

Monitoring report

Drobeta Turnu Severin County Hospital for Emergencies Psychiatry Department – Patients with Chronic Conditions (adults) - Gura Văii

Report realized within the project "SOS: Romanian NGOs for the Rights of Persons with Mental Disabilities in Institutions", implemented by the Legal Resources Centre (LRC) and co-financed by a grant from Switzerland through the Swiss Contribution for the enlarged European Union .

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Centrul de Resurse Juridice

Drobeta Turnu Severin County Hospital for Emergencies

Psychiatry Department - Patients with Chronic Conditions (adults) - Gura Văii

Date: 08 MARCH 2017 and 14 MARCH 2017 (return visit)

Duration: 14:00 - 17:00 and 11:00 - 15:00

Experts: MITAR Clara - lawyer, FRATILA Mugur - psychologist; Georgiana Pascu - program manager, Cezara Prepelitșă, legal advisor - program assistant, Vadim Chiriac - lawyer

Address: 2, JIDOVITEI STREET, GURA VĂII, MEHEDINȚI COUNTY

Type: EXTERNAL DEPARTMENT at the Drobeta Turnu Severin County Hospital for Emergencies

Specificity: PSYCHIATRY - PATIENTS WITH CHRONIC CONDITIONS, ADULTS

Capacity: 50 places / 50 patients admitted at the time of the monitoring visit

Interviews

Staff: **VLĂDOIU Aneta** (family medicine primary physician), **BALACI Iulia Alina** (primary physician - chief psychiatrist of the psychiatry department), **MOESCU D. Ileana-Daniela** (chief nurse), **NICOLĂESCU Constantin Claudiu** (specialist psychiatrist), **PLĂNICEANU Gulei Lenuța** (nurse), **BRĂȚIA Octavian** (nurse).

CONTEXT:

The first visit of the team took place on 8th March 2017. The return visit was organized on 14th March as a result of serious human rights violations reported by the team that came into contact with patients on 8th March 2017.

While on the first visit access to the premises was done without any problems, for the visit on 14th March, access was not allowed until a team consisting of the head of the department, a nurse and a social worker arrived at the external department of psychiatry in Gura Văii.

The department is located in an area adjacent to the Gura Văii commune, next to a derelict building, surrounded by garbage. The department is surrounded by a high metal fence and the guard is provided by a private security company. The building consists of the ground floor, two floors and a bridge. The rooms and the bathrooms are in a severe state of deterioration. In the yard, several metal beds were deposited, with no recreation or leisure facilities for the patients. The temperature inside the rooms was low, even if there were 14 degrees C outside. Most of the patients were in bed, clothed and covered with blankets. Five patients were watching a show on a TV set up on a wall. The room called club was equipped with several plastic chairs and the television was set up in a wooden box, up on a wall.

Information on access to support services for the development of independent life skills, ergotherapy or occupational therapy and the number of those who need legal representation could not be provided.

On a few occasions, specialized medical staff repeated to the team that patients for whom the LRC (the Legal Resources Centre) requires sheltered housing and access to independent living services are in fact people with "mental retardation", which is why it is appropriate for them to stay in the hospital all throughout their lives. Besides, according to the employees' declarations, they know most of the patients from the age of 3, when they were institutionalized in the Vânjuleț orphanage. Submitted petitions were also presented, which were sent in 2014 and 2015 by the social assistance service of the Drobeta Turnu Severin County Hospital for Emergencies to the General Department of Social Assistance in Mehedinti (GDSA) and to the county town halls asking for social investigations or the GDSA intervention for decongestion of the department and release of some places. No documents have been presented in which emergency intervention to ensure access to sheltered housing and adequate community services has been requested of GDSA Mehedinti.

The Legal Resources Centre (LRC) draws attention to the fact that institutionalization due to lack of places in community-based services constitutes an illegal deprivation of liberty and, implicitly, a grave violation of human rights, as this is also mentioned in the Convention on the Rights of Persons with Disabilities. Lack of representation of people with intellectual disabilities and mental health problems is also a matter that restricts access to justice for people with disabilities locked up in this department.

The LRC has asked the chief of the psychiatry department to allow access to the Mobile Legal Clinic for representation before competent authorities, in order to provide access to appropriate community services. Support services for people with intellectual disabilities and mental health problems imply both access to community life, personal development and dignified life, as well as the provision of adequate psychiatric therapies. **We request the management of the County Hospital, GDSA Mehedinti and the Mehedinti County Council emergency intervention for the provision of services in the community as they are mentioned by the international treaties to which Romania is a party.**

Main observed violations:

1. ISOLATION AND RESTRAINT. NON-VOLUNTARY ADMISSIONS. INTERVENTION IN CRISIS SITUATIONS

1.1 **There is no seclusion room.** Staff declare that they do not practice the physical restraint method.

