CENTRE FOR LEGAL RESOURCES

PROGRAMUL DE COOPERARE ELVEȚIANO-ROMÂN
SWISS-ROMANIAN COOPERATION PROGRAMME

Monitoring report

Neuropsychiatric recovery and rehabilitation center

Măciuca, Vâlcea County

"SOS: Romanian NGOs together for the rights of persons with mental disabilities institutionalized in closed facilities"

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Summary – Neuropsychiatric recovery and rehabilitation center Măciuca, Vâlcea County

- Residents of the Centre do not enjoy legal assistance, do not have access to information and communication facilities and their right to lodge a complaint is not respected. The provisions of the Order No. 67/2015 (Module III Activities / Services - Standard 1 Personal Care; Module IV Life environment - Standard 1 Safety and Accessibility; Module V Rights and Ethics - Standard 1 Respect for Rights of the Beneficiaries and Professional Ethics; Standard 2 Protection against abuse and neglect; Standard 3 Petitions / Complaints), art. 21 of the Romanian Constitution and art. 9, art. 12, art. 13 and art. 21 of the Convention on the Rights of Persons with Disabilities were violated.
- Only 4 residents of the center are placed under judicial interdiction and for only one person was ordered guardianship, although the center houses 48 residents, and in none of the cases the procedure was not initiated by the Centre. Thus, a violation of the provisions of Art. 111 of the New Civil Code, art. 25 para. 2 of Law 448/2006, art. 12 of the Convention on the Rights of Persons with Disabilities were found.
- The Centre has not taken the measure of removal of the guardians from the custody tasks, although one of the guardians administers the pension of a resident and does not pay on time the contribution for the service contract, and another guardian left to England and do not sign the documents and do not visit the resident. The provisions of Art. 4 of the Methodological Norms approved by Government Decision No. 268/2007, art. 12 of the Convention on the Rights of Persons with Disabilities and art. 44 para 2 sentence 1 of the Romanian Constitution were violated.
- Some of the residents' documents are either not signed, or signed by a person other than the resident or legal representative, or even signed by the person placed under judicial interdiction himself. The provisions of Art. 1179, art. 1180, art. 1204 of the New Civil Code and art. 321 New Criminal Code were violated.

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- In none of the cases of death in the center, a forensic autopsy was carried out, the police has been notified only in a few cases and in most death certificates it was not specified the real and determinant cause of death. The provisions of Art. 34 para 2, art. 34 item 3, art. 45 para 3 of the Methodological Norms approved by Order No 1134/2000, art. 185 para 2 of New Code of Criminal Procedure, art. 292 of the Law No 35/1997 and art. 2 of the European Convention on Human Rights were violated.
- Residents' wards are minimally furnished, they did not have their own clothing and were poorly dressed, both men and women have short hair, the walls have dampness and moisture, the dining room is located in a different building than the one residents live in, there are not personal hygiene items and temperature is low in the bathroom, the ward used as an isolator is not properly equipped, there are no rooms designed to respect the private life of the residents, there is no access ramp for the bedridden residents living upstairs or for those who require assistive means for their movement, there are no occupational therapies and residents do not benefit from effective programs to stimulate their development. The provisions of art. 50 of the Rules approved by Order 119/2014, the Order no 67/2015 (Module III - Activities / services; Standard 1 - Personal Care; Standard 4 regarding active life; Standard 3 Recovery / Functional Rehabilitation), art. 8 paragraph 5 of the Methodological Norms approved by Order 488/2016, art. 23 of Law 221/2010, art. 25 letter f), art. 42 of the Law no 487/2002, art. 6, art. 7, art. 72 paragraph 1 of the Law no 448/2006, art. 26 para 1, art. 34 para. 1 of the Romanian Constitution, art. 20 and art. 28 of the Convention on the Rights of Persons with Disabilities.
- The restraint measure is enforced in the center even when residents experience bouts of psychomotor agitation, staff do not have a register of the containment and restraint, just a notebook where some of the information required by law is written down and the instruments used for immobilization are not provided with padding or protective material. The provisions of art. 9 paragraph 10, paragraph 3 and paragraph 11 of the Methodological Norms approved by Order 488/2016, art. 5 letter q), art. 39 of Law

487/2002 and art. 14 of the Convention on the Rights of Persons with Disabilities were violated.

- The Centre has no psychiatrist although all residents are receiving psychiatric treatment, there was never a collaboration with a dentist and there is no record of the 112 ambulance service calls. The provisions of art. 24 of Law no 487/2002, the Order 67/2015 (Standard 2 - Support For Health), art. 25 letter c) of the Convention on the Rights of Persons with Disabilities were violated.
- Some residents worked at the house of the former head of the center, other residents were tied to beds in the gazebo located in the center's courtyard while some employees were also working for the former head of the center. The provisions of art. 22 para 1, para 2, art. 23 para 1, art. 42 para. 1 of the Romanian Constitution and art. 3 Article 4 of the European Convention on Human Rights were violated.
- There were no indications that the transfer of the residents from the center was done under the supervision of a commission formed in the center or at the level of SACPD Vâlcea to explore the need and opportunity of the transfer together with the concerned residents. The provisions of the Order no 67/2015 (Pct.S3.2 Subsection 13 - Standard 3 - Termination of Services) and art. 19 of the Convention on the Rights of Persons with Disabilities were violated.

A. GENERAL INFORMATION

According to the statistical report dated 31.12.2016 which was handed to the CLR experts by the social assistant Cârstea Elena Cornelia, the situation of residents by age is as follows:

- 10 young people aged between 20 and 34 years
- 20 residents aged between 35 and 49 years
- 18 residents aged over 50 years.

Therefore, on the date of the report there was a number of 48 residents in the center, out of which 21 women and 27 men.

According to the statistical report from 31.12.2016 which was handed to CLR experts by the social assistant Cârstea Elena Cornelia, the situation of residents per age and type of disability is as follows:

Most people living in the center - 41 out of 48 residents - suffer from mental disability. Out of these, most are enrolled in the disability level II (26 residents). There are 12 residents with disabilitiy level I - severe, as well as 3 residents with disability level III - medium.

In addition to the 41 residents with mental disabilities in CRRN Măciuca there are also 4 individuals with psychic disability and another 3 with associated disability.

Most of the young people aged between 20 and 34 years of CRRN Măciuca are suffering from serious mental disability, being a number of 8 out of 10. In respect of persons aged between 35 and 49 years, 14 out of 20 are diagnosed with serious mental disabilities. Out of the residents over 50 years old, 11 out of a total of 18 are suffering from severe mental disabilities.

Access in the institution

Upon entering the court of CRRN Măciuca, the CLR[1] Mobile Legal Clinic experts were greeted by the guard of the center, who informed that entering the center without the prior consent of the Vâlcea SACPD[2] Director, Nicolae Badea, is not allowed. After a phone conversation with the latter, he allowed the access of the CLR experts in the residential center.

In the courtyard of the center, the CLR experts were greeted by the geriatrist, Ms. Călinescu Felicia, and by the psychologist of the center, Ms. Alina Basanete. Both of these employees were temporarily transferred from the Govora Centre starting January 26, 2017 in order to coordinate all the activities in the center, including counseling, given the lack of specialists in the CRRN Măciuca.

On this occasion, general discussions about the center were held in the courtyard of the center, while both the doctor and the psychologist mentioned that they can not provide accurate information since they are not the full employees of the institution and do not have

[1] CLR – Centre for Legal resources.
[2] SACPD – Social Assistance and Child Protection Directorate

enough information, but that the staff of the center will cooperate with the CLR experts in this respect. Therefore, information regarding the number of residents at the time of the visit was provided - 48 residents placed in the center, out of which one person was in the hospital, resulting a total of 47 residents present. Another 50 residents were transferred to the Băbeni, Bistrita, and Zatreni centers, Vâlcea County.

The discussion with Dr. Călinescu was interrupted by a phone call of the Director of SACPD Vâlcea. After the phone conversation, the doctor invited the CLR experts in the medical office and stated that the SACPD Director would like the experts to answer the following 3 questions:

1. What kind of legislative initiatives does CLR have in relation to the amendment and completion of the Law on mental health?

2. Whether CLR could propose or support the idea (that the doctor also fully supports) that the type of establishments like CRRN Măciuca to pass again under the subordination of the Ministry of Health?

3. If CLR considers that the type of establishments like CRRN Măciuca should have a much smaller capacity, with a small number of residents of maximum 12 to 20 places and how much influence does CLR have to support such changes?

CLR experts discussed with the doctor and the psychologist of the Govora Center on the questions raised by SACPD Director. In the same context, dr. Călinescu indicated that it's her second or third time in center and for the psychologist it's her first time, therefore she cannot provide enough information but she will accompany the experts during the visit in the center. Dr. Calinescu also said that there is still no certainty about the duration of her deployment for the coordination of work in the center, but that she hopes it will not be too long since she cannot neglect her work in the Govora Center.

When asked by the experts about the reason for the head of center's dismissal, the Govora doctor said that this measure was the consequence of the disciplinary committee's decision and not of the information in the media which had distorted reality. She also stated that the SACPD Vâlcea Deputy Director, Mr. Antonie Ceauşu, had submitted several reports to the disciplinary committee, following the control visits carried out by SACPD Vâlcea in the center.

The doctor from Govora told the experts that the morning before their arrival, she had talked with the staff of the center and they are very indignant at the way the media treated the situation in CRRN Măciuca, considering that it distorted reality and communicated to the public many false information. Therefore Dr. Călinescu has expressed understanding for the fact that the employees are disturbed. She mentioned that the truth will be revealed by the results of the investigation and not by the media. At the same time, the doctor from Govora said that the center's staff remained the same and their only sanction was a warning. The doctor of the center, Ms. Maria Dumitrescu, was the only one penalized more severely by retaining 10% of her salary, for a period of two months.

The doctor from Govora also said that there is too much bureaucracy that takes too much time for the staff but nobody asks which way, how long and what exactly does the staff work since everyone is only interested in producing documents. To confirm the faulty manner that the media presented the situation in the center by specifying that CRRN Măciuca has not a doctor in place, the Doctor of Govora told the experts that this information is a false one since the center actually has a doctor employed but not a psychiatrist, and that the doctor's specialization is general medicine and he is working there since 2006.

Dr. Călinescu said that the center does not have a psychiatrist because there is a crisis at the ambulatory level of the health system and psychiatrists do not want to work in such centers because of low salaries and work difficulty and nobody applied for this advertised position. This is a situation frequently encountered at the Directorate level. Based on her information, CRRN Măciuca residents are transported to DRAGOESTI, as the territorial competent area. Meanwhile the doctor of the center, Ms. Maria Dumitrescu, entered the office and said that she is going to retire too.

Collaboration with the staff of CRRN Măciuca in the context of the media scandal.

Staff of the center has shown openness, availability and they collaborated with experts in all stages of the CLR monitoring visit.

According to the social assistant's statement, Ms. Cârstea Elena Cornelia, during 2016 several

control visits took place in the center. The first inspection took place in February 2016 and it was from the Ministry of Labour, the next inspection was from SACPD Vâlcea, the County Agency for Payments and Social Inspection (AJPIS) Vâlcea and, following the complaint made during summer, another control visit was carried out by Vâlcea County Council. Following these inspections, only adiminstrative problems have been found, but not residents' related ones. The social worker said he did not know how the situation has arisen in the media. An employee (carer, on sick leave on the date of the visit) made the complaint due to a conflict with the head of the center, but the result now is that all employees are affected from this and she doesn't know the reason of concerns of the respective employee.

B. SOCIAL CONTEXT OF THE INSTITUTIONALIZED PERSONS

Transfers – number of CRRN Măciuca residents

In relation to the number of residents housed in CRRN Măciuca between December 2016 - January 2017 contadictory information was provided:

CRRN Măciuca capacity according to SACPD Vâlcea official webpage	**70 places**
Press release of the Ministry of Labor from 25 January 2017	*„ According to statistics provided by the National Electronic Registry (RENPH) at December 31, 2016 there were 92 persons in the center..."*
Staff of CRRN Măciuca – registered nurses,	**89 persons** out of which 41 transferred in December 2016, 48 persons hosted in the

doctor	center on January 26, 2017
Staff of CRRN Măciuca – social assistant	**95 persons** out of which 47 transferred in December 2016 and another 48 persons on January 26, 2017

According to data provided by the social worker, more residents from CRRN Măciuca were transferred to other centers within the county, the situation by year being as follows:

- 2013 - 7 residents were transferred, one of them was taken by his family;
- 2014 - 7 residents were transferred;
- 2015 - 3 residents were transferred;
- End of 2016 (December) 47 residents were transferred.

Upon the request of CLR experts, the social worker could not provide nominal statistics or the reasons behind the transfer of residents in 2016, stating that there are only records regarding numbers and location of transferred persons, that is a total of 47 residents as follows:

- Bistrita assistance and care Center - 7 residents;
- Milcoiu assistance and care Center - 4 residents;
- Zatreni assistance and care Center - 2 residents;
- Neuropsychiatric recovery and rehabilitation center Babeni - 3 residents;
- Neuropsychiatric recovery and rehabilitation center Babeni no. 2 - 4 residents; - Babeni recovery center - 27 residents.

