and treatment for the various illnesses they developed during their stay in Poiana Mare which consequently caused them great physical and mental suffering and which amounted to inhuman and degrading treatment.

365. The Hospital was confronted with a lack of specialist skills (including dentists, physiotherapists, doctors specialised in domains other than psychiatry, pharmacists), a shortage of qualified personnel, a lack of adequate supervision and preventative checks, a lack of adequate medical equipment and facilities, inadequate record-keeping, and widespread indiscipline.

366. Despite lacking both specialist skills and equipment, the Hospital rarely referred patients for external treatment. Only three of the applicants were ever referred for emergency treatment, despite all of them experiencing a rapid deterioration in health prior to death. The Prosecutor's Office identified the refusal to transfer four out of the five applicants as a consistent failing.

The procedural obligation to investigate

As to the law

367. 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 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.

368. 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).

369. The requirements under the procedural obligation to investigate under Article 2 apply, mutatis mutandis, to situations arising under Article 3 (see above §278-291).

As to the facts

370. The applicants submit that the authorities omitted altogether to carry out a comprehensive investigation into the allegations of inhuman and degrading treatment made by the CLR. As detailed above at §292-309, the official investigation into all five applicants' death focused entirely on their immediate cause of death, while the issue of treatment and living conditions throughout their stay at the Hospital were largely ignored. In addition, aspects concerning the applicants' hospitalisation and continued stay at the Hospital, the adequacy of mental health treatment provided at the Hospital, ensuring that

the applicants benefited from all rights afforded to persons with disabilities living in the community were completely ignored by prosecuting authorities.

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

As to the law

371. The Court has interpreted Articles 2 and 3 to include the obligation to take preventative measures in order to safeguard life or protect against ill-treatment. The Court has held that in order to protect rights in the Convention, the State must take positive steps to prevent violations before they occur, and, when a violation is already occurring, to stop it once the authorities become aware of the situation. This obligation is a duty upon States to take steps to "safeguard the lives of those within its jurisdiction" (*Osman v. United Kingdom* §115; See also *Kılıç v. Turkey*, 22492/93, §62) by preventing violations and suppressing them when they have already taken place or are currently taking place (*Makaratzis v. Greece* 50385/99, §57).

372. The duty to put in place preventative safeguards is a procedural obligation necessary in order to guarantee the protection afforded under Articles 2 and 3 of the Convention as well as the right to an effective remedy under Article 13 (*Z and others v. United Kingdom 29392/95* §73). For instance, where a person's life is threatened by domestic abuse, the State must intervene if it has verifiable knowledge that the abuse is occurring *(Opuz v. Turkey, §130).* The Court has held that the State becomes responsible for a violation when authorities become aware of the situation. The State is obliged to "provide effective protection, in particular, of children and other vulnerable persons to prevent ill-treatment of which the authorities had or ought to have had knowledge" *(Z and others v. United Kingdom 29392/95* §73).

373. When measures are enacted, it must be shown that those measures were "appropriate and sufficient." When faced with a lack of any effort on the part of the State, the Court must then determine whether a minimum effort was possible and then whether it should have been made (*Ilascu and others v. Moldova and Russia*, §334).

374. Preventative positive obligations may include the duty to set up a "legislative framework" that provides protection 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".

375. Article 33 of the UN Disability Convention 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.

376. 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, to, inter alia, establish, at the domestic level, monitoring mechanisms. Although applicable to all detained persons, the provisions of the Optional Protocol are rendered especially urgent in the case of particularly vulnerable groups such as people with disabilities.

377. The preventative body recommended by the OPCAT provisions should be granted functional independence and be adequately staffed and funded. The mandate of the preventative body should include, at a 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.

378. 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.[256]

379. At the national level, many states in the Council of Europe area have in place monitoring mechanisms for mental health and social care institutions of variable effectiveness[257].

As to the facts

380. The Government has failed to respect its positive obligations to take preventative measures under Article 2 and 3 in two respects – firstly by failing to put in place an effective mechanism for monitoring the rights of persons placed in social care institutions and, secondly, by failing to act on the basis of information concerning the high mortality rate at the Hospital in order to prevent further ill-treatment and loss of life.

381. A number of State-appointed commissions with monitoring attributions have visited the Hospital in 2003 and 2004[258]. Although some reports were critical of certain

[256] §55 of the CPT Standards.
[257] "*Inspect!: Inspectorates of Mental Health and Social Care Institutions in the European Union*", Mental Disability Advocacy Centre, 2007, available at http://www.mdac.info/documents/122_Inspect.pdf .

aspects relating to living conditions, and the care and treatment available at the Hospital, they stopped considerably short of noting the gravity of the situation or mentioning the high mortality rate among its patients. In this regard, Jugravu Victoria, a member of the delegations during some of these visits stated during the official investigation that "she did not have any suspicion concerning the cause of death of patients which took place either in 2003 and 2004", and therefore "did not mention them in any of the reports on the visit"[259].