1.2 We express reasonable suspicion regarding the use of chemical restraint through psychotropic medication abuse. The nurse said that if they show agitated behavior, patients receive a Diazepam vial and a Haloperidol vial 3 times a day, so there is no need for physical restraint.

2. DEATHS

2.1 According to the staff, three patients died in 2015 and one patient in 2016. There is no separate evidence of deaths, we could not be provided with information on patient data and the causes of their death. All records of deceased patients are archived at the Mehedinti Psychiatric Hospital, including the certificates of death.

2.2 In 2016, there was only one death. Initially, this death was briefly presented to the LRC experts, the cause of death being explained as a cardio-respiratory arrest. Upon insistence of the LRC experts (we requested a discussion with the nurse who was actually present at the time of the incident), the following surfaced:

2.3 Around the end of May / early April 2016, at lunchtime, nurse Plăniceanu (who supervised, along with her other colleagues, the patients who were having lunch) had gone outside to bring patients to the table. During this time, the patient RG (who was eating lunch in the dining room, along with other patients and supervised by nurses), choked with a big (uncut, unchewed) piece of meat. The staff that was present at the time of the incident tried to give first aid: they put the patient in a safety position, struck him in the back, tried to unclench his mouth and tried to extract the piece of meat with the tail of a wooden spoon. The patient weighed more than 100 kg, so it was not possible for the staff to handle him, and the Heimlich maneuver could not be done properly. The staff of the department tried to give Mr RG a cardiac massage. None of the maneuvers performed were successful, the patient was showing obvious signs of suffocation, he tried to cough, but failed. Eventually, the emergency service arrived (announced by the unit's staff, but it is not clear after how long the Ambulance crew arrived). All maneuvers were late. The patient died. The Ambulance crew managed to extract (using a probe) the piece of meat. It was sent for expertise, together with the patient's inanimate body, to the Forensic Institute. An autopsy was performed, a death certificate was issued (according to staff statements, the cause of death was mechanical asphyxia and cardio-respiratory arrest), there was an investigation of the police (which took statements). The staff of the department say patients choking with a lump of food is one of the common problems they face. We do not have additional information, it is not clear what was the result of the investigation. According to the statements of the chief nurse, there were no administrative, disciplinary or criminal sanctions following the incident.

3. LIVING CONDITIONS

3.1 The department is located at the edge of the Gura Văii locality (Mehedinți County, about 15 km away from the center of Drobeta Turnu Severin and about 3 km away on a relatively degraded route from the national road crossing Gura Văii) on the border with a hilly and wooded area. The location is isolated, desolate and insalubrious. The department is organized into a deserted block



that has been used as a housing block for military sappers many decades ago. The final access to the psychiatric department is done by crossing a precarious, narrow, 20 m long, metallic bridge, crossing an insalubrious valley. The block in the immediate vicinity of the department (a block-pair) is in ruin. Nearby there are other blocks / dwellings that make up a small marginal colony of Gura Văii (a former colony of workers). The building where the Gura Văii Psychiatry Department for Patients with Chronic Conditions is organized lies at the foot of a wooded hill. The building consists of the ground floor and two floors and a bridge. The heating is provided by a diesel / fuel oil plant. Hot water is provided by electric boilers.

Room 1: 5 beds, non-functional washbasin; Room 2: 5 beds, non-functional washbasin; club - about 13 places; Room 3: 5 beds, (women); Room 4: 5 beds; Room 5: 5 beds; Room 6: 5 beds; Room 7: 6 beds; Room 8: 5 beds (2 patients); Room 9: 6 beds; Room 10: 6 beds. There also is a room with 2 beds. Total rooms: 11. Total beds: 53. Some beds in the rooms are in an advanced state of degradation and are not used. They have not been taken out of the rooms. Other: doctor's office, lockers for auxiliary staff, nurses' office, treatment room, lounge, dining room.

3.2 Living conditions are primitive and degrading. The rooms are paved with cement (2nd floor) or with cement covered with linoleum (1st floor: the linoleum is outdated, degraded), equipped with metal beds, windows (many of them degraded, all with metal bars), some rooms have sinks (no functional sink has been encountered, they are degraded, broken, without faucets, decommissioned). Some rooms are provided with metallic, degraded and insalubrious nightstands. Beds are old, degraded, rusty and dirty. The state of degradation of the rooms on the second floor is more advanced than that of the rooms on the first floor. There is no other equipment in the rooms (chairs, tables, cupboards).

3.3 Patients do not have the possibility to keep personal belongings in the rooms.

3.4 All the spaces in which the patients live or spend their free time are sterile, unpersonalized, without aesthetic elements, there are no posters, photographs, the atmosphere is flat, austere.