According to the information provided by the employees of the Centre of recovery Babeni emerged that 28 persons were transferred, out of which 27 in December 2016 and one person in January 2017. The transfer records provided by the medical staff of CRRN Măciuca for 2016 reveals that 41 residents were transferred as follows:

Zatreni assistance and care center - 3 residents;

Centre for assistance and care Bistrita - 7 residents;

Centre for assistance and care Milcoiu - 4 residents;

Babeni recovery center - 27 residents.

It is obvious that the transfer was done without any analysis of the medical and psychosocial needs of the CRRN Măciuca residents and that specialized staff of this institution possess contradictory information on the number of transferred persons and the reasons for the transfer. According to the information received from the employees of the center, all residents who were transferred in 2016 left the center in early December.

Regarding the selection of residents transferred to other centers we have obtained more information/versions:

1. Need of sanitation measures in some wards, approximately 41 residents hosted in two wards being transferred to other centers;
2. Not only the residents occupying wards subject to renovation were transferred but residents were selected from the whole center, the remaining ones being distributed in different wards;
3. The selection criteria were established by the Director General and Deputy Director of SACPD Vâlcea. The latter wandered through the center premises together with a team from SACPD Vâlcea and he selected the residents that are to be transferred based on the established criteria. Following the discussions held with the Deputy Director, Mr Anthony Ceauşu, at the SACPD Vâlcea premises, the selection was made according to the following criteria:

- File based;
- Opinion of Center's specialized staff;
- Option expressed by the beneficiaries.

The reason why these residents were transferred in such a short time was provided by almost almost all staff as that of center's need for sanitization measures and the renovation of two wards, and that the renovation process began in December. There were no reasons

provided for the urgent sanitization of the two wards in December. On the day of the CLR visit there were no renovation work activities going on in the two wards (January 26, 2017).

Based on the statements of other employees, the main reason for transferring so many residents in such a short time was that there were some photos posted on a social network showing bed-bound and seats-bound residents and their condition of living in the center. Also due to complaints of some employees, the decision to urgently reduce the number of residents, cleaning wards and changing the furniture was taken.

Following the discussions with the staff of CRRN Măciuca it wasn't possible to determine the exact reason for the transfer of residents, although this should have been known by everyone involved, meaning staff, residents and the center that took up the residents.

Moreover, we were not provided with documents regarding names of the transferred persons, the social worker stating that there are no such records nor copies of the transfer orders.

Apparently, there was no committee set up by SACPD Vâlcea in order to individually analyze the opportunity of transfer for each resident, nor discussions with residents in this regard. Moreover, based on the findings of the CLR experts, the staff did not know the reasons of the transfer and the criteria for the selection of residents, meaning that their closest persons (social workers, nurses, etc.) who best know the condition and evolution of residents were not consulted on the need for taking such a measure.

However, the procedure established by the legal framework is totally different. Transferring a resident is only possible in two situations:

- on written request of the resident;

-upon recommendation of the center, when it is no longer able to provide adequate services or when closing the center, by observance of a specific procedure.

Point S3.2 of the Minimum quality standards for adults with disabilities (approved by Order no.67 / 2015 of the Ministry of Labour) provides cases of termination of services provided by the center, as follows:

,, - Indefinite transfer to another center residential / other institution, **on the written**

request of the beneficiary or, where appropriate, his legal representative; prior to the beneficiary check out from the center, the consent of the receiving center/institution shall be checked;

- **on recommendation of the residential center** that is no longer able to provide all the appropriate services based on the needs of the beneficiary or when the center terminates its activity; at least 30 days prior to the date when it is estimated to termination its services the center decides, together with the beneficiary and the General Directorate of Social Assistance and Child Protection in whose jurisdiction is found, how to address the situation of each beneficiary (transfer to another center , fixed-term rebound in the family, etc.); "

Based on the experts' findings, there are no indications that the legal provisions have been observed in relation to the transfer procedure. There are also no indications that a committee had been established in the center or at SACPD Vâlcea level to analyze together with the concerned residents the need and opportunity for their transfer. Moreover, taking into consideration the staff statements according to which the transfers have been made within maximum few days regardless of their reason, **it is obvious that the 30 days deadline has not been respected**.

For example, one day from the visit in the Măciuca center, more specifically the morning of January 27, 2017, during the monitoring visit organized by other experts of the Center for Legal Resources in the Galata social educational and residential Complex, Iasi county, experts have witnessed the transfer of a beneficiary of this center to Hospice Hîrlău. The head of the institution has stated that the transfer is done because the beneficiary needs special care, and the center had to receive another beneficiary from the Child Recovery Center Galata who had reached 18 years old. The transfer was carried out by the doctor institution on the basis of the transfer documents. According to the statements of the head of institution and the experts' findings, Complex employees were very found of the respective resident and it was very difficult for them to assist the transfer of that beneficiary. After the transfer, a psychologist of the institution came to meet the experts in tears while being extremely nervous because of the transfer.

C. ACCESSS TO JUSTICE, REPRESENTATION

Complaints

When asked about the existence of a register for complaints in the center, social worker Elena Cornelia Cârstea told the CLR experts that **there is such a register but there were no complaints registered so far**. Ms Carstea added that the center also has a dedicated box for complaints in place but "minutes showing that it was found empty have been drawn". CLR experts have not been provided with the respective minutes. The box for complaint was placed on the left wall at the entrance of the social assistance office.

When asked what the concrete procedure for registering a complaint is by the residents, the social worker told the experts that if someone wants to complain, residents have the possibility to write and record the complaint. Because of the very brief answer, experts have expressly asked the social worker if residents are provided with pens and contact details of the responsible institutions. The answer to this question was that residents are provided with such instruments if necessary. During this discussion the doctor from Govora, Mrs. Felicia Călinescu, intervened saying that, usually, residents' complaints are verbal.

In the same context, the masseur of the center said that there is a resident named P. C. who often says he wants to leave and to privatize. CLR experts interviewed the respective resident and staff statements confirmed. The resident was sociable and open and stated that he wants to leave to privatize, that he graduated a privatization course after the revolution and he came to the center to rehabilitate for his own discernment and then implement his projects. It is worth mentioning that this was the only example given to the CLR experts in relation to complaints of the residents, however these are rather wishes of the respective beneficiary to leave the center and live independently than real complaints.

However the CLR experts consider it impossible that there were never any complaints in the Măciuca center, even just verbally as doctor from Govora mentioned, and that the social worker' statements according to which there are minutes saying the box for complaints was found empty are just absurd.

CLR experts have not seen in the center any phone numbers and contacts of support institutions such as police, ambulance displayed, and there was no phone, computer with internet for the use of residents and any other means of communication.

Concluding on the state of affairs outlined above, the opinion of CLR experts is that the situation in the Măciuca center seems to be as follows: the discussions we have had with the staff revealed that they don't know the requirements of the national and international legal standards in relation to the residents right to complain beyond the formal issues. The fact that there is a box for complaints does not necessarily mean that residents have a real opportunity to use this tool, and discussions with staff didn't show that residents were advised to follow this procedure or that they have been explained how to make a complaint by an effective manner and with taking into consideration their state of health. Minimum quality standards provide that respecting the right to make a complaint is not just a placing a box, drafting minutes and providing with pens and paper. In order to ensure the observance of this right it is also necessary to ensure the access of such persons to the support they may need for the submission and staff at least try to eliminate obstacles and barriers to such access, through explanations, guidance, etc. CLR Experts highlight that there are residents in the center who, despite their health problems, can communicate and understand certain things, so the assumption that a resident would like to file a complaint cannot be excluded. Moreover, **it is absurd that there were no complaints as long as the residents of CRRN Măciuca worked at the house of the head of the center and some of them were tied to beds, therefore it is clear that these people had grievances and would have liked to express it by making a complaint**.

In addition to the above mentioned issues CLR experts highlight that, given the health problems of residents in the Măciuca center, there are two categories of persons who could exercise their right to complain:

1. 1. Persons whose discernment is little affected so they can express themselves both verbally and in writing (out of 48 residents of CRRN Măciuca, only 4 people are under judicial restraint and only 1 person has an appointed curator, therefore it may

be assumed that the remaining 43 residents could have discernment and ability to make a complaint);

2. 2. Persons who cannot complain because of their state of health (either because they do not have discernment to understand and follow the procedure, either because they can not move).

The residents in the first category could make a complaint themselves (or at least with the support and guidance of the staff) while residents in the second category could exercise this right only by representation of their guardian and/or curator, but only five residents of CRRN Măciuca have an appointed tutor/curator). For the rest of the residents, in the absence of a legal representative it is clear that only the staff of the center could make a complaint, which means that there would be an obvious conflict of interests. Hence, access to the box for complaints can prevent abuses, but also to maintain them in case of those residents who cannot complain.

Given this abusive situation, CLR experts do consider that the **provisions of the Convention on the Rights of Persons with Disabilities have been violated**. This violation is also possible by the fact that the **Monitoring Council** is still not operational although it was established by Law no. 8 of January 18, 2016 on the establishment of mechanisms under the Convention on the Rights of Persons with Disabilities therefore its so badly needed tasks currently cannot be implemented including for the benefit of the Măciuca center residents, given the fact that the Council should examine on a periodical basis the observance of rights of persons with disabilities in institutions and take any necessary measures.

The National Agency for Payments and Social Inspection has not complied with its obligations in relation to CRRN Măciuca either, given that, according to art. 5 of O.U.G. 113/2011, the Agency applies the policies and strategies of the national social assistance system developed by the Ministry of Labour, Family and Social Protection, with the following main objectives:

"c) prevention of error, fraud, abuse and neglect in the social protection system;

h) ensuring the provision of information needed for achieving the policies and strategies of social assistance;

i) facilitating access for persons entitled by law to social assistance benefits;"

The Agency for Payments and Social Inspection also has breached her legal obligations set out in article 16 c) of the above mentioned legal act, given that this institution have the following responsibilities:

"b) refer the matter to the competent prosecuting authorities where facts meet the elements of a criminal offense;

d) carry out control missions at county level, based on travel orders and by compliance with the methodologies, instructions and work procedures;

f) evaluate, monitor and control the activity of both public and private service providers in terms of standards of quality and cost, as well as their efficiency and performance;"

Therefore CLR experts consider that from the legal point of view, people with disabilities from CRRN Măciuca do not receive legal assistance, the staff does not ensure their access to the support they may require in exercising their legal capacity, the staff is not trying to eliminate obstacles and barriers to such access and does not ensure the right to freedom of expression and opinion, including freedom to seek, receive and share information and ideas, residents do not have access to information and means of communication, including technologies and information systems and communications and other facilities and services, on an equal basis with others, so that there was a manifest violation of the provisions of **Order no. 67 of January 21, 2015 regarding the approval of the minimum quality standards for the accreditation of social services for adults with disabilities and art. 9 (Accessibility), art. 12 (Equal recognition before the law), art. 13 (Access to justice), art. 21 (freedom of expression and opinion and access to information) of the Convention of 26 September 2007 on the Rights of Persons with Disabilities** adopted by Law 221/2010, which provides as follows:

Art. 9: Accessibility:

1. “1. To enable persons with disabilities to live independently and participate fully in all aspects of life, State Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, transportation, information and communications, including technologies and information systems and communication and other facilities and services open or provided to the public, both in urban and rural areas. These measures, which include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:
   a) buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
   b) information services, and other communications, including electronic services and emergency services.
   2. State parties will also take appropriate measures for:
   a) develop, promulgate and monitor implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;
   d) to provide in buildings and other public spaces, signs in Braille language and easy to read and understand means;
   f) to promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;
   g) promote access of persons with disabilities to new technologies and informatic systems and communications, including to internet."

Art. 12: Equal recognition before the law:

1. "1. The States Parties reaffirm that persons with disabilities have the right to recognition of their legal capacity, everywhere they are.
2. State Parties recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all areas of life.

3. The States Parties shall take all appropriate measures to ensure access of people with disabilities to the support they may require in exercising their legal capacity.
4. 4. Member Parties shall ensure that all measures relating to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, no conflict of interest and have no undue influence, are proportional and tailored to the person's situation, apply for the shortest time possible be subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the rights and interests of the person."

Art. 13: Access to justice:

1. "The States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including the provision of procedural and age-appropriate adjustments in order to facilitate an active role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages."

"Art. 21: Freedom of expression and opinion and access to information:

1. "State Parties shall take all appropriate measures to ensure that persons with disabilities can exercise their right to freedom of expression and opinion, including freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice, as defined in art. 2, including:b) accepting and facilitating, in official relations, the use of sign languages, Braille, augmentative and alternative communication and all other accessible means, ways and formats of accessible communication, based on their own option."

The provisions of **Order no. 67 of January 21, 2015 regarding the approval of the minimum quality standards for the accreditation of social services for adults with disabilities** were also violated in CRRN Măciuca, as follows:

SUBSECTION 3: MODULE III ACTIVITIES / SERVICES (Standards 1-6). Subsection 31: STANDARD 1 PERSONAL CARE: "(2) 4.S1.4 The Center performs continuous information of beneficiaries / guardians / conventional representatives on the activities / services performed, the procedures used, and any aspects deemed useful. At least annually it shall be organized an information session for beneficiaries on the current work of the center."