382. Other commissions which visited the Hospital did not notice anything wrong in relation to the living conditions, care and treatment delivered at the Hospital. The Internal Audit Commission, which visited the Hospital on 16 January 2004, made the following observations in relation to the quality of medical service provided by the Hospital:

The in-patient medical services of which the [patients] benefit consist of consultations, investigations, setting the diagnosis, medical treatment […], medication and sanitary materials, recommendations for discharge.
The laboratory investigations recommended by the specialist doctors are undertaken in optimal time, and the results thereof are attached and entered in the medical records.
The activity of taking biological samples is undertaken by the auxiliary medical personnel, in adequate hygienic and sanitary conditions.[260]

383. The same commission noted that "*wards selected randomly for verification, ensure the hygienic and sanitary conditions necessary for carrying out the medical activities*"[261].

384. In view of the above, the applicants submit 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.

385. Furthermore, although the authorities were well aware of the high mortality rate among patients at the Hospital, they did nothing to prevent the deaths of the applicants.

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[258] Exhibits 168-174.
[259] Jugravu Victoria, 31 January 2005, exhibit 141.
[260] Internal public audit report, 16 January 2004, exhibit 170.
[261] Idem.

VIOLATION OF ARTICLE 13 IN CONJUNCTION WITH ARTICLES 2, 3 AND 14

386. The applicants submit that the absence of effective remedies in respect of the breaches of their rights under Articles 2, 3, and 14 amounted to a violation of Article 13 of the Convention.

387. 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).

388. 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*, §§157-158). 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).

389. 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.

390. The case of *Dodov v. Bulgaria* concerned the disappearance of an elderly woman from a State-run nursing home. The applicant complained that his mother's life had been put at risk through negligence on the part of the staff of the nursing home, that the police had not undertaken all necessary measures to search for his mother immediately after her disappearance, and that the ensuing investigation had not resulted in criminal or disciplinary sanctions. The applicant also complained that his attempt to obtain compensation in civil proceedings had been frustrated by the dilatory approach of the defendant State authorities and that the proceedings had been excessively lengthy. The Court examined the applicants' submissions from the viewpoint of the positive obligation under Article 2 to set up an effective judicial system. In that context the Court examined

the whole range of remedies available under Bulgarian domestic law that offered the possibility of seeking accountability, namely criminal, disciplinary and civil proceedings.

391. 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 the applicant's inability to use an existing effective remedy due to his mental illness placed authorities under an obligation to provide an alternative 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*).

392. It is submitted that no effective remedies existed with regard to violations of the applicants' rights which occurred either during their lifetime or after they died.

393. It is submitted that the applicants faced a series of obstacles in accessing remedies that might have been available domestically during their lifetime. Although this has never been assessed adequately, it is reasonable to assume that the applicants' functional capacity would have been limited in various degrees due to their mental health conditions. No guardian or any other authority entitled to protect the applicants' individual interests existed at the relevant time who could have assisted them in accessing existing remedies. Any attempts at accessing available remedies would have been further hampered by the fact that the applicants were under the complete control of staff at the Hospital. The letter sent by a group of patients to a local newspaper asserts that letters of complaint had been in fact sent to the Ministry of Health, which failed to treat them seriously and instead sent them back to the Hospital's management[262].

394. In relation to the applicants' deaths, it submitted that Article 13 required a range of remedies which included, but was not limited to criminal investigation. Furthermore, the remedies required were necessary not only in order to secure the truth and accountability in relation to the circumstances in which the applicants died, but also to identify the root causes of the breakdown of the mental health system, prevent further violations and secure systemic reform. In the present case, the relevant domestic law purported to provide the possibility of seeking redress through criminal, administrative and disciplinary proceedings.

(i) Criminal proceedings

395. According to the Romanian Constitution, prosecutors "represent the general interests of society and defend the rule of law" (Article 131§1). Prosecutors take on additional duties to protect certain marginalised and vulnerable groups such as people with disabilities living in social care institutions. Thus for example, according to the Mental Health Law, the Prosecutor's Office has the role to control the legality of

[262] The letter from patients to the newspaper *Gazeta de Sud*, exhibit 33.

involuntary commitments to psychiatric hospitals[263]. Furthermore, the Family Code entitles the Prosecutor's Office to initiate the procedure of incapacitation and placement under guardianship, which is framed as a measure of protection for the interests of persons with mental health problems[264]. Finally, the ability of the Prosecutor's Office to initiate ex officio criminal investigations in relation to suspicious deaths becomes particularly crucial in circumstances such as in the case at hand, where the victim lacks any family to pursue proceedings on their behalf.

396. The Prosecutor's Office failed however in its obligation to provide protection for vulnerable persons such as the applicants. The Prosecutor's Office has generally refrained from exercising its powers to provide protection to people with disability, deferring at almost every opportunity to the judgment of medical professionals and government officials. The Prosecutor's Office failed to take any measures to prevent the harm caused to the applicants. After the applicants died, the Prosecutor's Office initiated an investigation only after they were subject to domestic and international pressure. The criminal investigation utterly failed to establish how the applicants died and failed also to bring those responsible for the applicants' deaths to justice (see above §292-309).