3.5 Patients with severe pathology (especially those diagnosed with different degrees of intellectual retardation, with incontinence) are generally admitted to the second floor.

3.6 Patients do not have their own clothes, most of them wear the same clothes for a week, do not use pajamas (they sleep in the same clothes they wear over the day for 1 week).

3.7 Each floor has a sanitary group equipped as follows: 3 rusty, degraded Turkish toilets, 3 washing places. There is no separation between the washing places, they are delimited by a curb about 30 cm high. The pipes, the tiles and the faucets are degraded, rusty and damaged. In one of the sanitary groups, a hose hangs, without looking like a shower. There is no functional sink.

3.8 Patients bathe once a week, when their clothes are also changed. There are situations in which some patients need a daily bath due to physiological / medical problems (for example, incontinence).

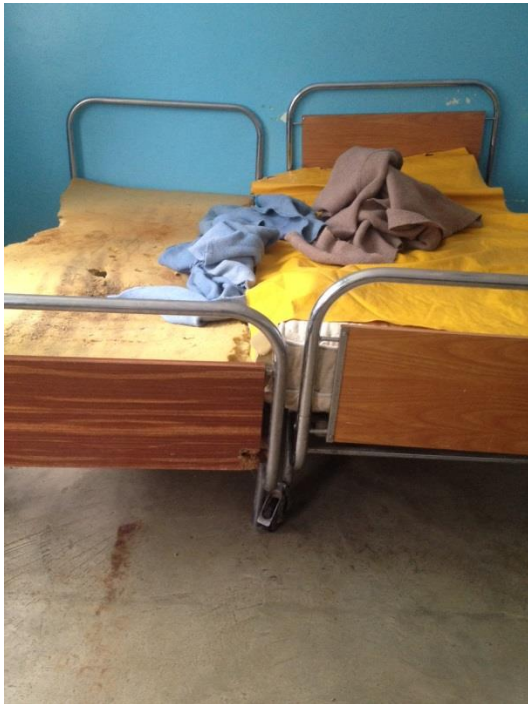
3.9 The patients observed at lunchtime (at the time of the monitoring visit, lunch was served at about 16 o'clock) have a bowl and a plate (both of which are made of steel, obsolete, bent) - and have 1 spoon. Each patient receives half a piece of bread. For some patients, the bread is placed on the plate, over the gravy in the plate, so that at the time the patients sit down and start eating, the bread is soaked and moistened. Patients who extracted the piece of bread and placed it on the table were noticed. The tables and chairs are obsolete, rusty and some are broken. The tables are covered with mat. Places in the dining room are insufficient (about 20 places).

3.10 We have encountered 3 situations in which the patients were staying 2 in the same bed. The staff justifies this state of affairs as patients' choice.

3.11 Hot water is provided by electric boilers and heat by a diesel / fuel oil plant.

3.12 There is no mobile telephony signal on the perimeter of the Gura Văii psychiatry department.

3.12 There is no possibility that the privacy, dignity or private life of patients is respected.



4. PLACEMENT UNDER INTERDICTION. GUARDIANSHIP

4.1 According to the nurse, at least 25 patients with severe mental retardation require placement under interdiction and the appointment of a representative. They come from the Severin Placement Centre for children with disabilities and at the age of 18, they were institutionalized in the Hospital of Psychiatry, the Department for Chronic Conditions. Everyone has a severe mental retardation diagnosis, they do not have a family or a legal representative. Although they do not have the necessary discernment to look after their own interests, none of them has a tutor/ legal guardian.

4.2 **Almost all records of informed consent on admission are signed, by such patients included (they were asked to sign, to make a "scribble on paper"), even if they did not understand what they signed,** as for the hospital, it was enough to have a signature on these documents to be considered that it was okay and the patients agreed with the admission. All patient decisions are taken by the medical staff, without the possibility of contesting or verifying them.



5. DIAGNOSIS, TREATMENT, SERVICE

5.1 The Gura Vail Psychiatric Department for chronic conditions at the Drobeta Turnu Severin County Hospital for Emergencies addresses the problems specific to the chronic psychiatric pathology. In the Gura Vail Psychiatric Department for chronic conditions, 50 patients are admitted for an indefinite period. According to the department staff, about 3 of the admitted patients are diagnosed with different mental retardation forms/ degrees of mental debilitation. Other encountered pathologies: different forms of psychosis, dementia.

5.2 **There are 2 patients with visual impairments.** For them, there is no specialized staff or specific accessibility.

5.3 The department has 1 specialized physician in psychiatry and 1 family medicine physician. The department does not have a social worker, psychologist, ergotherapist or occupational therapist.