SUBSECTION 4: MODULE IV RURAL LIFE (Standards 1-6). Subsection 41: STANDARD 1 SAFETY AND ACCESIBILITY: "3.S1.3 Center provides the necessary means for remote communication. The center has at least one telephone accessible to the beneficiaries or a mobile phone and a PC or laptop with internet access. The Center provides the residents with necessary equipment for remote communication."

SUBSECTION 5: MODULE V RIGHTS AND ETHICS (Standards 1-4). Subsection 51: STANDARD 1 Respecting beneficiaries rights and professional ethics:

"(1) The residential center respects the rights of beneficiaries provided by the law. Expected results: Rights of recipients are known and respected by the staff. 7.S1.7 Center ensures that staff know how to approach and relate to the beneficiaries, according to their particular situations. Center provides training for hos own personnel on how to approach, communicate and relate to beneficiaries, depending on their psycho-behavioral particularities.**"**

SUBSECTION 52: STANDARD 2 PROTECTION AGAINST ABUSE AND NEGLECT:

"(1) The residential center takes action to prevent and combat all forms of abusive, neglective and degrading treatment of the beneficiaries. Expected outcomes: Beneficiaries are protected from abuse, neglect, discrimination or inhuman or degrading treatment. (2) 1.S2.1 Center uses its own procedure for identifying, reporting and solving cases of abuse and neglect among their beneficiaries. The procedure for identifying, reporting and solving cases of abuse and neglect is available on paper and in an accessible format (easy to read, Braille, CD video / audio etc.), at the premises of the center. 2.S2.2 Center encourages and supports the beneficiaries to report

any form of abuse, neglect or ill-treatment to which they are subjected by people they come into contact with, both at the center and in the family or in the community."

SUBSECTION 53: STANDARD 3 REFERRALS / COMPLAINTS:

"(1) Residential center encourages the beneficiaries to express their opinion on any matters concerning the activity of the center. Expected results: Aspects and situations that displease the beneficiaries are known so that they can be adressed in a timely manner. (2) 1.S3.1 Centre provides the necessary conditions for the expression of beneficiaries' opinion on the services they receive. The Centre establishes its own procedure regarding reports and complaints that is to indicate: means of communication with the beneficiaries, wording of the notifications and complaints, to whom it is submitted and how it is registered, how to respond to the beneficiaries and how to solve it. The center offers the recipients a container-type mailbox, where they may lodge complaints / claims in written on the negative aspects they found, and proposals for improving the work of the center. Contents of the mailbox shall be checked weekly by the head of the center in the presence of two beneficiaries and recorded in the register for complaints / petitions and registered. Box for notifications and complaints is placed in a place accessible to all the beneficiaries. 2.S3.2 Center informs the beneficiaries on the way of submitting any complaints / claims. 3.S3.3 The center ensures the registration and recording of complaints and petitions."

Tutorship. Placement under judicial restraint.

Non-placement under judicial restraint.

CLR experts have analyzed the files provided by the social worker Cârstea Elena Cornelia. Out of 48 residents hosted in CRRN Măciuca at the date of the visit, only 4 people were placed under judicial restraint and for only one person the guardianship measure had been ordered and in none of these cases the procedure had not been initiated by the Centre. This is not in accordance with the legal provisions since CRRN Măciuca has a clear obligation to require placing under judicial restraint of all other residents who do not have the ability to make decisions alone, guardianship being a measure of protection to be urgently established in

such situations. CLR experts have met in the center people who were not placed under judicial restraint although their state of health clearly required setting up such a measure.

CLR experts emphasize that the responsible staff of the center disregards the fact that placement under judicial restraint represents a measure to protect residents from abuse of third parties and its own incompetence or recklessness. Moreover, placement under judicial restraint represents a measure for the protection of third parties as well since, unknowing the mental health condition of those who they are concluding contracts or any other legal agreements, later on these acts are likely to become void.

The initiation of court proceedings for the placement under judicial restraint is also necessary to meet the medical requirements (hospitalization, anesthesia, surgery, etc.), where legal provisions require that the legal representative to sign the documents relating to the resident when the latter is not able to express his consent and the respective signature must be preceded by studying medical documentation that can only be done on the premises of the medical unit. Whether discussing of persons hosted in institutions or in the community, the institution of legal representation must operate the same.

The legal obligation of the Măciuca center to initiate the procedure for placing under judicial restraint clearly flows from **art. 25 paragraph 2 of Law 448/2006 on the protection and promotion of rights of persons with disabilities** - republished - which provides as follows: "If the disabled person, regardless his/her age, is entirely or partly unable to manage his personal assets, he/she enjoys legal protection in the form of tutorship or guardianship and legal assistance "and also from those of the **New Civil Code** according to which:

Art. 164 "(1) The person who lacks the necessary discernment to take care of his own interests, because of alienation or mental debility, shall be placed under judicial restraint. Art. 165: The restraint measure may be required by the persons referred to in art. 111, which applies accordingly. Art. 111: They shall notify the court of guardianship immediately after learning of a minor that is deprived of parental care in the cases provided for in art. 110: a) persons close to the minor as well as managers and tenants of the child's household; (..) d) local government bodies, care institutions and any other person."

No removal of tutor from the tutorship tasks.

CLR experts noticed that there are two types of files in the social worker's office:

1) personal files of residents, where evaluation reports, service provider contracts, court rulings, etc. are included;

2) files (2 in total) where only original important documents of the residents (ID card, birth certificate, disability certificate) are included as these are the documents that the staff needs most frequently (according to the social worker statement).

Following the reading of documents provided by the social worker, CLR experts noted that persons placed under judicial restraint in CRRN Măciuca are the following:

1. **A.A.** born on 10.23.1972, having as the appointed tutor S.C. (aunt) in Ramnicu Vâlcea. For the resident A. A., placed under judicial restraint, the pension is collected by his tutor, according to the social worker statement;
2. **C. D.**, born on 21.10.1971;
3. **R. M**., born on 10.07.1962, having as the appointed tutor R.C. (cousin) in Ramnicu Vâlcea;
4. **G.M.**, born on 10.05.1961, having as the appointed tutor D.C.V. (his son who left to England).

The social worker said that in the center there is only one case where the family pays the contribution for social benefits, the person concerned being the curator of the resident. Out of the 4 cases of judicial restraint, the CLR experts found that in 2 cases the tutor removal from the tutorship tasks was necessary, as it follows:

Case of G.M. Her tutor has left to England for more than two years and the last document in the file that is signed by her tutor is dated 2014. The social worker told the experts that the resident G. M. was sent to the center by her son who simply doesn't care about the pension of the resident although he is her tutor, and that he is currently living in England. According to the statement of the social worker, the respective resident is able to communicate but that there are times when she lacks coherence. She is spending her pension for cigarettes and coffee. The resident sold the appartment where she was living with her son and then she bought another appartment in a building on the outskirts

of Ramnicu Vâlcea, she has also had alcohol problems which is why her son feared that she could sell the new appartment and decided to send her to this center. The social worker also said that this is the only resident out of the four persons under judicial restraint whom they can talk to and that she is able to understand some issues. The CLR experts have interviewed the respective resident and indeed she understood some aspects. She was sociable and when the experts had to leave she expressly asked them when exactly they will come back. Upon entering the center, the resident asked the experts for money.

CLR experts checked the documents in the file of this resident and it appears that her tutor left to England for more than two years and he doesn't duly fulfill his tutorship tasks, the latest documents signed by him in the file are related to some payments dated 2014 or 2013. In the file there is also the **answer no. 4491/R/10.31.2016 of the Local Council of Ramnicu Vâlcea** municipality following the request no. 385/10.03.2016 that had been sent by CRRN Măciuca to request for a social investigation at the tutor's household. The Local Council's response states that the respective tutor is working in England for more than 2 years and that the inspectors of the Guardianship Service and Child Protection Authority from Ramnicu Vâlcea tried to contact Mr. D.V. through electronic communication in order to clarify some aspects of his incumbent responsibilities as a tutor but **he has not answered to this request**."

The resident's file also shows that the center was informed by the Office for Pensions of the Vâlcea County by letter no. 23565/07.07.2016, on the fact that a withholding of a sum amounting to 36 lei has been in applied starting from August 2016 to recover the amount of 857 lei. The Center asked the judicial executor for clarifications on the retention by letter no 237/07.21.2016. From the documents in the file it is not clear the reason for retention of this amount enforced by the judicial executor S.M. from Pitesti, Arges County, but **it might draw the conclusion that the tutor has not met his tutorship task in this respect either, since the resident was retained this amount of her pension and also that the Office for Pensions requested clarification from the center and not from the tutor. Also, according to the answer no. 97 dated 26.02.2015 of CRRN Măciuca in reply to this request, the center expressly states**

that the tutor "keeps in touch by phone with the resident and he is visiting her not very often".

Therefore, for at least 2 years starting from 2015, the tutor lives in England, he has not visited his mother and the center did not take any measure in relation to the failure of the tutor to fulfill his tasks. CRRN Măciuca should have had immediately requested the removal of the tutor from his tutorship. Lack of collaboration between the tutor and the Măciuca center is unlawful and unjustified. Tutor's passive conduct may determine both civil and criminal liability. The tutor may also be removed from the tutorship tasks if he does not comply with his legal obligations towards the resident. In his capacity a tutor he is obliged to annually submit to the tutorship court a report on how he took care of the resident and how he managed his assets, on which occasion it may be decided on applicable measures and sanctions.

Case of the A.A. resident. The tutor collects the pansion of the resident but she doesn't pay on time the contribution for the service provision contract signed with CRRN Măciuca.

As for the situation of the resident A. A., born on 23.10.1972, the tutor S.C. (aunt) in Ramnicu Vâlcea, his pension is collected by his guardian, according to the statement of the social worker. Also, in this file there are letters of CRNN Măciuca from 2015 (no.69/02.16.2015) and 2014 (no.582/28.11.2014), where the Măciuca Center clearly informs the Social Assistance and Child Protection Directorate of the Vâlcea County that the tutor does not duly fulfills his task in the way that there are delays in payment of bills for caregiving services, by a letter from 2014 (no.582/11.28.2014) while also asking for support in order to replace this tutor. Moreover, by the letter no.497/03.11.2014, CRRN Măciuca requested to the Mayor of Ramnicu Vâlcea to exempt the resident from paying taxes for his building and land in Ramnicu Vâlcea, given his social situation and expressly stating that "all these efforts were supposed to be made by Ms. S.C. - in her capacity as the tutor of the beneficiary". By letter dated 12.11.2014, Ramnicu Vâlcea Town Hall answers the request made by CRRN Măciuca by indicating that residents can not benefit from the tax exemption and by also showing that the tutor had submitted a request for exemption that was also rejected. According to the Report dated

27/10/2014 and signed by the Head of the Măciuca Center, by the specialist inspector and by the administrator and registered by the Social Assistance and Child Protection Directorate of the Vâlcea County on 10/28/2014: the tutor had a delayed payment of the monthly contribution amounting to 4,717 lei for caregiving services during 2012-2014; Măciuca center required the Tutorship Service and Child Protection Authority to replace the tutor but there was no answer to this request; the tutor receives a monthly pension of the beneficiary amounting to 691 lei; during the audit mission it was found that Ms. S.C. intends to sell the property consisting of a building and related land located in the city of Ramnicu Vâlcea (..) this situation appears from the statement of the above mentioned person, registered 1487 from 02.04 .2014 with the Ramnicu Vâlcea Local Council, Directorate of Social Protection. By the answer no. 1399 of 04.25.2014 of the Local Council of Ramnicu Vâlcea - the Department of Social Protection Center in reply to the above mentioned report of Măciuca Center, this institution states that there is no reason to replace the tutor.

According to the tax decision dated 13.02.2012, as identified by the CLR experts in the file, payment obligations of the resident for Ramnicu Vâlcea budget as taxes, due on 31.03.2012 and 30.09.2012 were in total as follows: 304 lei for the land plot and 120 lei for the building. In the file there is a request sent by CRRN Măciuca on 16.03.2011 to the tutor to come to the center to sign the contract for services supply and the payment commitment. The contract for services supply concluded on 10.12.2009 between the Social Assistance and Child Protection Directorate Vâlcea and the resident A.A., born on 23/10/1972, placed under judicial restraint is not signed by the resident nor by his tutor S.C. (aunt) from Ramnicu Vâlcea, although the name of the tutor is clearly written. The payment commitment from 10.12.2009 is also not signed by the tutor or by the resident.

In relation to this resident, the CLR experts consider that it is self-evident that the tutor does not properly fulfill his tutorship task and CRRN Măciuca was supposed to take all necessary steps to replace the tutor by informing the Court especially due to the fact that there were suspicions that she intended to sell the assets. CLR experts noted that the center has

made some steps to replace the tutor, but it had to continue its efforts and to successfully complete them.