397. It is important to reiterate that the official investigation, flawed as it was, managed to determine significant shortcomings in relation to the living conditions, care and treatment available at the Hospital, and these shortcomings contributed significantly to the applicants' deaths. The Prosecutor's Office considered however that these were merely "administrative shortcomings" and consequently referred the file to medical authorities and asked them to take measures to improve these failures (see above §129). The Prosecutor's Office failed to monitor whether the relevant medical authorities managed to take any measures in that regard.

(ii) Administrative proceedings

398. Domestic and international outrage in relation to the situation at the Hospital which ensued after the CLR publicised the findings from their visit in February 2004, placed the spotlight firmly on the government's poor mental health policies. The Ministry of Health, which finances and coordinates the activities of the Hospital, is the main authority in charge with mental health-related policies. However, over the past five years the Ministry of Health has done little other than short term measures aimed at improving basic living conditions (i.e. in the aftermath of the scandal the Minister of Health sent the Hospital 700 kilograms of meat for feeding the patients[265]). The Ministry promised on a couple of occasions after the applicants' death to close down the Hospital but has not done so (see above §154). After significant procrastination the Ministry managed to achieve the transfer of forensic patients away from the Hospital, but only in exchange for a promise that the Hospital's bed capacity and personnel structure would remain unchanged (see above §155). The Minister of Health's approach to the tragedy at the Hospital has been characterised by lack of transparency and reluctance to engage in real

[263] Exhibit 190.
[264] Exhibit 190.
[265] Press release of the Ministry of Health 2 March 2004, exhibit 183.

change. It failed to investigate the root causes of the abuses which took place at the Hospital and bring about the reform of the mental health system. Although conditions at the Hospital have improved marginally, the situation there remains fundamentally unchanged. Reports of suspicious deaths, abuse, and mismanagement continue to surface in local and national media, and the mental health system remains largely unchanged since 1989.

(iii) Disciplinary proceedings

399. The Minister of health visited the Hospital in the immediate aftermath of the revelations made by the CLR regarding the situation there in February 2004. On this occasion he announced that the manager of the Hospital Rodica Pesea was suspended from her job. This however was not apparently in relation to the deaths themselves, but to previous reports concerning the manager's failure to contain the pediculosis outbreak at the Hospital. Furthermore, Pesea continued to work at the Hospital as a psychiatrist and head of pavilion. Also on this occasion, the Minister took the decision to dismiss the director of the Dolj Public Health Department and the Director of the Romanian Railways Company's Hospital. It is unclear how these decisions, particularly the latter one, were related in any way to the mortality rate at the Hospital (see above §153).

400. On 1 June 2006 the Ministry of Health decided to reappoint Rodica Pesea as Hospital Manager despite protests from the part of staff and civil society, and despite the fact that a criminal investigation concerning the deaths of numerous patients under her management was still open (see above §156).

VIOLATION OF ARTICLE 14 IN CONJUNCTION WITH ARTICLES 2 and 3

401. The authorities discriminated against the applicants on the basis of their actual or perceived mental health problems and on the basis of their social origin, together or separately, in breach of Article 14 taken together with Articles 2 and 3, on a number of counts. Thus, conditions of care and treatment at the Hospital were significantly poorer than conditions in medical establishments whose purpose is to provide treatment and care to the majority population. The applicants were subjected to disproportionate and arbitrary restrictions on their freedom of movement as well as being under extraordinarily restrictive levels of control on the basis of their perceived dangerousness. The authorities' failure to provide treatment to the applicants specific to their individual circumstances, with the purpose of expediting their return to the community, was a further violation of Article 14. Furthermore, the authorities' failure to act in a timely manner upon information regarding the abuses committed at the Hospital in order to prevent further deaths, as well as the criminal investigation, were based on overly-deferential attitudes towards the medical profession and ingrained stereotypes concerning people with disabilities. Finally, it is submitted that the applicants' social origin shaped their placement and treatment at the Hospital.

As to the Law

402. In order for Article 14 to be applicable, a complaint of discrimination must fall within the ambit of another Convention right, although it is not necessary that there be a violation of that substantive right (*Belgian linguistic case* (merits), judgment of 23 July 1968, Series A no. 6, § 9).

403. 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 is 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).

404. 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).

405. 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 reaches 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(*Nachova v. Bulgaria*, *DH v. Czech Republic*, §179).

406. The Court only recently made its first ever finding of discrimination on the basis of disability under Article 14 of the Convention in the case of *Glor v. Switzerland*. That case concerned the obligation imposed by the Swiss authorities on the applicant, who suffered from a physical disability, to pay a tax for exemption from military service, based on his inability to serve in the army. The Court found, in the circumstances of the case, that there was a violation of Article 14 in conjunction with Article 8 of the Convention.

407. The Court clarified in this case that Article 14 contains a non-exhaustive list of prohibitive grounds and that 'disability' was subsumed in the reference to "other status"

(§80)[266]. The Court highlighted the existence of a consensus in Europe and around the world "on the necessity of safeguarding persons suffering from a disability from discriminatory treatment", and mentioned the U.N. Disability Convention as evidence of this trend (§53). The Court also stated that the policy at issue had to be assessed against the necessity of "promoting the full participation and integration in society" of people with disability (§83). Finally, the Court clarified that in light of these imperative considerations, the margin of appreciation available to States "to establish a differential legal treatment for people with disabilities was significantly reduced" (§83).

