CENTRUL DE RESURSE JURIDICE

Nr.597/02.12.20201

To:
The Ministry of Labour and Social Solidarity (MMPS)
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The National Authority for the Rights of Persons with Disabilities, Children and Adoptions (ANDPDCA)
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The General Directorate of Social Assistance and Child Protection Vâlcea (DGASPC)
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Subject: Referral under Government Ruling no. 27/2002 on the regulation of the activity of resolving petitions and on the basis of the art. 4, i) Law no. 8 of 2016, in conjunction with art. 33 of the **Convention on the Rights of Persons with Disabilities (CRPD) ratified by Law no. 221 of 2010**. and the Collaboration Agreement with the Ministry of Labour and Social Protection no. 1619/09.01.2020 **on inhuman, degrading treatment, the serious health conditions and vulnerability state (and lack of adequate medical treatment) of Ms. G.S, a resident with disabilities, institutionalised in CIA Zătreni**

Dear Mr. Minister,

The Centre for Legal Resources Foundation (CLR) is a Romanian legal entity, based in Bucharest, no. 19 Arcului Street, 2nd district, registered in the register of legal entities by Civil Sentence no. 276/18.12.1998 of the Bucharest Tribunal, VAT code RO 11341550, with the registration number in the Register of Associations and Foundations 380/1998, represented by Georgiana Iorgulescu, as executive director, whose object of activity is the protection of the rights of persons with disabilities.

CLR formulates, pursuant to G.R. no. 27/2002 regarding the regulation of the activity of resolving petitions, the notification regarding the facts described below

COMPLAINT

1. The factual situation

In fact, on November 23, 2021, the Centre for Legal Resources received an anonymous petition by phone regarding the case of a young woman with severe disabilities, resident of a residential care centre subordinated to the General Directorate of Social Assistance and Child Protection Vâlcea (hereinafter referred to as **DGASPC Vâlcea**).

The resident has a certificate establishing the degree of disability issued by Vâlcea County Commission for the Evaluation of Adults with Disabilities (founded under the Law no. 448/2006 – on the protection and promotion of the rights of persons with disabilities) – the certificate is permanent and unrevisable and it's dated from November, 6th, 2018. The

woman was institutionalized from June, 10th, 2012, in Zătreni Care and Assistance Centre (hereinafter referred to as **CIA Zătreni**). According to the whistle-blower, from July 2020, Ms. G.S suffers from pain cause by a fracture of the right femur, improperly treated at that time, and she is not guaranteed access to specialists and appropriate medical treatments. Furthermore, Ms. G.S is very thin, with only 'skin and bone', as she can only eat soup and bread (processed food). Some of the centre's employees, who wanted to help her, were **threatened with dismissal**, as well as with the criminal charge of negligence at work.

The injured person – Ms. G.S., is in great pain, crying and whining every night since the date of the harmful incident; the young resident is a person with severe intellectual disabilities, immobilized in bed, nonverbal, with bilateral blindness, so she cannot seek specialized medical help alone, cannot defend herself or represent herself.

Following the telephone petition, on November 25, between 10.00 AM and 1.30 PM, two representatives of CLR – Mrs. Georgiana Pascu (program manager) and Ms. Oana Dodu (project assistant) made an unannounced monitoring visit to **CIA Zătreni, subordinated to DGASPC Vâlcea, in order to observe the way in which rights of institutionalized persons with disabilities are respected and guaranteed in that particular social care centre**. The visit was made under **art. 4 letter i) of Law no. 8 of 2016** in conjunction with art. 33 of the **Convention on the Rights of Persons with Disabilities (CRPD) ratified by Law no. 221 of 2010**. CLR also wanted to check **residents' access to the cell phone**, that was made available to residents in order to facilitate their access to communication and the opportunity to complain. The device has a phone subscription paid by CLR, but was permanently closed and no telephone has been received since its transmission (the cell phone was purchased and sent to CIA Zatreni in 2020 by CLR in collaboration with UNICEF and ANDPDCA within the project *"COVID-19 Response: protection of children and adults with disabilities in the public care centres, as well as of professionals and carers in residential centres"*) .

Upon arrival of the team, the head of the centre - Mr. Alin Lăzărescu, a social worker in charge of the institution for only a few weeks, checked the necessary formalities regarding the prevention of the COVID-19 pandemic (verification of green certificates, temperature, etc.) and allowed access to CLR representatives in the main building that accommodates residents with disabilities. The centre's chief, the doctor and the two nurses have accompanied CLR representatives during the visit in the centre and in the discussions with residents and other staff members.

The centre is organized in a single pavilion with ground floor and first floor (a building with residents' bedrooms, medical office, activity/therapy rooms, dining room, etc.), an office building (where the offices of the social worker, pharmacy and head office are) and a large courtyard with several swings and benches. In total, in the centre, there are 17 bedrooms, on 2 floors, and at the time of the visit there were 69 residents, with various disabilities (intellectual, psychosocial, neurological, Down syndrome, epilepsy, dementia, etc.), aged between 25 and 82 years old. The rooms have 5-6 beds, wardrobes for each resident, a desk, a TV; the rooms were warm and clean. The last person with disabilities was institutionalized here in April 2021, coming from the residential Centre of Băbeni. The centre is being restructured, and only 50 residents will remain, and the others will be transferred to a new centre that is going to be built in Vâlcea. Most of the residents are former institutionalized children with disabilities from placement centres for whom the management of DGASPC Vâlcea did not contract social services in the community and elderly people diagnosed with neurological diseases for which care services were not provided at home or in the community.