Conclusion

In relation to the situation presented above, in both of the cases CLR experts consider that CRRN Măciuca clearly violated the provisions of a**rt. 4 of the Methodological Norms of 14 March 2007 for the implementation of the Law 448/2006 (CHAPTER II: Rights of disabled persons. SECTION 1: Health and Recovery)**, according to which: "The social worker within the specialized public service where the disabled person has the legal residence shall have the matter, shall answer to complaints/claims, establishes that the family or the legal representative of the disabled person does not ensure or violate the rights of the disabled and informs the local government authorities accordingly."

There was also a violation of the following legal provisions: **Art. 174 New Civil Code: Obligations of the tutor - "(1) The tutor is obliged to care for the person placed under judicial restraint,** to speed up his/her healing and to improve his/her living conditions. To this end, he will use the income and, if necessary, all the assets of the person placed under judicial restraint."

Art. 158 of the New Civil Code: Removal of the tutor: "In addition to other cases provided by law, **the tutor is removed if commits abuse, negligence or other facts that make him unworthy of being a tutor, and if does not fulfill the task properly."**

Art. 12 of the Convention of 26 September 2007 on the Rights of Persons with Disabilities, ratified by Law no. 221 of 11 November 2010, Equal recognition before the law:

"1. The States Parties reaffirm that persons with disabilities have the right to recognition everywhere they are, of their legal capacity. (..)

3. The States Parties shall take all appropriate measures to ensure access for people with disabilities to the support they may require in exercising their legal capacity.

4.The States Parties shall ensure that all measures relating to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, no conflict of interest and have no undue influence, are proportional and tailored to the person's situation, apply for the shortest time possible be subject to regular review by a competent, independent and impartial authority or judicial body. (..)

5. In accordance with this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to manage their own income and access equal to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property."

Article 1 of the Additional Protocol to the Convention for the Protection of Human Rights and Fundamental Freedoms. Protection of property: "Every natural or legal person is entitled to the peaceful enjoyment of his possessions. No one shall be deprived of his possessions except in the public interest and subject to the conditions provided by law and by the general principles of international law."

Documents unsigned or signed by someone else other than the resident or the legal representative.

As noted above, the most recent documents signed by the tutor of the resident G. M., as identified by the experts, are the payment commitments from 2014 or 2013. The commitment of payment from 2016, having the registration no. 61195/25.11.2016 from the Social Assistance and Child Protection Directorate Vâlcea, is issued only by the resident, but NOT BY LEGAL REPRESENTATIVE and it is not specified who exactly signed it. In the file there is also the letter no. 4491/R/31.10.2016 of the Local Council of Ramnicu Vâlcea in reply to the request of Măciuca Center no. 385/03.10.2016 calling for a social inquiry at the tutor's place of residence.

From the reply of the Local Council it appears that the tutor is living in England where he is working for more than 2 years and that "the inspectors of the Tutorship Service and Child Protection Authority Ramnicu Vâlcea tried to contact him by electronic means of communication in order to clarify aspects related to his incumbent responsibilities in his capacity as a tutor but it has not complied with those requests."

The signature on the commitment of payment dated 01.01.2014 written by the tutor does not seem to be the same as the signature on the 2016 commitment of payment (also signed by the Social Assistance and Child Protection Directorate of the Vâlcea County Director, Nicolae Badea), although there can be noted an attempt to make the two signatures to look similar. Since the documents clearly show that the resident's tutor finds himself in England for more than 2 years and even the social worker confirmed this fact, it might say that **the signature issued during 2016 was a fake one**.

An additional reason related to the fake signature is that the commitment of payment issued in 2016 (December 5) for the resident A.A. placed under judicial restraint, is signed BY THE TUTOR S.C. (aunt) from Ramnicu Vâlcea, and this statement is explicitly mentioned on the commitment of payment.

During the discussions held with the staff of the center the CLR experts found that sometimes even the employees sign on behalf of the residents. The social worker has even asked the CLR experts who exactly should sign the contract for services supply when residents do not have discernment. The social worker stated that she considers it is not normal and legal for an employee of the center to sign these contracts, nor can an employee be forced to be a tutor for the residents. The social worker also stated that so far staff has not encountered any problems in hospitals because of the lack of a legal representative for residents. Doctors in hospitals have agreed to intervene for the residents if a representative of the center accompanying the resident signed the necessary papers. As mentioned by the social worker, there was a case in Drăgăşani where the head of the center himself went to the hospital and put the stamp of the institution, although she was not very sure about this information.

The experts have identified in the file of the resident P.A., who died on 14.07.2016 according to the death certificate no. 322844/2016, that the contract for services supply concluded between the resident and CRRN Măciuca in 2006 is signed neither by the resident nor by any legal representative, the signature section having only the impression of a fingerprint. Same situation applies to the contract for services supply between the resident C. D., born on 21.10.1972, and CRRN Măciuca in April 2006 that is not signed by the resident or any legal representative, the signature section having only the impression of a fingerprint.

The contract for services supply concluded in 2006 between CRRN Măciuca and the resident RM, born on 07.10.1962, having R.C. (cousin) from Ramnicu Vâlcea as appointed tutor from 2005, is not signed by the tutor but only by the the resident, although she was placed under judicial restraint at that time (placement under judicial restraint had been made in 1996). Therefore, against this situation, CLR experts consider that:

1) in regard to the contracts and payment commitments not signed by the resident or by their legal representative, as well as the contracts having only the fingerprint of the resident or the signature of the resident placed under judicial restraint (instead of the tutor signature), CLR experts consider that from the legal perspective, there was no effective provision of information for the residents on the content of the documents, on the rights and obligations they have and the legal consequences of the documents they sign. As a consequence, these documents are legally void so they not can produce legal effects since it cannot be considered that in given the circumstances a valid consent was expressed. There were taken measures with legal consequences without any prior notice and a real agreement on them, CRRN Măciuca did not even ensured the presence of the tutor who is who is able to understand the legal effects of the documents drawn up on behalf and for the residents.

The reasoning of the experts is based upon the following legal provisions that have been violated by the Măciuca Center:

Art. 268 of the New Code of Criminal Procedure regarding the role of the signature:

"(1) The signature of a document makes full faith until proven otherwise, on the consent of the party that signed in relation to its content. If the signature belongs to a public official, it confers authenticity of that document, under the law."

Art. 1179 of the New Civil Code, clearly stipulates for the essential conditions for the validity of the contract:

"(1) The essential conditions for the validity of a contract are: 1.capacity to conclude a contract; 2. parties consent."

Art. 1180 of the New Civil Code regarding the capacity of the parties: "Any person who is not declared incapable by law nor banned to sign certain contracts can conclude contracts."

Art. 1204 of the New Civil Code provides: "The consent of the parties must be serious, expressed freely and knowingly." and, according to **Art. 172 of the New Civil Code** regarding acts concluded by persons placed under judicial restraint "The legal documents signed by the person placed under judicial restraint, other than those referred to in art. 43 para. 3, are subject to cancelation even if the person was having discernment at the time of their conclusion**."**

With regard to the **documents signed by a person other than the resident or the legally appointed tutor**, CLR experts consider that the following legal provisions may be applicable: **Art. 321 of the New Criminal Code - Forgery**: "(1) Forgery of an official document during its preparation by a public servant while performing his official duties by certification of actions or circumstances which are not true or by deliberate omission to insert certain data or circumstances, shall be punished with imprisonment from one to 5 years. (2) The attempt shall be punished."

D. LIVING CONDITIONS IN THE INSTITUTION – accommodation and food

D.1. Structure of the center – accommodation

The center is surrounded by a concrete fence and white painted wood. The gate is made of metal, purple painted so that outsiders can see the courtyard only through the blank spaces of the gate and through the small space between the gate and wooden fence. In front of the

entrance gate of the center one can see some of the windows of the gazebo (where the bedrooms are located) which are insulated and some of them have bars. Exterior color of this gazebo is pink, and in some parts experts observed broken plaster and dirty sides of the wall. The outside of other buildings of the center is similar, having a neglected appearance.

CRRN Măciuca is formed (in terms of useful space) of a building arranged on one level (ground floor and first floor), an appendix serving as the social assistance office located in the same yard and an appendix where the dining room and the kitchen are located.

The entrance in the building yard is by stairs and an access ramp made of concrete, quite steep. The building where residents are accommodated has 12 wards, 10 of which are occupied. There are three lounges downstairs, two of which, according the CRRN management and Social Assistance and Child Protection Directorate Vâlcea, are under renovation. We mention that on the date of the monitoring visit there were not any renovation works in progress; except for the furniture stored outside the CLR experts have not identified any construction materials or scaffoldings. Ground floor also hosts the medical office, the seclusion room (also under renovation) and the bathrooms at the end of the hallway. The smell in the seclusion room is a heavy one.

First floor is designed similarly to the ground floor, noting that on the date of the visit the access was posible only through some narrow and steep stairs without any accessory instrument to facilitate climbing (rail fastening). No access ramp to the floor was identified, although the experts have found in the wards upstairs bedridden residents or who require assistive means for their movement.

The wards are bright, accessorized with transparent white curtains and no draperies to prevent the sunlight. They have a capacity of 7, 6, 5, 4 or 3 beds, beds and the rest of furniture (two residents wardrobe, bedside tables, table, chairs) are new, made of brown color wood.

The number of existing beds in a ward does not comply with minimum quality standards set by the Order no.67/2015 stating that a bedroom/private room must allow the placement of up to 3 beds and basic furniture and for each beneficiary would be allocated 6 sqm in bedroom/private room.

The staff representatives stated that iron beds have been used about two years ago in the center, but they were gradually replaced by wooden ones (contradictory information provided by the staff. Some of them argue that in December 2016 the furniture was replaced, while others state that the change was done gradually for each ward). As for the floor coverings, in some wards there is parquet floor while in others there is gritstone, and in the lobby on the ground floor and first floor there is concrete screed. The walls are faience tiled to a height of 1.30 cm that gives the appearance of a hospital room instead of a residential center bedroom.

The wards are very poor due to minimal furniture, some slightly accessorized to suit the preferences of the beneficiaries. The large distance of approx. 40 meters between the baths at the end of the lobby and the wards are a discomfort for the beneficiaries and staff. Staff of the center has an allocated bathroom upstairs that is locked.

The distance between the bathrooms and wards place a burden on the work of the staff in relation to the compliance with the legislation in force that impose by Order 67/2015 on minimum quality standards for the center to provide the necessary assistance for the residents who find themselves in a situation of dependency, to perform the activities of daily life, respectively to provide the necessary assistance to perform their movement in and outside the center.

In the bathrooms it was very cold (**according to the Order no.119/2014 toilet and bath temperature shall be 22°C**), and there were no personal hygiene items such as toothbrush/toothpaste, soap, towel, toilet paper or shampoo. The walls of the center wear dampness and moisture, the CLR experts being previously informed by the employees of the center about this problem. During the visit, the staff wash the floor using a mop and a bucket, but the monitors didn't observe the use of any cleaning/disinfection products.

In accordance with art. 50 of the Decree No.119/2014 for approval of the Norms for hygiene and public health of the life environment of the population "*cleaning, disinfection, pest control, pre-collection and disposal of solid waste will be made subject to certain conditions: floors are cleaned with the wiper moistened in cleaning products; chemical disinfection is done*

only if the surfaces are visibly soiled with blood or biological fluids; dry sweeping is prohibited; walls and pavements, if designed with washable materials, they are cleaned with the cleaning products periodically and when visibly soiled; in case of no washable materials, cleaning is done with a vacuum cleaner; furniture and windowsills are dust wiped daily by using soft cloth impregnated to retain dust; objects at height and upholstery furniture should be cleaned daily with a vacuum cleaner; restroom sites and urinals are cleaned with brush, appropriate cleaning and disinfecting products and disinfected; hoop of the restroom shall be wiped with cleaning products; chemical disinfection will be made when the restroom was used by someone suffering from an acute diarrheal disease; bath tub shall be cleaned with cleaning products, followed by disinfection; these activities shall be performed daily and after each client; cabin shower, tub and walls are cleaned with cleaning and disinfecting products; these activities shall be performed daily and after each client; curtains in bathrooms and showers shall be washed once a week; soap and soap dispensing devices: solid soap is kept dry in a soap dish to allow water to drain or suspended by a magnetic device; it is preferable for wall mounting of soap dispensers; soap dishes and wall dispensers shall be cleaned and rinsed with hot water before refilling; cleaning equipment and materials: cloths, sponges, brushes and windshields shall be washed daily with cleaning products and rinsed with hot water; they shall be dried and stored dry."

Considering the order no. 67 of January 21, 2015 for the approval of the minimum quality standards for the accreditation of social services for disabled adults (Module III - Activities/services, Standard 1 - Personal Care) it is noted that the center does not provide adequate conditions for ensuring personal hygiene. Besides sanitary spaces, the Centre should ensure that every beneficiary has personal hygiene items (toothbrush, toothpaste, soap, towels, etc.). Personal hygiene items should be provided from the center, this enabling residents to use their own personal hygiene items, according to their preferences.