408. In analysing the "reasonableness" of the justification advanced by Swiss authorities for the differential treatment at issue, the Court also took into consideration the failure to provide for "reasonable accommodation" to the applicant in finding a solution which responded to his individual circumstances:

[La Cour] se demande néanmoins ce qui empêcherait la mise en place de formes particulières de service pour les personnes qui se trouvent dans une situation semblable à celle du requérant. On peut penser notamment à des activités qui, bien qu'exercées au sein même des forces armées, exigent des efforts physiques moindres et qui seraient, dès lors, susceptibles d'être assurées par des personnes se trouvant dans la situation du requérant. Les législations de certains Etats prévoient, pour les personnes souffrant d'une incapacité partielle, des solutions de remplacement au service militaire au sein même des forces armées. En pratique, ces personnes sont recrutées à des postes adaptés à leur degré d'incapacité et à leurs compétences professionnelles.

409. The Court is yet to deliver any findings of discrimination based on "social origin", although this ground is mentioned explicitly in the enumeration included in Article 14.

410. Discrimination based on disability has been the object of more attention in international and comparative law.

411. The UN Disability Convention proclaims equality as one of its overarching values. 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

[266] The European Social Charter Committee, the body of the Council of Europe dealing with social, economic and cultural rights had already adopted this view in two of its decisions - Autisme-Europe v. France and Mental Disability Advocacy Center v. Bulgaria, concerning the right to education of children with disabilities.

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.

412. 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 *Eldridge et al. v. British Columbia (Attorney General).*[267] 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 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]."[268]

413. 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.*[269]

414. 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.*[270]

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[267] *Eldridge v. British Columbia (A.G.),* [1997] 3 S.C.R. 624
[268] Ibid § 73
[269] Ibid § 56
[270] 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

As to the facts

415. It is submitted that the applicants have been discriminated against on the basis of their disability and social origin, combined and separately.

(i) Substandard conditions of care and treatment

416. It is submitted that the applicants suffered from direct discrimination by reason of having been provided with care and treatment of a significantly lower quality/standard than that available to the majority of the population, on the basis of their actual or perceived disability.

417. As demonstrated above, poor living conditions (in particular lack of food, heating and poor hygiene) and inadequate care and treatment contributed decisively to the applicants' death. The applicants were hospitalised and subsequently detained in an environment that, rather than providing appropriate and necessary care and treatment to alleviate their unfortunate condition, instead exacerbated their ill-health to such a degree that they ultimately died. It is submitted that there is a significant degree of difference between the standards of care and treatment available in the Hospital compared to those available in medical establishments facilitating the general population.

418. Some indicators illustrate this difference. The daily food allocation for a patient during January-February 2004 was only 33,084 ROL (approx. 0.82 Euro/day), which represented circa 60% of the sum set by the law[271]. At the beginning of 2004, the Hospital only employed 299 staff, as opposed to 492 required by the law[272]. Only 11 doctors (5 psychiatrists and 6 GPs) worked at the Hospital, which meant that the doctor/patient ratio was of one psychiatrist for 88 patients and one GP for 73 patients[273]. This was vastly inferior to the ratio required by the law - a doctor for every 10-14 patients[274]. Many Hospital wards were overcrowded, with patients having to share the same bed. It is clear from any reasonable analysis of the Romanian health system that incidents of overcrowding only occurred in hospitals purporting to provide mental health treatment to patients. Whereas legislation in force provided that all social insurance holders had the right to "at least one preventive control every year, depending on the sex and the age group", "aimed at tracing diseases which could have major consequences for morbidity and mortality", patients at the Hospital only benefited from one multidisciplinary consultation on admission to hospital. The Hospital also experienced

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of the Special Rapporteur on Disability of the Commission for Social Development E/CN.5/2005/5 30 November 2004, at §101 and 116

[271] Ministry of Health report, 23 March 2004, exhibit 171.

[272] The 2005 CPT Report, §25, exhibit 177. The norms of personnel for medical services were regulated at the relevant time on the basis of the *Order no. 208/17 March 2003 on the approval of norms of personnel*, exhibit 190.

[273] For example, the *Order no. 208/17 March 2003 on the approval of norms of personnel* required a doctor for every 10-14 patients and a nurse for every 8-12 patients, exhibit 190.

[274] Idem.

significant shortages of essential drugs, which are which are available as a matter of course in other medical establishments.

419. To some extent, the absence of necessary facilities and equipment at the Hospital could have been compensated by referring the applicant concerned to specialised establishments. This however happened very rarely (see above §97), and was also due to the stigma associated with mental disability among medical professionals. Thus, a doctor at the Hospital stated that "psychiatric patients may not be hospitalised in the same place with healthy patients"[275]. The Hospital manager at the time noted that "specialised hospitals answer to our appeals with great difficulty because the somatic ailment is accompanied by a mental disease which as a rule everybody is trying to avoid"[276]. Calina Viorica, another doctor from the Hospital, stated that she noticed a feeling of "reluctance from the part of external experts with regard to mental disease"[277].