5.4 In emergency cases, the emergency line 112 is called. Also, every Wednesday, a car from the Drobeta Turnu Severin County Hospital for Emergencies is assigned to take patients with various problems to various medical consultations in the town of Drobeta Turnu Severin.

5.5 The only intervention provided is psychiatric drug intervention. The department does not have rooms, staff or facilities for providing leisure activities programs and alternative / complementary interventions to psychiatric intervention.

5.6 **Patient admission period: indefinite.**

5.7 Patients do not carry out any activity. Two rooms called clubs were visited. One of the rooms, dark, with about 15 chairs (most of them placed one over the other, unused), had a TV set installed in a wooden box on one of the walls (for patients not to have access to it). It was turned on at the time of the visit and about 3 patients were following the program. This TV is the only way to spend the time that the patients of the Gura Vail Psychiatry Department for Chronic Conditions

have. More than 10 years ago, there have also been occupational therapy activities. The second club is an empty room where a wooden bench (an outdoor bench) and a unitary set of several chairs (specific to the subway or waiting stations) are arranged along the walls. There is no other equipment.

5.8 The staff of the department stated that, sometimes, there is the possibility of "playing music into the club", but the psychiatrist forbids this during his program (08:00 - 15:00) because the sounds and noises disturb him and he has to do office work, needs to fill in the observation sheets and the noise does not allow him to focus.

6. STAFF OF THE DEPARTMENT

6.1 Staff of the Department: 13 medical assistants, 1 chief medical assistant, 15 nurses, 1 psychiatrist, 1 family medicine physician, 1 social worker (also serving the acute psychiatric department of Drobeta Turnu Severin County Hospital for Emergencies). Shifts are organized 12/24 and 12/48 as follows: 4 day-shift nurses and 2 night-shift nurses 3, 4 medical assistants during the day shift, 2 medical assistants during the night shift. Doctors have a program from 08:00 to 15:00.

7. OTHER ISSUES

7.1 Patients cannot leave the unit. The psychiatrist of the department states that there are no reasons why patients should leave the department, and it is not necessary to apply the involuntary admission procedure.

7.2 At the first visit, the psychiatrist of the Department participated in the discussion with the LRC experts about 15 minutes. After being presented with the situation and the context of the visit, he insisted that he had nothing to declare and suggested that we contact the spokesman of the Drobeta Turnu Severin County Hospital for Emergencies. After initiating the monitoring visit, at 15:00, the psychiatrist (finishing his work schedule) left the department.

7.3 The staff of the department said that in the past there was a conflict between the doctor and the employees.

7.4 At the time of the first monitoring visit, the staff of the department could not provide us with information on the income (pensions etc.) of the patients. This information does not get to the department and it is not clear who gets and who manages this income. The nurse assumes that patients' pensions are received by their families. However, according to this, there is no possibility for the pensions to be brought to the hospital as there is no one to manage them, so no action has been taken to solve the situation. We requested to see the files of at least two patients who had pensions to see if any action was taken, but the social worker (who serves both psychiatric wards and the County Hospital) was not on the ward at the time of the visit, and the files, as the nurse informed us, are not in the doctor's office, but the social worker keeps them in another place.

8. CONCLUSIONS

8.1 We appreciate that the Gura Vaii Psychiatry Department for Chronic Conditions is a deposit of human beings with inhuman and degrading living conditions.

8.2 We appreciate that the rights to health, private life, decent living conditions and freedom are being violated. We appreciate that patients admitted to the Gura Vaii Psychiatry Department for Chronic Conditions are subjected to degrading and inhuman conditions and treatments.

8.3 The lack of awareness and concern among staff about this state of affairs is an indicator that suggests a rooting in the collective mentality of the belief that people with mental or intellectual disabilities are human and social rejects, a burden that is unnecessary for society, beings who does not deserve to resources to be invested in, who do not deserve the attention, respect, love or appreciation of society.

8.4 We suspect the abuse of psychotropic medication.

8.5 We consider that the residual potential of the persons admitted to the Gura Vaii Psychiatry Department for Chronic Conditions is unused, allowed to dissolve progressively, following a process of brutalization due to both the degrading life conditions and the abuse of psychotropic substances, the lack of valorization or respect as human beings, the lack of contact with the community, the lack of opportunities to spend free time, the complete lack of recovery, rehabilitation, occupational therapy, psychological support.

8.6 We draw attention to the severe risk of deprofessionalization, brutalization and dehumanization and the staff working in such conditions.

8.7 The isolated location, the relatively difficult access, the lack of mobile telephony signal, the prohibition to leave the department are factors that severely decouple the patients from the society and the community and they do not have the real possibility to live connected to the social reality, unable to access (accompanied or unaccompanied, for recreational or educational purposes) the community.