It is noted that there is not a continuous improvement and adaptation of the environment which, according to minimum standards provided by Order no.67/2015, involves creating a living environment as friendly and similar to the one outside the institution. It is necessary a plan that takes into consideration: schedule for daily cleaning and sanitation, works

to facilitate access in common areas, facilitating independent living, renovating interiors - painting, adapting to the individual needs to ensure access to physical, communication and information environment, etc., arranging exterior spaces: banks, gazebos, green spaces, own transport facilities, development of documents and procedures laid down by the minimum quality standards, etc.

In a building behind the two-levels pavilion there is the central heating serving the bedrooms, and a room for laundry machines and dryers (as specified by social worker). The heating of the center is ensured by two central heatings. During the visit, there was running water, hot in the bathrooms, but sometimes the staff is forced to carry water by car from other sources (well, spring) because it happened for pipes to freeze during winter. The appearance is that of a hospital whose conditions are poor and not of a place where people live permanently.

One of the nurses invited the CLR experts to come back visiting the center after one month when there will also be whetstone and faience. He also said that it would have been better with a hospital linoleum as it is more aesthetic and easier to maintain. He also stated that about 2-3 years ago there were carpets in the center but due to a SANEPID[3] control their use was forbidden. In his view, the center must have a familiar look which is the essential idea of a recovery center as a rule and not the appearance of a hospital. On the other hand, he believes that this involves financial investment but money is insufficient.

The presence in the center of both females and males. Status/situation of residents

In the wards there are both women and men. The residents bedridden due to a visual disability (blindness) or other disabilities live in the same room as the beneficiaries being able to move. There is no privacy of personal space that is specific to a home.

The general appearance of most residents was degraded, wearing shabby clothes in a state of deterioration. Residents have short hair, both men and women. At first glance the women can not be distinguished from men. During the visit we have met at different times a resident in the center courtyard that had his pants wet, and given the location of the spill, we

[3] SANEPID –Public Health Control Authority

could reasonably assume that it was urine. Also, some residents in the courtyard were lacking winter clothing/jackets. According to the statement of social worker, residents don't have their own clothes so they're wearing the clothes provided by the center but only some of them manage to recognize their own clothes.

According to Standard 4 regarding the active life and social contacts of the Order no.67/2015, the Centre should ensure beneficiaries the possibility to use their own clothes and shoes, according to their preferences. If necessary, the center provides beneficiaries clothing, underwear and shoes, and the beneficiaries must be encouraged to dress according to their wishes.

Bathing is done about three times a week.

Communication is easier with some residents, while in other cases it is very difficult or sometimes even impossible. Residents came to the center from the juvenile units or they were institutionalized due to the fact that their families could not provide caregiving for them. In general, they said they were happy with the conditions and how they are taken care for at the center.

D.2 Food

As specified by the doctor present in the center, the amount allocated per day for meals is 16.60 lei/resident, which is the legal norm in force. Residents receive three meals a day, hot meals and snacks between meals. From the discussions with them it appears that one snack a day consists of a fruit. The social worker said that the menu is based on the residents' desires. We express our reservation on this issue, on the one hand given that some residents are unable to communicate, and secondly because the staff declares that "there is no special menu".

During the visit (at noon) there were two cooks who were preparing lunch. Because the dining room is located in another part of the building than the one where they live, residents are forced to cross the courtyard to eat even during the winter. The dining room was separated

from the kitchen by a wall. During the monitoring visit, there were residents who refused to dine in the special room and who were returning with the meal in their wards.

E. MEDICAL SERVICES

The center has a medical office located on the groundfloor of the main building, one medical doctor employed of the center and thirteen registered nurses. The services provided by the medical office are the following: providing the medication prescribed by the specialist; check of the ward cleanliness by the nurses; participation in setting the menu for residents. Despite the fact that the center has a medical doctor employed, he complains because in this capacity he is not entitled to issue prescriptions. Employees are thus forced to call the family doctor outside the center to either get prescriptions or necessary referral tickets to various specialists whenever there is a health issue among residents. According to the statement of the social worker, the family doctor lives in the neighboring village and he comes to the center every time he is called. All residents are enrolled with the neighboring town family doctor, Dr. Băbeanu Ioana.

Apparently the general state of health of the CRRN Măciuca residents is a good one and we have not met people with a health condition visibly degraded during the monitoring visit. On the other hand, CLR experts didn't identified any clear medical record showing the results of laboratory tests of the CRRN Măciuca residents or the frequency these tests are made throughout a year.

In relation to the emergency situations the staff uses the 112 ambulance calls, but there are no records of such requests made so far. According to their statements, the problem encountered in the collaboration of the center with medical units is that after the ambulance picks up and transports the resident at the hospital, the center is asked by the hospital for an attendant of the resident. This request is impossible to satisfy, as reported by the medical staff, because of the lack of staff.

In general, the center's staff complain and accuse a difficult collaboration with the rest of the medical units in the county. Specialist doctors alone treat the residents properly but they have

a very busy schedule, which results in delayed scheduled visits and a long waiting time in the medical facilities. On the other hand, staff consider that this is rather a matter of the health system in general and that it is neither their task nor it is their possibility to produce a change or to work towards resolving this issue.

Stomalogical services

According to the statements of the medical staff, the center is not working and has never worked with a dentist. Following the questions of CLR experts on how they solve a situation where a resident would need to consult a dentist, staff replied that: "a dental abscess we can solve it here, what else can we do". Despite the fact that in recent years, the residents needed the intervention of a dentist and that the direct observations of the CLR experts confirm this fact, CRRN staff apparently has not taken any steps to identify a specialist to colaborate with. They claim that in the past 10 years have managed to deal with any dental problem occurred.

Neuropsychiatric medical services

Every resident of CRRN Măciuca receives psychiatric treatment. The physician assessment is performed every 3 or 6 months, depending on each person's situation and development. Residents of the center are usually transported to the psychiatric hospital in Dragoesti. On the occasion of the transfers to other centers in the county, according to the statements of the General Assistance and Child Protection Directorate deputy director, Mr. Anthonie Ceauşu, ten residents were hospitalized in the Psychiatric Hospital Dragoeşti. Meanwhile they returned to the centers where they were transferred to in early December 2016.

According to the medical doctor of the center, psychiatric drugs therapy provided to residents include medication such as Zyprexa, Convulex, Levomepromazine, Orfiril, Haloperidol, Diazepam, Seroquel, Risperidone. After the discussions with the medical staff it does not appear that there is a common practice of the center to follow the progress of treatment and

side effects of drugs on residents and to pass this information to the treating psychiatrist. On the occasion of regular psychiatric evaluations of those under treatment the attendant doesn't provide the medical doctor any document (eg. observations sheets, developments in the state of health) so the center doesn't have any practice in this respect.

The doctor from Govora, Ms. Călinescu, said that residents are chronic psychiatric patients, persons who can no longer be treated in the psychiatric departments of the hospitals because of their chronic, long-lasting treatment.

Restraint measures

In addition to the situation of residents with binding straps, as showed in the photographs published in the media and which the staff denies, CRRN Măciuca is implementing the restraint measure of residents in situations of psychomotor agitation. Staff claims that they use this method as a "last resort" measure. The center holds a registry where the restraint situations are recorded by the medical doctor of the center. For each of these situations the following information are mentioned: the date, the name of the resident, the description of the resident status that led to the restraint decision, length of restraint (usually about 40 minutes). During 2016, according to the data recorded in the registry, immobilization occurred in eight situations.

According to Article 9 paragraph 10 and 11 of Decree 488/2016 (updated) for approval of the application of the Law on Mental Health and Protection of People with Mental Disorders no. 487/2002 "all information about the extent of restriction will be recorded both in the **clinical record and the registry of the containment and restraint** (CRRN Măciuca has not such a registry in place, only a notebook where there are noted some of the information required by law), and in the observation sheet and in the Register of the containment and restraint the following information will be recorded: the hour and minute of using the restrictive measure; the degree of restriction (partial or total), in case of restraint; circumstances and reasons that led to the use of restrictive measure; name of the doctor who ordered the restrictive measure; names of medical staff members who participated in the application of restrictive measure; the

presence of any physical injuries suffered by the patient or medical staff regarding the application of the restrictive measure; hour and minute of each monitoring visit of the patient by indicating the vital functions values, fulfill of physiological or other needs, as applicable; hour and minute of lifting the restrictive measure".

On request of CLR experts the doctor of the center presented the instruments used during physical restraint. It is worth mentioning that despite the declaration of medical staff on the degraded look of these instruments - "Excuse us, belts are pretty worn" - they were in good condition and clean. At the same time, these tools were lacking soft padding for protection. CLR experts express their doubts regarding the use of these tools, given the difference between the staff statements and the direct observation (see Annex 1 - Photo of physical restraint straps). Moreover, even on the date of the visit, **the doctor was training the medical staff on the way of proper application of physical restraint method** by using the specific instruments.

In relation to this specific issue, article 9, paragraph 3 and 4 of the Order 488/2016 expressly and clearly regulates that restraint devices are wide leather belts or equivalent, fitted with bed attachments and cuffs for carpal joints, tarsal, chest and knees. The straps should be adjustable cuffs, coupled with a soft lining (sponge, felt, special polyurethane etc.). Use of improvised materials (bandages, gauze, twine etc.) that may cause wounds to the restrained patient is strictly forbidden.

According to the nurses' statements, it appears that the restraint method is used to restrict freedom of movement of residents when they go through bouts of uncontrollable psychomotor agitation, but they have not clearly explained for the CLR experts how exactly are they restrained. We were informed that there were situations where the female staff was physically assaulted by residents, which resulted in a harm of their bodily integrity.

The content of article 5 lit. q) of the Law nr.487 2002 on mental health and protection of people with mental disorders (consolidated version) expressly defines the notion of restraint as "restricting the freedom of movement of persons, by using appropriate means to prevent the free movement of one arm, both arms, a leg or both legs or to completely immobilize the patient by specific protected means without causing bodily harm". The restraint measure is an

exceptional measure that can be imposed only under certain conditions and has a subsdiar character. Thus, Article 39 of the above mentioned legal act provides the following:

,,(1) Hospitalized persons may be restricted their freedom of movement by the use of appropriate means with the purpose of saving from a real danger and, specifically, their own life or other person's life, physical integrity or health.

(2) It is forbidden to immobilize hospitalized persons by chains or handcuffs, and the immobilization with specific protected means without causing injuries is allowed only in exceptional circumstances, which are established by the implementation rules of this law.

(3) The measure of restraint can not be used as a sanction, can not be part of the treatment program and can not be ordered for suicides or self-isolation or as a solution to the lack of personnel or treatment, as a penalty or as a form of threat or to force having good manners or to prevent property damage. This measure can be enforced only if the application of less restrictive techniques was inadequate or insufficient to prevent any impact or injury.

(4) In case of suicide or self-isolation, the measure of restraint can not be used for more than two hours.

(5) The use of means of restraint must be proportionate to the state of danger, to be applied only for the necessary period only when there is no other way to avoid the danger and never have the character of a penalty.

(6) The use of means of restraint must be authorized beforehand by the head of department, except where the urgency does not allow this, in which case the situation is to be immediately notified to the head of department.

(7) The use and cessation of use of any means of restraint shall be recorded in a special register prepared by each psychiatric unit."

Given that the ward previously used for the seclusion of beneficiaries is currently under renovation, there should be other space that the staff can use when isolation or restriction is required. In this context, art. 40 para. 1 of the Law no. 487/2002 states that "hospitalized

persons may be temporarily isolated, without restraint, to protect them in case they pose a danger to themselves or others. This measure must be applied with caution and only if any other method proved ineffective". These measures acually have no factual framework that could ensure their implementation in CRRN Măciuca on the date of the monitoring visit.

Moreover, the ward previously used as a seclusion room, the CLR experts noticed that it was not properly equipped according to existing laws - the door was made of PVC material, tiles, and the walls were not padded. In this respect, art. 8 paragraph 5 of Order no. 488/2016 for the approval of the application norms of the Law on Mental Health and Protection of People with Mental Disorders no. 487/2002 establishes the following: *creating of a protected enclosure will be achieved through the use of acoustic materials; the walls shall be covered with durable, one-piece materials; the floor will be covered with a single piece linoleum, and lighting will be protected and low-voltage. The door will be metallic, fitted with a visitation window. The windows will be doubled, with Plexiglas glazing resistant to scratches, breakage and fire, with blinds and opening system from outside*.

Minimal amenities of a protected enclosure are the following: chair and table fixed to the wall with rounded corners; bed with mattress fixed to the floor; ceiling shower; washbasin and metal toilet bowl fastened to the wall.

We stress the importance of freedom and security of the person, as regulated by article 14 of Law no. 221 of 11 November 2010 ratifying the Convention on the Rights of Persons with Disabilities, adopted in New York by the General Assembly of the United Nations on 13 December 2006, opened for signature on 30 March 2007 and signed by Romania on 26 September 2007 which requires that States Parties (especially the centers) will ensure that persons with disabilities on an equal basis with others, enjoy the right to liberty and security of person and are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is under the law and that the existence of a disability will not in any way justify the deprivation of liberty.