(ii) disproportionate and arbitrary control

420. It is further submitted that the disproportionate restrictions on the applicants' freedom of movement and the ideology of coercion and supervision prevalent at the Hospital were based on widespread stereotypes concerning the presumed dangerousness of people with mental disabilities. It should be reminded in this context that most observations made by psychiatrists in the applicants' medical records referred to whether they were "cooperative" or "calm" on the day. As such this attitude was discriminatory and without any conceivable foundation or justification.

421. As demonstrated already, the applicants' placement and continuous stay at the Hospital may be regarded as a "deprivation of liberty" in accordance with Article 5 of the Convention (see above §333). The applicants' placement and continuous stay at the Hospital was open-ended and not subject to review. Once inside the Hospital, the applicants were subject to a "high security" regime, similar to the regime of a detention facility. The only therapy available at the Hospital was psychiatric medication, the unrestrained and indiscriminate use of which seemed to be directed at ensuring the compliance of patients perceived as dangerous (also see above §101).

422. In the absence of any assessment of the danger posed by any of the applicants to themselves or others and of any adequate diagnosis of their mental health condition (see above §325-326), these restrictions were arbitrary and discriminatory and based on their actual or perceived mental disabilities.

(iii) lack of an individualised approach

As recognised by the Court in the *Thlimennos* case, discrimination also exists when authorities treat in the same way persons whose situations are significantly different. By

[275] Prodan Gheorghita, 14 September 2009, exhibit 99.
[276] Pesea Rodica, 14 September 2009, exhibit 98.
[277] Calina Viorica, 16 September 2004, exhibit 105.

failing to treat the applicants on the basis of their individual needs and circumstances, the authorities discriminated against them on the basis of their mental disability. The Hospital treated people with widely differing physical and mental health conditions in the same way. This is another instance in which the Hospital resembled a detention facility rather than a medical establishment.

423. First and foremost, the hospital failed to treat "forensic" patients differently from "voluntary" patients. As already stated, these two groups of patients shared the hospital's facilities. This confusion resulted in the application of the "high security" regime and of a mentality based on control and supervision of all patients regardless of their condition or the reason for their hospitalisation.

424. Among "voluntary" patients, everybody was treated more or less in a similar manner. Long-term commitment of persons with intellectual disabilities or mild mental health problems such as depression in a psychiatric hospital is contrary to best medical practice and standard medical guidelines. Once inside, an individualised therapeutic approach should have been devised with the firm objective of returning the person concerned to the community, and ensuring that progress towards this goal was constantly monitored. The legislation, and best medical practice, requires that an individualised treatment plan is devised, which includes a combination of pharmacotherapy, rehabilitative and therapeutic activities, including occupational therapies, group therapy, individual psychotherapy, art, drama, music sports, education and suitable work. In addition, and depending on the mental and physical health of the person concerned an individualised diet may be required.

425. In the case at hand all applicants received more or less identical treatment heavily based on pharmacotherapy, and lacking in any alternative therapies. The treatment delivered to the applicants did not change in time nor was it dependent on the applicants' individual circumstances. The food, insufficient as it was, was the same for all applicants, regardless of individual dietary requirements. This was the case with Maria Bestea, who suffered from pains related to deglutition throughout her stay at the Hospital and towards the end of her life was no longer able to eat the food provided by the Hospital at all.

(iv) the authorities' discriminatory attitudes

426. It is submitted that the passivity of the authorities, including the Prosecutor's Office, was informed by discriminatory attitudes and widely shared stereotypes towards persons with disabilities, as well as by an overly-deferential approach towards the medical profession, both before and after the period within which the applicants died.

427. Authorities, including the Prosecutor's Office were aware of the situation at the Hospital well before the period when the applicants died, including with regard to the spiralling mortality rate. It is telling in that regard that although the Prosecutor's Office opened individual criminal files on each death which occurred at the Hospital in 2002, 2003 and the first months of 2004, no criminal charges have been filed in relation to any of those cases. Even where serious instances of misconduct and abuse have been

identified, they were generally ignored altogether. This approach inspired confidence in those involved in the treatment and care of patients at the Hospital and in other mental health establishments that any abuses committed against people with disabilities could be carried out with impunity. The indifference of the authorities, and in particular the Prosecutor's Office, towards ensuring the proper investigation and prosecution of the perpetrators was incompatible with the principle of equality of every person before the law.

(v) discriminatory treatment based on "social origin"

428. It is further submitted that the applicants' placement and subsequent treatment at the Hospital were informed and shaped by their social origin, in addition to their actual or perceived mental health problems. As already illustrated, all applicants belonged to the group of so-called "social cases", people with a marginal social status, who are found in a situation of vulnerability due to a combination of many factors – lack of family support, lack of income, lack of a home or substance-abuse problems. As shown above, "social cases" were more likely than others to end up in the Hospital, remain there for a long period of time and be subjected to inhuman and degrading treatment. In fact authorities and medical professionals attempted at various stages of the investigation to portray the placement of social cases at the Hospital as a measure of social support to their benefit.

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

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

Decision no. 3617 in file 472/54/2008 of the High Court of Cassation and Justice, 7 November 2008 (exhibit 85)

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

Proceedings in this case were extraordinarily complicated, mostly due to procedural errors committed by the Prosecutor's Office, as well as the lack of transparency during the official investigation. Therefore, some ramifications of the proceedings remain unknown to the applicants. The following are however the most important decisions in the case at hand.

- Resolution of non indictment, Dolj Prosecutor's Office, 7 June 2004/Miorita Malacu
- Resolution of non indictment, Dolj Prosecutor's Office, 7 June 2004/Maria Bestea
- Resolution of non indictment, Dolj Prosecutor's Office, 22 June 2004/Maricica Barbu
- Resolution of non indictment, Dolj Prosecutor's Office, 25 June 2004/Ioana Istrate

- Resolution of the High Court Prosecution Office, 31 August 2004/Miorita Malacu
- Resolution of the High Court Prosecutor's Office, 31 August 2004/Maria Bestea
- Resolution of the High Court Prosecutor's Office, 31 August 2004/Ioana Istrate
- Resolution of the High Court Prosecutor's Office, 31 August 2004/Dumitru Ticu
- Resolution of the High Court Prosecutor's Office, 31 August 2004/Maricica Barbu
- Resolution, High Court Prosecutor's Office, 11 February 2005/Dumitru Ticu
- Resolution, High Court Prosecutor's Office, 11 February 2005/Miorita Malacu
- Resolution, High Court Prosecutor's Office, 11 February 2005/Maria Bestea
- Resolution, High Court Prosecutor's Office, 11 February 2005/Ioana Istrate
- Resolution, High Court Prosecutor's Office, 16 February 2005/Maricica Barbu
- Resolution of cancellation, High Court Prosecutor's Office/Dumitru Ticu
- Resolution of cancellation, High Court Prosecutor's Office/Maricica Barbu
- Resolution of cancellation, High Court Prosecutor's Office/Ioana Istrate
- Resolution of cancellation, High Court Prosecutor's Office/Miorita Malacu
- Decision in file no. 106/P/2006, Craiova Court of Appeal, 16 March 2006.
- Decision in file no. 6969/54/2006, Craiova Court of Appeal, 6 June 2006.
- Decision in file no. 18114/54/2005, Craiova Court of Appeal, 8 June 2006.
- Decision in file no. 4948/1/2006, High Court of Cassation and Justice, 15 June 2006.
- Ordinance, Prosecutor's Office attached to the Craiova Court of Appeal, 10 October 2006.
- Resolution, High Court Prosecutor's Office, 21 May 2007.
- Ordinance of cancellation, High Court Prosecutor's Office, July 2007.
- Resolution of non-indictment, High Court Prosecutor's Office, 8 October 2007.
- Resolution, High Court Prosecutor's Office, 11 December 2007.
- Decision in file 472/54/2008, Craiova Court of Appeal, 10 April 2008.
- The operative part of Decision no. 3617 in file 472/54/2008 of the High Court of Cassation and Justice.

431. 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

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

No claims for just satisfaction will be submitted.

VIII. STATEMENT CONCERNING OTHER INTERNATIONAL PROCEEDINGS

433. 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)

434. The applicants' medical records

Maricica Barbu

1. Medical record 19 June 1985-26 July 2002.
2. Medical record 29 July 2002-15 January 2004.
3. Record of interruption of pregnancy, 7 January 1986.
4. Death certificate, 15 January 2004.
5. Ordinance, Dolj Prosecutor's Office, 12 March 2004.
6. Forensic report, 25 March 2004.
7. Letter of request, High Court Prosecutor's Office, 12 October 2004.
8. Forensic report, National Forensic Institute, 17 November 2004.

Maria Bestea

9. Medical record, 5 July 1996 – 20 January 2004.
10. Death certificate, 20 January 2004.
11. Ordinance, Dolj Prosecutor's Office, 12 March 2004.
12. Forensic report, 26 March 2004.
13. Letter of request, Dolj Prosecutor's Office, 15 April 2004.
14. Forensic report on exhumation and annexes, 4 June 2004.
15. Forensic report, National Forensic Institute, 17 October 2004.

Ioana Istrate

16. Medical record, 29 June 1994 - 2 February 2004.
17. Temperature log.
18. Death certificate, 4 February 2004.
19. Ordinance, Dolj Prosecutor's Office, 12 March 2004.
20. Forensic report, 25 March 2004.
21. Letter of request, High Court Prosecutor's Office, 12 October 2004.

22. Forensic report, National Forensic Institute, 17 November 2004.

Miorita Malacu

23. Medical record (27 March 1990-7 February 2004)
24. Temperature log.
25. Discharge note, 27 December 2001.
26. Death certificate, 9 February 2004.
27. Ordinance, Dolj Prosecutor's Office, 12 March 2004.
28. Forensic report, 23 March 2004.
29. Letter of request, Dolj High Prosecutor's Office, 26 March 2004.
30. Forensic report on exhumation and annexes, 3 June 2004.
31. Letter of request, High Court Prosecutor's Office, 12 October 2004.
32. Forensic report, National Forensic Institute, 17 November 2004.