F. PSYCHO-SOCIAL SERVICES

CRRN Măciuca has not hired any psychologist, so residents do not benefit from psycho-therapeutic programs. In one of the buildings of the center, in a hall with an area of about 30 square meters, there are four fitness machines (treadmill, stepper, bicycle, trellis), a TV and a massage bed. According to the staff statements, residents spend time in the gym on a daily basis. They are divided into groups of 2-3 people. A session lasts for an hour, and there are up to 4 groups every day (see the schedule of activities - Annex 2). The groups were made up according to their abilities. The same criterion was also used for scheduling their activities in the gym room. This means that "the best" are attending after having their breakfast because they are able to manage without any assistance (they can manage the morning preparation activities without the staff support - cleaning, getting dressed). Around lunchtime, those who need help in preparation activities are also brought in the gym room. During these sessions the residents are colouring, doing sports, watching TV, some of them write letters to their families or requests to the management of Social Assistance and Child Protection Directorate.

Given the fact that in the same room also operates the social worker, the physio-therapist and the masseur of the center, it is not possible to organize more meetings per day. In the same room the documents of the residents are also stored.

The medical doctor Călinescu said that he would like to move the physical therapy room inside the center so that it can be accessible to residents and not to force them to climb the stairs of the building.

As it happens in most of the centers and institutions hosting people with intellectual and/or mental disabilities, the residents are not systematically involved in structured programs that fulfill - both naturally and for therapeutic purposes - their need to be useful, to perform various tasks, and to develop and/or enhance various skills for independent living. When they express the need to be involved in household related activities like daily activities of the center - in the absence of systematic occupational therapy programs - the staff is not properly trained to decode this need of the residents and to translate their need to the possibility to have their nervousness diminished at or during their involvement in those household activities.

Access to open air spaces

Residents live a quite sedentary life, meaning that their recreational work is limited to the space of the center courtyard where there are some benches. Residents take care of three cats that were seen on the roof of the annex building where the dining room is located. There are no specially arranged spaces for them to carry out recovery and rehabilitation activities tailored to their real needs. They do not benefit from programs to stimulate their development in any way.

G. LIFE IN THE COMMUNITY

G1 Visits

Only a part of those living in the center are visited, while the other residents do not have relatives/friends anymore. There are no specially designed rooms to ensure privacy in relationships when residents are visited by outsiders.

These issues highlight a failure to meet minimum quality standards stipulated by Order no. 67/2015 stating that the Centre should provide beneficiaries means of communication with family members and friends (phone, e-mail, to facilitate sending and receiving correspondence by post). In addition, there should also be a **dedicated space at visitors' disposal and adapted to the specific needs so as not to disturb other beneficiaries**.

G2 Communication

During the monitoring visit the CLR experts found letters of the residents, which were filed together with colored plates on the occasion of various recreational activities. The social worker said she is personally in charge with sending and handing the letters to residents, stating that they "get paper and pencil if they ask for". However, CLR experts did not see any record of that correspondence and among the interviewed residents there was nobody to confirm or refute this statement.

G3 Activities/participation in the community

There are residents who are allowed to visit the residence where they came from or their relatives provided that they get permission ticket in advance.

As indicated by staff representatives, the community "is accustomed to them", some residents go to the store or to the church, but the gate of the center is not open and only a few of them may go outside. Resident T.G is going alone at the fair, staff representatives saying that he plays folk music and during the village holidays he is performing in spectacles.

CLR experts interviewed resident T.G. and he was sociable, his ward is clean and he alone may take care of his personal space. Resident told the experts that the food in the center is good, "bathing is always available, here is luxury and nobody stayed in such a room like mine". At the time of the interview, the resident was watching TV in his room.

The social worker said that they have collaborations with the Jehovah's Witnesses church in the village, who sometimes come to the center with gifts, perform some artistic moments and sing Christmas carols. Residents also receive some donations from the Red Cross organization, including food. According to the staff statements, there are no volunteering activities in the center.

Order no. 67/2015 on minimum quality standards for social services with accommodation organized as residential centers for adults with disabilities stipulates that the Centre should encourage active life of beneficiaries for their participation in the daily activities of the center, in order to preserve functional autonomy and an independent life.

The indicated legal act imposes that the center to organize a monthly program of activities to promote active learning activities that require minimal physical, mental and intellectual effort (gymnastics, dance, chess games, backgammon, reading, listening to music, painting, etc.).

Depending on the season, the center should schedule and organize outdoor activities and should encourage beneficiaries to engage in household activities (cooking, gardening, etc.).

H. STAFF OF THE INSTITUTION

In accordance with the organizational chart that was handed to the experts by the social worker, on 17.01.2017 the staff situation in CRRN Măciuca is the following:

Management staff		
1.	**Head of Center**	**1 position**
Personal cu funcții de specialitate îngrijire și asistență:		
2.	Medical doctor	**1 position**
3.	**Psychiatrist**	**Vacant**
4.	**Psychologist**	**Vacant**
5.	Social worker	2 positions
6.	Registered nurse	14 positions
7.	**Asistent medical**	**1 vacant position**
8.	Registered nurse BFT	1 position
9.	Masseur	1 position
10.	Nurse	27 positions
11.	**Nurse**	**2 vacant positions**
12.	Caregiver	4 positions
13.	**Caregiver**	**1 vacant position**
Administrative staff:		
14.	Specialty Inspector	1 position
15.	Administrator	1 position
16.	**Storeman**	**1 vacant position**
17.	Cook	6 positions
18.	Mechanic	1 position
19.	Qualified worker	1 position
20.	Seamstress	1 position

21.	**Stoker**	**2 positions**
22.	Stoker	2 positions
23.	Washerwoman	2 positions
24.	Guardian	4 positions
	Vacant	**10 positions**

According to the staff statements, the center has not enough employees. Dr. Călinescu mentioned that, in general, the nurses positions are not filled although there is such a huge need. There are 27 nurses in the center working in night shifts and day shifts. The work schedule of the employees ends at 15:00 o'clock.

I. DEATHS

In none of the deaths occurred in CRRN Măciuca it was not carried out a forensic autopsy, although this was required by law, according to Order no. 1134/C/2000 - Methodological Norms for conducting expertises, findings and other forensic works stating in art. 34, para. 2 "forensic autopsy of the corpse is carried out on request of the judicial authorities, only by the coroner, being mandatory in the following cases: [...] 3. Cause of death is suspicious". The police was called in several cases, and a police agent from the police station Măciuca came to the center and drew up a report showing that no wounds were found and therefore he doesn't consider any of the deaths to be of a suspicious cause.

However, in these cases the death of a resident is considered as **a suspicious death** since, according to art. 34, para. 2 pt. 3 of the above mentioned Order, "a death is considered as a suspicious death in the following situations: let.d - when death in custody occurs, such as the death of persons in detention or deprived of liberty, deaths in psychiatric hospitals, deaths in hospital prisons or in police custody, death associated with the activities of police or army if the death occurs during public demonstrations or **any death that raises suspicion violations of human rights such as suspicion of torture or any other form of violent or inhumane**

treatment". Therefore the assessment of a police agent alone on this issue constitutes a flagrant violation of the legislation in force.

Autopsy is mandatory in all cases of death occurring in such a center, regardless of the assessments police agents or of the family doctor.

CLR experts have noted that all death certificates that they have seen in the files are prepared by the family physician of the residents.

The staff was not aware of the legal provisions relating to cases of suspicious death and they do not consider that the beneficiaries find themselves into custody or that they are deprived in any way by the liberty. However, in all cases of death occurred in the center, staff should have immediately notified the judicial bodies as an autopsy is mandatory and shouldn't be left to the decision of family physician, who considers that in most cases it is not necessary.

Moreover, CLR experts highlight that it is worrying that the police agents are not aware of the legal provisions concerning the mandatory forensic examination in cases of death occurred in the center as this negligence may lead to preventing the identification of possible criminal law violations.

This is even more serious given that most of the deaths investigated by the CLR experts raise serious doubts, since these people died of bronchopneumonia or acute bronchitis and in at least two cases it is not apparent from the documents that an ambulance or specialized medical services were called for. On the contrary, it appears that the residents' state of health has visibly deteriorated in front of the staff until the occurrence of death.

These legal provisions are corroborated with paragraph 2 of Article 185 of the New Code for Criminal Procedure stating that "*the prosecutor shall immediately conduct a forensic autopsy if the death occurred during the period when the person is the custody of the police, the National Administration of Penitentiaries, during non-voluntary hospitalization or in the event of any death raising suspicion of human rights violation, torture or any inhuman treatment*".

Art.292 of the Law No.35/1997 on the organization and functioning of the Ombudsman institution shows that "***place of detention*** *means any place where persons are deprived of their liberty by a decision of an authority, on its request or by its explicit or tacit consent"* and,

"***deprivation of liberty*** *means any form of detention or imprisonment or the placement of a person in a public or private custodial place that he can not leave at his own will, by decision of any judicial, administrative or other authority*".

It should be noted that in such cases the doctor who is called to establish death has the obligation to inform the forensic service, the obligation that is apparently unknown to the family physician of the residents who should have refused to issue the death certificate and to inform the judicial bodies, as required by the legal provisions in force: art. 45, para. 3 of the above mentioned Order provides that "*the release of death certificate can not be done without the external examination of the corpse by the medical doctor.* ***In case of finding, on this occasion, one of the circumstances referred to in Article 34 paragraph. (2) the medical doctor is obliged to refuse to issue the death certificate and to request the judicial bodies an autopsy to elucidate the cause of death***".

From the information gathered by the CLR experts at CRRN Măciuca and the data previously provided by SACPD Vâlcea on the situation of deaths ocurred in CRRN Măciuca during 2015-2016, the following aspects can be noticed:

- The situation of deaths provided by SACPD Vâlcea for 2015 does not fully reflect the situation in the center, in the way that the SACPD also includes the resident P.A., who died at the age of 59 because of a stroke. Hence, as provided by SACPD, five residents died during 2015, and according to the situation and death records for 2015 provided by the staff of CRRN Măciuca, only four residents have died;
- In none of the deaths occurred in the center there was not any forensic autopsy performed and both the family doctor and the police agents who were called in some cases, did not comply with their legal obligation to notify the judicial bodies regarding the deaths ocurred in the center;
- Both the situation provided by SACPD Vâlcea for 2015 and 2016 regarding the deaths ocurred in CRRN Măciuca, do not mention in all cases what was the cause of death, although this information had been requested by the CLR.

Given the legal provisions that were violated, the failure to notify deaths ocurred in the center and to request an autopsy, the failure to specify the determining cause of death for residents of CRRN Măciuca, in conjunction with the findings of CLR experts, respectively that in many cases of deaths due to strokes the real cause is actually acute bronchopneumonia /acute bronchitis, we can conclude that there are serious suspicions about the circumstances in which these deaths occurred.

According to the statement of the social worker, in CRRN Măciuca it was never done a forensic examination and police was notified only two times, namely in 2016, assessment reports being concluded on these occasions. Police was called this time because "they were young" and because "there have been many pressures lately". As an example, she mentioned the case of a resident who had a stroke and he wasn't young, but they called the police, while in case of a 39-year resident who died in 2016, a hormonal problem was found to be the cause of death. The family doctor from the neighboring village calls the police to come in the center because he is the person issuing the certificate of death. Dr. Călinescu mentioned that if one compares the number of deaths from CRRN Măciuca to other centers, the number is really not that high.

Center staff said that residents who have families are taken home and buried there. The other residents are buried at the village cemetery and in the center "there is a notebook that we use when we contact the families". If the family cannot come to take them, then the residents are buried in the cemetery. Some residents are aware of the deaths ocurred in the center and others are not, as most residents have severe disabilities. The registered nurse said that all residents have a family in some way, but while working in the center for 16 years he found that very few residents are being visited. He also said that 2-3 years ago it was a habit that after each death the family to pick him up from the center and bury him without following the Christian formalities (e.g. diptych). The reason for this was to be eligible for the death benefit provided by the municipality amounting to 27 million lei, which is "*some sort of family business*". He added that some members of the family can hardly wait to collect the pension of

residents while instead of visiting or bringing them anything, they are actually interested in their pension.

According to the statement of social worker, there are medical documents (old) for the deceased persons, others than the documents made available to the experts that were stored in the closed pharmacy, the key being with one of the registered nurses of the center who was not present in the center on the date of the visit.

According to the statements of the center employees, they are unhappy with the press. In this regard, they showed that CLR announced a huge number of deaths in relation to Măciuca and Babeni centers by indicating cardio-respiratory failure as the cause of death. They stated that all certificates ascertaining death indicate as an immediate cause of death the cardio-respiratory failure, and only after that all other information must be specified, irrespective that death occurs in the hospital with a stroke or a tumor, the immediate cause of death is cardio-respiratory failure, and therefore the message sent by CLR was a mistaken one.

Situation of deaths per 2016, as provided by the documents made available to the CLR experts, is as follows:

1. **M. E. born on 11/07/1977,** died on **05.04.2016**, according to the medical certificate of death no. 322830/2016.