435. The criminal proceedings

33. Criminal complaint by CLR (including "the CLR Report" and "the patients' letter").
34. Criminal complaints by Amnesty International and A.N.A.P.A.S.S.
35. Task allocation note, 23 February 2004.
36. Information note, 27 February 2004
37. Notice of initiation of criminal investigation, Dolj Prosecutor's Office, 12 March 2004
38. Information note, 19 March 2004
39. Resolution of non indictment, Dolj Prosecutor's Office, 7 June 2004/Miorita Malacu
40. Resolution of non indictment, Dolj Prosecutor's Office, 7 June 2004/Maria Bestea
41. Resolution of non indictment, Dolj Prosecutor's Office, 22 June 2004/Maricica Barbu
42. Resolution of non indictment, Dolj Prosecutor's Office, 25 June 2004/Ioana Istrate
43. Letter of the CLR, 24 August 2004.
44. Resolution of the High Court Prosecution Office, 31 August 2004/Miorita Malacu
45. Resolution of the High Court Prosecutor's Office, 31 August 2004/Maria Bestea
46. Resolution of the High Court Prosecutor's Office, 31 August 2004/Ioana Istrate
47. Resolution of the High Court Prosecutor's Office, 31 August 2004/Dumitru Ticu
48. Resolution of the High Court Prosecutor's Office, 31 August 2004/Maricica Barbu
49. Letter of the High Court Prosecutor's Office, 2 September 2004.
50. Letters of the Hospital, October 2004.
51. Report, High Court Prosecutor's Office, 16 September 2004.
52. Report, High Court Prosecutor's Office, 10 November 2004.
53. Opinion, the National Forensic Institute, 18 January 2005.
54. Information note, Dolj Prosecutor's Office, 10 February 2005

55. Resolution, High Court Prosecutor's Office, 11 February 2005/Dumitru Ticu
56. Resolution, High Court Prosecutor's Office, 11 February 2005/Miorita Malacu
57. Resolution, High Court Prosecutor's Office, 11 February 2005/Maria Bestea
58. Resolution, High Court Prosecutor's Office, 11 February 2005/Ioana Istrate
59. Resolution, High Court Prosecutor's Office, 16 February 2005/Maricica Barbu
60. Information notes, High Court Prosecutor's Office, 16 March 2005.
61. Complaint by the CLR (Maricica Barbu)
62. Complaint by the CLR (Maria Bestea)
63. Complaint by the CLR (Dumitru Ticu)
64. Complaint by the CLR (Ioana Istrate)
65. Complaint by the CLR (Miorita Malacu)
66. Resolution of cancellation, High Court Prosecutor's Office/Dumitru Ticu
67. Resolution of cancellation, High Court Prosecutor's Office/Maricica Barbu
68. Resolution of cancellation, High Court Prosecutor's Office/Ioana Istrate
69. Resolution of cancellation, High Court Prosecutor's Office/Miorita Malacu
70. Information note, High Court Prosecutor's Office, 28 February 2006.
71. Decision in file no. 106/P/2006, Craiova Court of Appeal, 16 March 2006.
72. Decision in file no. 6969/54/2006, Craiova Court of Appeal, 6 June 2006.
73. Decision in file no. 18114/54/2005, Craiova Court of Appeal, 8 June 2006.
74. Decision in file no. 4948/1/2006, High Court of Cassation and Justice, 15 June 2006.
75. Proposal of referral, 8 December 2006.
76. Ordinance, Prosecutor's Office attached to the Craiova Court of Appeal, 10 October 2006.
77. Resolution, High Court Prosecutor's Office, 21 May 2007.
78. Ordinance of cancellation, High Court Prosecutor's Office, July 2007.
79. Information note, High Court Prosecutor's Office, 5 July 2007.
80. Resolution of non-indictment, High Court Prosecutor's Office, 8 October 2007.
81. Complaint by the CLR, 19 November 2007.
82. Resolution, High Court Prosecutor's Office, 11 December 2007.
83. Appeal brief by the CLR.
84. Decision in file 472/54/2008, Craiova Court of Appeal, 10 April 2008.
85. The operative part of Decision no. 3617 in file 472/54/2008 of the High Court of Cassation and Justice, 7 November 2008.
86. Correspondence between the CLR and the High Court Prosecutor's Office.

436. Witness statements

87. Padureanu Marin, 16 April 2004.
88. Andrei Marius, 16 April 2004.
89. Picu Lelia, 16 April 2004.
90. Segarceanu Aurelia Lavinia, 16 April 2004.
91. Prodan Gheorghita, 14 September 2004.
92. Ghitulescu Lidia, 14 September 2004.
93. Ghitulescu Lidia, 14 September 2004.
94. Mitroaica Paul, 14 September 2004.