According to the death certificate no. 3/04.06.2016 issued by Dr. Ioana Băbeanu MD, the resident died at **16:00** at CRRN Măciuca, and the causes of death were the following:

a) The direct cause (immediate) - Severe acute cardiorespiratory insufficiency

b) Initial morbid condition

Disease or illness that triggered the conditions referred to in section b and a and which represent the determining cause/causes - acute Bronchopneumonia

Other important morbid conditions

Morbid conditions contributing to death but not related to the disease or morbid condition which caused it - Infantile encephalopathy; deep mental retardation; schizophrenia.

In the file there is a report prepared by a police agent of the Police Station Măciuca, agent Daniel Nastase Eugen (the experts mention that they do not understand very well the name on the document) on **06.04.2016**, excplicitly showing that he was informed by Băbeanu Ioana on the death of the resident, and on this occasion he went to the center where he found the following: "*the discussions revealed that the above-named died on **05.04.2016 around 18:00 o'clock**. Ms. Băbeanu Ioana, family doctor from Fârtăţeşti states that deceased is on her list of patients, being registered with chronic infantile encephalopathy sequelae - profound mental retardation and schizophrenia. Following the performed checks, it appears that the deceased shows no signs of violent death and there are no suspicions regarding the death*". The report was signed by the police agent, the registered nurse Balea Melania (the experts mention that they do not understand very well the name on the document), the medical doctor of the center, Ms. Maria Dumitrescu and the social worker, Ms. Săndulescu Paula.

The report prepared by the police agent of the Police Station Măciuca is dated on 06/04/2016 and the resident died on 05/04/2016.

The resident joined the CRRN Măciuca on 07.08.2012, according to the order of hospitalization no. 89/31.07.2012.

In the resident file there is a handwritten document signed by a social worker, stating that "The social worker from the Mayoralty of Verguleasa Village, Olt County, was contacted and the family was informed".

In the evaluation sheet existing in the file it is expressly stated by the CRRN Măciuca personnel that the resident "does not keep in touch with her family".

According to the disability certificate no. 867/03.06.2004 issued by the Vâlcea County Council, the resident was diagnosed with infantile encephalopathy sequelae, profound mental retardation, behavioral disorders, severe functional impairment, disability code 5 irrevocable and permanent. The individual intervention plan in the file is not signed by the resident nor by any legal representative, only can a fingerprint be noticed under the signature section.

2. P. A., born on 10/02/1937, died on 14.07.2016, according to the death certificate no. 322844/2016. According to the death certificate no. 9/15.07.2016 issued by Dr. Simona Miclea, the resident died at CRRN Măciuca at 9:20, and the causes of death were the following:

a) The direct cause (immediate) - **cardiopulmonary arrest**

b) Initial morbid condition

Disease or illness that triggered the initial conditions referred to in point b and a and representing the determinant cause/causes of death - **senile dementia, mental retardation**

There are no medical documents in the file. There is no report prepared by the police. In the resident file there is a handwritten and unsigned document, stating that she was buried at the cemetery of Măciuca village, after CRRN Măciuca was informed by the Mayoralty Lăpuşata that there is no one to bury her**.**

According to the reply letter no. 4588/17.10.2014 of the Mayoralty Lăpuşata, the resident had two brothers (P.C. and P.I.) and from the discussions with them it shows that "P. A., being admitted to this center for a long time, they do not want integration into their families because they lack financial and material resources and they want her to stay in the center".

According to the disability certificate no. 4153/15.10.2002 issued by I.S.P.T.H. Vâlcea, the resident was diagnosed with profound mental retardation, placed under judicial restraint, serious functional impairment, disability code 5, irrevocable and permanent.

The services supply contract concluded between the resident and CRRN Măciuca in 2006, is not signed by the resident nor by any legal representative, only a fingerprint can be noticed under the signature section.

3. S. I. born on 27/09/1964, died on 11.12.2016, according to the death certificate no. 592286/14.11.2016. According to the death certificate no. 22/14.11.2016 issued by Dr. Ioana Băbeanu MD, the resident died at CRRN Măciuca, at **07:30**, and the causes of death were the following:

a) The direct cause (immediate) - **cardiopulmonary arrest**

b) Initial morbid condition

Disease or illness that triggered the initial conditions referred to in point b and a and representing the determinant cause/causes of death - **Stroke**

Other important morbid conditions

Morbid conditions contributing to death, but not related to the disease or the morbid condition which caused it - **Infantile encephalopathy; Mental retardation with behavioral disorders**.

In the file there is a report prepared by a police agent of the Police Station Măciuca, Daniel Nastase Eugen (experts do not understand very well the name written on the document), on 14/11/2016 (experts states not understand very well the date written on the document) stating expressly that he was informed by the Director of CRRN Măciuca on the death of the resident, and on this occasion he went to the center where he ascertained the following: "S.I. (..) Appears in the medical records with ECI sequelae, mental retardation with behavioral disorders. **There are no visible injuries, and it was established that he died on 12.11.2016, 07:30 o'clock**, **probably because of the disease he was suffering of**". The report was signed by the police agent, the social worker Elena Cornelia Cârstea and by the registered nurse.

The report prepared by the police agent of the Police Station Măciuca, is dated 14/11/2016 (experts do not understand very well the date written on the document) and resident died on 12/11/2016.

In the resident file there is a reply letter of the Grindu Village Mayoralty, Ialomita County, stating that the resident had a brother named S.G., and "the family has never visited him and doesn't want him to come back in the family because they have no financial resources to ensure his basic needs".

According to the disability certificate no. 950/06.03.2004 issued by the Vâlcea County Council, the resident was diagnosed with infantile encephalopathy sequelae, medium mental retardation, behavioral disorders, severe functional impairment, disability code 5, irrevocable and permanent.

4. L. A., born in 1970, died on 14.08.2016.

The death certificate was issued by the family physician of the residents, Dr. Băbeanu Ioana, cause of death being **cardiopulmonary arrest, following a myocardial infarction and profound mental retardation**. But it appears that no ambulance or the police had been called and no forensic examination was conducted. The resident had a disability certificate, grade 2, according to which the diagnosis was mental retardation with behavioral disorders. It doesn't follow from the medical records in the file the circumstances of resident death. It is mentioned by the doctor of the center that his blood pressure was read on **05.03.2016**, on **12.04.2016** and then on **14.08.2016** when it is noted that the resident died at **16.00**.

Situation of deaths in 2015, according to the documents examined by CLR experts is as follows:

5. S. C., born in 1980, died on 07.04.2015.

The death certificate was prepared by the family doctor, Dr. Băbeanu Ioana. According to this certificate, the resident has died of a cardiac arrest, amid acute bronchopneumopathy. Initial diagnosis indicated in the resident's certificate is schizophrenia, profound mental retardation.

In this case the police was called and a report was drawn up by mentioning that the police agent Radu Octavian within the Police Station Măciuca, was informed by the head of the center, Smărăndoiu Sergiu, regarding the death of the resident, therefore he went to the CRRN Măciuca to examine the corpse.

Registerings of the police agent are the following: "... there were no injuries found on his body to be causally related to his death. The discussions with the staff and the doctor of CRRN Măciuca, Dr. Maria Dumitrescu, revealed that lately the concerned resident refused food because of some medical conditions".

These are the only indications included in the report by the police agent that led him to the conclusion that it was not necessary to notify the forensic services in order to perform the autopsy. It worths mentioning that t**he report was drawn up on 08/04/2015** and the resident **died on 07/04/2015**.

The medical record in the file mention that between 24 to 28 February 2015 he was suffering from acute bronchitis, resulting to have received treatment with Gentamicin between 25-28 February along with other medications.

It is also mentioned that between 6 to 22 March the general condition of the resident is not a satisfactory one, and that he is receiving the treatment on a permanent basis, between March 23 to 31 and 1st to 4 April.

The last registering in the sheet is dated 07.04.2015, when the doctor noted that at 10:45, the resident deceased following a cardiac arrest. He also makes the following note: "I mention that lately the beneficiary refused to eat so his health condition became serious - sprue, cyanotic face, anxiety and sad look".

There are no indications in the medical record that an ambulance had been called for or that the resident had been taken to hospital to receive specialized care.

6. **Z. A., born in 1964, deceased on 24.02.2015.**

In the resident's file there is not the certificate ascertaining death, but only the death certificate. The staff told us that the resident died at the hospital in Mihăeşti, but the staff there did not provide them with the certificate ascertaining death.

According to the medical referral letter drawn up by the medical doctor Băbeanu Ioana on 19/02/2015, the resident was sent to the Mihăeşti Hospital, Pneumophtisiology department.

From the medical record in the file it results that the doctor of the center diagnosed the resident with **acute bronchitis** and fever from 4 to 8 February 2014, thus receiving an antibiotics treatment. This treatment is extended in March 2014, being mentioned that between 26 - 31 March 2014 the antibiotic treatment continues. After a few brief notes on the state of the resident, in January 2015 he has fever again, he has pains and it seems that on February 19 the family doctor is sending him at the Mihăeşti Hospital, Pneumophtisiology department, where he dies a few days later, on February 24, 2015.

There is not any note in the medical record that during that year, since February 2014 when the bronchitis had started, until February 2015 when he died, an ambulance was called

for or that the resident was seen by a specialist doctor and received the appropriate treatment.

7. **P. V., born in 1948, deceased on 26.01.2015.**

Neither this file includes the certificate ascertaining death. From a hospital discharge letter issued by the Pneumophtysiology Hospital Mihăeşti it results that the resident was admitted on 13.01.2015 with a diagnosis of acute COPD (chronic obstructive pulmonary disease), chronic exacerbated respiratory failure, nonspecific **bronchial pneumonia**, schizophrenia, sinus tachycardia.

The resident is discharged on **19/01/2015**, having a positive evolution and the recommendation to continue the antibiotic treatment, avoid cold, moisture and physical effort.

The resident dies in the center on **26.01.2015**. According to the statements of the CRRN Măciuca staff, the certificate ascertaining death was requested and rendered to the family of the resident.

The file does not contain any record showing that the certificate ascertaining death was really rendered to the resident's family.

8. **L. M., born in 1956, deceased on 06.04.2015.**

There is not any certificate ascertaining death in this file. The resident died in the Vâlcea hospital and, according to the statements of the staff, the certificate was taken by the family of the resident. In the medical record there are no information showing anything about the deterioration of the resident's state of health, it is not specified the cause of death and there are no any other information.

Other deaths:

9. **S. L., born in 1977, deceased on 28.08.2014.**

The certificate ascertaining death was issued by the family doctor, Dr. Băbeanu Ioana, and the indicated cause of death was cardiac arrest amid an **acute broncho-phneumopathy**.

This case was also referred to the police by the registered nurse, Ms. Elena Rada, so the police agent Eugen Nastasie from the Police Station Măciuca came to the center. The police

agent mentioned in the report he drew up the following: *"... I have identified the body of S.L. and following the examination no visible injuries or other traces that could have caused death were found. Also, the registered was registered in the records as suffering from infantile encephalopathy sequelae and medium mental retardation with behavioral disorders. The body of the deceased was found in the bathroom, and from the discussions with the officer on duty it results that they found her wrapped in a blanket on her bed as she used to lay down and eventually they took her there to remove it from the other patients. There are no suspicions on the death of ...* ".

The resident file did not include the medical record so it cannot be established since when she was suffering from bronchopneumonia, if she received medical treatment, if she has been seen by a specialist doctor, what was the evolution of the disease and which were the causes determining death.

10. <u>G. B. C, born in 1995, deceased on 22.09.2013.</u>

The certificate ascertaining death was issued by the family doctor, Dr. Băbeanu Ioana, and the cause of death was cardiopulmonary arrest, against a background of **acute broncho-pneumopathy**.

The police was informed by the head of center, so the police agent Nastasie Eugen came to the center and drew up a report on 23.09.2013 stating that there are no traces of violent death. It was not requested any forensic expertise and from the medical records in the file there are no indications on how the death has occurred.

As for the lack of medical records in some of the residents' files, the members of the staff that the CLR experts discussed with said that the medical records of the residents who deceased before 2015 are kept in the pharmacy room. On the date of the visit, the pharmacy room was locked since the registered nurse who had the key was not on duty that day.

At the same time, in all medical records that we have examined it is mentioned that on 03/12/2014, the residents were given Decaris. According to the prospectus, it belongs to the group antinematode, imidazothiazole derivatives; it has a vermicide action by the paralysis of

the helminths muscles and it is indicated for the following infestations: Ascaris lumbricoides, Necator americanus, Strongyloides stercocalis, Trichostrongylus colubriformis and duodenal Ankylostoma.

1. INHUMAN AND DEGRADING TREATMENTS

In the Case of Valentin Câmpeanu v. Romania (Valentin Câmpeanu - institutionalized person with disabilities, who died at the Poiana Mare Psychiatric Hospital), the European Court of Human Rights, in interpreting Article 2 of the Convention (the right to life shall be protected by law) ,, held that the first sentence of Article 2, para.1 requires the state not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to protect the lives of those within its jurisdiction "(par.130).

Further on, in the interpretation of the same article, the Court states that "when the authorities decide to place and keep in custody or detention a disabled person, they should guarantee special care in providing special conditions required by the disability of the person (see Jasinskis v. Latvia, nr.45744 / 08, para. 59, December 21, 2010, with further references). More broadly, the Court held that states have an obligation to take specific measures to ensure effective protection against ill-treatment of vulnerable people of whose existence authorities know or should know (see Z. and Others v. The United Kingdom the United Kingdom [GC], no. 29392/95, para. 73, ECHR 2001-V). **Consequently, when a person is taken into custody in a state of good health, but later dies, it is the duty of the state to provide a convincing and satisfactory explanation on the events that led to the death of that person** "(para.131).

The Court has also found a violation by the Romanian State of the Convention in that the **,,authorities failed to ensure Mr Câmpeanu not only basic health services, but failed to even clatify the ciecumstances of his death, including the identification of those responsible**". (para.145).

Further on, in the next paragraph the Court states that ,,**Court observes that local authorities have committed several procedural irregularities, among them they have not done an autopsy shortly after the death of Mr Câmpeanu, thereby breaching internal legal**

provisions, and the lack of an effective investigation on the therapeutic approach applied in this case. "

The Court therefore concluded that the Romanian State is guilty of violating Article 2 of the Convention, given that it "**failed to protect the life of Mr. Câmpeanu during his stay in the care of the internal medical authorities and because it did not conduct an effective investigation to establish the circumstances that led to his death**. "

Given that Romania has already been sentenced by ECHR because it failed to protect the life of a disabled person under its care despite having known the findings by the Court and the provisions of the internal legislation on the obligation of carrying out forensic autopsy in these cases, we may conclude that:

- There is a reasonable suspicion about the circumstances in which residents from CRRN Măciuca died, bearing in mind that in most cases the cause of death was bronchopneumonia / bronchitis;
- It requires an investigation aimed at elucidating the circumstances of the deaths, given that the legal provisions were not respected by the personal when it comes to referral to judicial bodies and since the cause of death was omitted from reports submitted to CLR.

Article 15 of Law No. 221/2010 provides the categorical imperative that no one shall be subjected to torture or any kind of punishment or cruel, inhuman or degrading treatment. In particular, no one shall be subjected without his free consent expressed to medical or scientific experimentation. In addition, States Parties shall take all appropriate legislative, administrative, judicial or other measures to prevent persons with disabilities from being subjected to torture, cruel treatment or punishment, inhuman or degrading treatment, on equal terms with others.

In addition to those above, Article 16 of the same law provides that **no one shall be subjected to exploitation, violence and abuse**, and to this end, States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect

persons with disabilities both in the family and outside it against all forms of exploitation, violence and abuse, including their gender.

At CRRN Măciuca, following discussions with some of the staff of the Center, the CLR experts have identified the following situations of exploitation and abuse:

- Some residents and some of the staff worked at the Director's house;
- While the employees were working in the house of the Director of the Center, the residents were tied to beds and the Director's wife supervising them. Some residents were tied in the pavilion of the Center;
- In exchange for the work they had undertaken, employees were rewarded with days off, during which were not present in the center, but were listed in the timesheets as being present. With no one to supervise the residents, while employees were not at the center, they were tied to beds again; (Except those who made these statements, no staff or resident, provide clear information on the situation)

States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of assistance and support to persons with disabilities, for their families and caregivers, according to sex and age, including providing information and education on how they can avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services respond to issues of age, gender and disability.

To prevent all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programs designed to serve persons with disabilities are effectively monitored by independent authorities.

States Parties shall take all appropriate measures to support their physical, cognitive and psychological rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Recovery and reintegration shall take place in an environment which fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender and age specific needs.

During the visit CLR experts found:

- All residents have short hair, whether they are male or female;
- Most residents do not benefit from their own clothes;

Article 3 of the European Convention on Human Rights provides that "No one shall be subjected to torture or to inhuman or degrading treatment or punishment".

ECHR has constantly emphasized the importance of this provision of the Convention and the absolute nature of the prohibition contained in it: "The Court recalls that Article 3 enshrines one of the fundamental values of a democratic society, prohibiting in absolute terms torture and punishment and inhuman or degrading "(Aydin v. Turkey, judgment of 25 September 1997).

2. PRIVATE AND FAMILY LIFE

Space for couples. Reproductive health

In the center there is a couple of residents, but they are not supported to have a family life through private space or through discussions with personnel specialized on contraception.

On reproductive health the Centes doctor filed an application requesting the same contraceptive methods – IUD (sterilet) - for all women in the center.

The visit at Babeni Center, where the residents have been transferred

Standard No. 4 regarding the active life of the Order 67/2015 sets the Center's obligation to ensure the necessary conditions for the private life of the beneficiaries. The Centre must respect private life of beneficiaries and, where appropriate, to ensure proper conditions for couples formed in the center, while providing counseling regarding contraception.

Moreover, Article 23 of Law No. 221/ 2010 provides that States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and interpersonal relationships, on an equal basis with others, so as to ensure:

a) The right of all persons with disabilities who are of marriageable age to start a family on the basis of free and full consent of the intending spouses;
b) b) The rights of persons with disabilities to decide freely and responsibly the number of children and the interval between births and the right to access adequate information age, education on reproductive and family planning and the means necessary to enable them to to exercise these rights;
c) c) People with disabilities, including children, retain their fertility on an equal basis with others.

The CLR experts went to the center of Babeni where 28 residents were transferred. The visit to this center lasted around 15 minutes. Dr. Felicia Călinescu informed the experts that all residents on the ward visited by the experts have been transferred from Măciuca center and they came to center on December, 1 or 2, 2016.

When asked about the criterion on which residents were selected for this transfer, the staff did not give a concrete answer. The pychologist Alina Basanete from Govora Center, assumed that probably the criterion considered was their health. Dr. Felicia Călinescu from Govora Center stated that the Deputy Director Anonie Ceauşu of the SACPD Vâlcea may be able to provide more information related to this issue since he attended the transfer. She also assumed that the criterion could have been related to the fact that some residents were institutionalized as children in this center (in this sense, she has indicated as an example, resident named I).

Dr. Felicia Călinescu presented the experts one of the residents who appeared in mass media and said that it came from Dragoesti, Vâlcea. The resident seemed to have have self-inflicted wounds on the face.

The CLR experts have noticed that these residents might have in common their age (they seemed very young) and their health (very degraded). The experts were not able to interview any resident because they did not seem coherent, despite their open and sociable attitude. There have been only minor contextual conversations with some residents. A resident in response to the experts' questions, said that he got used in this center and that he enjoys more here than ay Măciuca center. Another resident embraced a staffer, while another one was sitting on the floor trembling. The staff said that this is not a crisis but just pretending. The staff's answer was right. The resident had traces of self-inflicted wounds on her face and Dr. Felicia Călinescu asked the staff to grant the resident with the necessary medical aid. Another resident accompanied the experts on their way out the center (while insisting to do that) and at the end, the resident hugged doctor Felicia Călinescu.

The staff from Babeni Center said that residents are spending their time watching TV, playing, listening to music and sometimes dancing. The rooms are occupied by 3, 4 or 5 persons. The staff underlined that the Center will no loger be so crowded after some residents will be moved to the 2nd floor. Dr. Felicia Călinescu said that in the courtyard of the Centre there are some swings and a pavilion.

The critical situation at CRRN Măciuca

Out of the conversations with some of the staff, we may conclude that the situation at the CRRN Măciuca during 2016, until December, was as it follows:

- - The Center was in an advanced state of decay, wards were not cleaned, beds were iron made, no mattresses, residents had no clothes, some of them were tied;
- - The situation has deteriorated since June 2016 when the Director of the center, Sergiu Smărăndoiu, began renovating his personal house with the support of some of the center's employees and some of the residents;
- - Since the Director's wife had been transferred from the Elderly Care Residence in Bălceşti to CRRN Măciuca, as Chief Nurse of the Center, she was responsible with the timesheets of the employees

- - The Director of the Cneter developed an entire system to seal materials from the wearhouse of the Center, manipulating his emplyeees to write false necessity statements. He would take the materials, hide them near his office and eventually take them out of the center by car. These issues were raised in a criminal complaint that is now pending before the Prosecutor Office - Balacesti Court. One of the employees has expressed doubts about the investigation conducted in the case, given that the center's employees are brought to hearings at Bălceşti by the Director's wife.
- - In September the President of the Vâlcea County Council, Mr. Constantin Radulescu, was notified on the situation at CRRN Măciuca. As a result, he conducted an inspectyion vissit in October, but no action has been taken at that time;
- - After November 15, 2016 a series of photos with najed and bed-tied residents were sent to several employees of the Center. On December 1, the photos have reached the President of the County Council, Mr. Constantin Radulescu;
- - 2 days later, he visited the Center and previously informed the management about the visit to come. Thus, before reaching, all center employees were called home, and at 6:30 a.m they made arrangements in the Center for the visit. Starting that day (December 3, 2016) the Director of the Center was dismissed and replaced with Mr. Gerard Stoicănoiu. During his interim mandate, Mr. Stoicănoiu Gerard changed the iron beds with new wooden furniture; residents were transferred to other centers, since the center was overcrowded (In Room No.3 there were accommodated 17 residents in 11 to 12 beds). The first residents were moved exactly during the day of the inspection, by 2 minibuses provided by SACPD Vâlcea.
- After January 1, 2017, Sergiu Smărăndoiu was reinstated Director of Center, but removed from office after mass-media presented the photos and the story.

The information provided by the staff of the Center are contradictory. Some staffers claim that the photos from mass media are "not real" in the sense that they were created intentionally; residents were tied to beds and banks in the central courtyard, for the purpose of shooting, in order to be used against the Director. The staff, also, say the Director of the Center

failed to build a good relationship with its employees, "*It was patronizing, he misbehaved, dis not cooperated with the team and there were organizational problems*".

The characteristics limitations by most of the residents from CRRN Măciuca has made it difficult for CLR experts to communicate with many of them. Out of the few conversations with some of the residents the experts found that: "*we work at some of the Center's employees and at some peopole in the village because we need money*".

Despite the fact that none of the staff members present during the visit confirmed the restraint as it appeared in the photos published by the mass media, however, none of them have denied the possibility of its use by other colleagues "I have not seen anything, but it may have happened on another shift."

CLR experts do believe that both situations are extremely serious, both tiding (physical restraint) residents with straps for prolonged periods of time, leaving them unattended, as well as the physical restraint with demonstration purposes (manipulation or coercion) of residents that are unable to defend (their exposure without clothes in front of other residents of the center, and before the general public) for revenge / settle accounts among center staff.

Recommendations:

- Within and without refurbishing the Centre with European funds or by sponsorships and donations. Customizing wards according to the needs and personality of beneficiaries. Creating a salon for cultural, educational and recreational activities that contribute to the psychological development and improve residents' quality of life;
- Establish a dining hall inside the Center so that the beneficiaries have no longer to go outside to dine;
- Supplementing care staff and the specialists considering the number of residents of the center and their needs;
- The application of specific contraceptive methods depending on age, health status and desire of the beneficiaries;

- Ensuring proper sanitary conditions of persons with neuropsychiatric disabilities, ensuring current specialized healthcare; conducting occupational therapy activities for training, development and strengthening life skills, self-service and self-catering;
- Organization of cultural and educational activities, social activities and leisure activitities involving family members, caregivers, and community members;
- Adapting the physical environment to facilitate access by persons with disabilities (ramps, wheelchair lifts functional).

SACPD Vâlcea and County Council Vâlcea:

- To provide explanations and answers to the situations observed and described in this report;
- To allocate the necessary budget for CRRN Măciuca, given the minimum quality standards on accreditation of social services, given the profile and the pathology of the residents and the number of vacancies;
- To actively support through sustained efforts and adequate funding, access to the most effective medical and related services of the residents from CRRN Măciuca, especially prescription drugs, medical tests, dental services;
- To accelerate the process of deinstitutionalization of residents from CRRN Măciuca.

CRRN Măciuca:

- To ask an opinion by the SACPD Vâlcea with regard to the problems identified by the CLR experts in this report and a plan to address these problems;
- To notify the competent authorities in order to perform the autopsy whenever a resident dies in the Center and to archive records of death certificates of their residents and all medical documents;
- To initiate and monitor carefully the procedure for restriction on legal capacity;
- Understanding the difficulties arising from overcrowding, staff shortages and failure to meet minimum quality standards on accreditation of social services, to continue the

efforts to provide the most effective treatments for the residents in CRRN Măciuca in respect of their right to life, health and decent health services;

- To request for local national or international professional support with regard to the management of the extreme medical conditions that involve self infliction by the residents in order to identify the best medical, psychological and environmental solutions to prevent, reduce or eliminate these symptoms;
- To reflect on the mission of CRRN Măciuca with regard to their duty to socially and professionally reintegrate the residents.
- To analyze and identify the causes of this situation and to initiate any action necessary to accelerate the processes of deinstitutionalization and / or integration / family reintegration of the residents in CRRN Măciuca.

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This report does not necessarily reflect the position of the Swiss government. Responsibility for its content lies entirely with the Center for Legal Resources.