95. Oprescu Viorel, 14 September 2004.
96. Grigorescu Ioana, 14 September 2004.
97. Pesea Florina, 14 September 2004.
98. Pesea Florina, 14 September 2004.
99. Prodan Ghorghita, 15 September 2004.
100. Segarceanu Aurelia, 15 September 2004.
101. Picu Lelia, 15 September 2004.
102. Tomescu Veronica, 15 September 2004.
103. Ionete Gheorghe, 16 September 2004.
104. Stoicu Patru, 16 September 2004.
105. Calina Viorica, 16 September 2004.
106. Ionete Dorina , 16 September 2004.
107. Ruieneanu Radu, 16 September 2004.
108. Prodescu Vasile, 9 November 2004.
109. Tomescu Veronica, 9 November 2004.
110. Prodescu Claudia, 9 November 2004.
111. Dan Maria, 9 November 2004.
112. Stoicu Daniela, 9 November 2004.
113. Andrei Marius, 10 November 2004.
114. Mitroaica Daniela Adi, 10 November 2004.
115. Rajnita Irina, 10 November 2004.
116. Ruieneanu Simona, 10 November 2004.
117. Purcarin Ilie, 10 November 2004.
118. Matea Florian, 10 November 2004.
119. Padureanu Ioana, 10 November 2004.
120. Caramida Aurica, 10 November 2004.
121. Boroga Georgeta, 11 November 2004.
122. Gaspar Cornelia, 11 November 2004.
123. Garoiu Carmen, 11 November 2004.
124. Truica Florea, 11 November 2004.
125. Burlan Florea, 11 November 2004.
126. Raduta Gheorghe, 11 November 2004.
127. Ciurea Ion, 11 November 2004.
128. Iuta Raluca, 11 November 2004.
129. Iordache Cristina, 11 November 2004.
130. Mitroaica Paul, 11 November 2004.
131. Grigorescu Ioana, 11 November 2004.
132. Padureanu Gheorghe, 11 November 2004.
133. Anghel Simona Daniela, 11 November 2004.
134. Ioana Floarea, 11 November 2004.
135. Iancu Adela, 11 November 2004.
136. Minoiu Simona, 11 November 2004.
137. Popa Petre, 11 November 2004.
138. Caramida Ada, 11 November 2004.
139. Caragea Marin, 11 November 2004.
140. Radescu Mariana, 11 November 2004.

141. Jugravu Victoria, 31 January 2005.
142. Pesea Florina, 10 February 2005.
143. Grigorescu Ioana, 10 February 2005.
144. Mitroaica Paul, 10 February 2005.

437. Documents related to the situation at the Hospital

145. GP's job descriptions.
146. Opening hours at the Hospital
147. 2002 Internal Hospital Rules.
148. 2004 Internal Hospital Rules.
149. Contract of provision of medical services, 202/2004.
150. Hospital personnel scheme.
151. 2002-2003 Budget tables.
152. 2003 budget proposal, 10 October 2003.
153. Letter of the Hospital, 14 January 2003.
154. Letter of the Hospital, 20 January 2003.
155. Letter of the Hospital, 26 February 2003.
156. Letter of the Hospital, 17 March 2003.
157. Letter of the Hospital, 8 May 2003.
158. Letter of the Dolj Health Insurance Department, 23 May 2003.
159. Letter of the Hospital, 15 September 2003.
160. Letter concerning the Hospital staff situation on 30 September 2003.
161. Letter concerning the debts incurred by the Hospital on 31 October 2003.
162. Letter of the Hospital, 22 January 2004.
163. Letter of the Hospital, 3 February 2004.
164. Letter of the Hospital, 4 February 2004.
165. 2004 budget, 20 February 2004.
166. Alimentation standards, 19 November 2004.
167. Letter of the Hospital, 14 December 2004.
168. Ministry of Health/Ministry of Justice report, 18 July 2003.
169. Ministry of Health report, 2 September 2003.
170. Internal public audit report, 16 January 2004.
171. Ministry of Health report, 23 March 2004.
172. Ministry of Health report, 25 November 2004.
173. Letter of the Ministry of Health, 22 June 2005.
174. Response of the Ministry of Health, 5 December 2005.
175. 1995 CPT report and the Government's response.
176. 1999 CPT report and the Government's response.
177. 2004 CPT report and the Government's response.
178. List of patients who died at the Hospital in 2002 and 2003.
179. List of patients who died at the Hospital between January 2004 – May 2004.
180. List of patients who died at the Hospital between January-April 2005.

438. Other documents

181. ”*Spitalul de Psihiatrie Poiana Mare, Istoric*”.
182. Ministry of Health press releases, 2004-2006.
183. CLR press releases.
184. Amnesty International documents.
185. Selection of articles concerning the Hospital from Gazeta de Sud.
186. Selection of articles concerning the Hospital from www.editie.ro .
187. “*Nebunie la Poiana Mare, balamuc la Ojasca*”, 31 January 2006, www.9am.ro.
188. “*Despre mizeria din spitalele de psihiatrie romanesti*”, Revista 22, 11 May 2005 – transcript of debate concerning the situation at the Poiana Mare Hospital.
189. The CLR Statute.
190. Selected domestic legislation.

X. DECLARATION AND SIGNATURE

439. 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 11 December 2009

Georgiana Iorgulescu
Executive Director
Centre for Legal Resources

Padraig Hughes
Litigation Director
Interights

Constantin Cojocariu
Lawyer
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