At the time of the visit, the doctor was also in the centre - she is appointed at CIA Zătreni every Tuesday and Thursday between 7 AM and 2 PM (the rest of the week she is in another centre in the county). Among the residents, only one person has been recently hospitalized in another medical unit (in the gastrointestinal diseases department) for a week.

During the visit, CLR team requested information about the number and rooms in which residents are bedridden or have difficulties moving, their division into rooms, given that the centre has one floor (we note that the centre has no elevator). Initially, the doctor and the nurses replied that since September (approximately) all the residents immobilized in bed who were in the upstairs bedroom have been moved to other rooms on the ground floor to facilitate their care. Access to each of the bedridden persons was requested. A list of the residents' names who are accommodated in the respective rooms is shown on the door of each bedroom. We noticed that in the description of immobilized persons, Ms. G.S. - for whom CLR was notified by phone, was not presented to us. The name of Ms. G.S. was also written on the door of the last bedroom (no. 14) on the left side of the upper floor of the building, where there are two rooms with a passage between them. We requested information about this and only then the staff accompanying us indicated where Ms. G.S had been moved. We asked for clarifications regarding the omission of the young woman's presentation from the first moments of the visit and the reason why her presence in the centre was not mentioned to us.

Ms. G.S., resident of the centre, was at the time of the visit in room no. 10 on the left side of the first floor. The bedroom had five beds, two closets, a table and bedside tables. From the discussions with the employees, we found out that the woman is 33 years old (she was born in 1988), she has been in the centre for about 10 years, but she has always been institutionalized (since childhood), **she is not placed under legal guardianship and according to the disability certificate she has a severely disability degree, with the right to have a personal assistant**, but no person has been identified to be employed as her personal assistant. She is not visited by relatives or family members, no one contacts her. In fact, the discussions with the employees and the management of DGASPC Vâlcea showed that the residents are deprived of their liberty: **they have not left the centre and have not received visits from relatives** since the beginning of the COVID-19 pandemic, i.e. about two years.

Ms. G.S. was moaning loudly when we entered her room. The centre's staff said that Ms. G.S. was placed in room no. 14 until July 18, 2021, when she was found - by a caregiver at the time of cleaning the building - early in the morning with a fractured right femur, lying on the floor or in bed or it is not known how (employees present during CLR visit stated that they are not sure of the position in which she was found). In the Register of handing over the reception of the caregivers' turn, this mention appears: "At the 7 o'clock shift I found the beneficiary from room 14 with a swollen leg, the 112 service was called and she was taken to Vâlcea" (our note - County Emergency Hospital from Râmnicu Vâlcea). The event was recorded **in the incident Register of the centre,** the employees called 112, and Ms. G.S. was taken by ambulance to the Vâlcea County Emergency Hospital for treatment. It is not known when the incident took place, or who was present at the time, if she was hit or fell from the high bed without protection, or how long did she lay on the floor in agony with her fractured leg. We mention that **the lady cannot move her arms or legs and that she cannot communicate easily, she cannot see, she has a weight far below the lower limit, a cachexic aspect, like "skin and bone"**.

Ms. G.S. was, according to the observation sheet **no. F815867** from the Register of Orthopaedic and Traumatology Consultations, between July, 18th and July, 28th, 2021 in the County Emergency Hospital from Râmnicu Vâlcea, at the orthopaedics department, at Mr.

Dr. **B.R.S., returning to the centre with a splint on her right leg. The main diagnosis in the discharge note** is "*S72.40-fracture of the lower extremity of the femur, unspecified part., fracture ⅓ one-third femur*; secondary diagnosis *F729 - Severe mental retardation without mention of behavioural deficiency; Z91.1 Personal history of not following a medical treatment or a regimen"*. The centre's doctor mentioned that the splint was taken down by the nurses from the centre, without returning to a specialist doctor to consult it or to recommend the removal of the splint. Since then, she has been given algifor algocalmin whenever she is in pain to calm down.

The statements of the employees become contradictory at this point - although the injured party is immobilized in bed, the incident was not notified to the judicial investigation bodies. According to the **MMPS Order no. 82 of January 16, 2019** on the approval of specific mandatory minimum quality standards for social services for adults with disabilities, Social Service Provider (FSS) **registers in the Register of cases of neglect, exploitation, violence and abuse <u>all situations of neglect</u>**, exploitation, violence, degrading treatment, emotional, physical or sexual abuse and acts for resolution, with the support of the beneficiary, the residential centre and/or the competent bodies.

According to **MMPS Order no. 29/2019** for the approval of the Minimum Quality Standards for the accreditation of social services for the elderly, the homeless, young people who have left the child protection system and other categories of adults in difficulty, as well as for services provided in the community, services provided integrated canteens and social canteens (excerpt from the ministerial order):

*"**The centre provides evidence of special incidents affecting the beneficiary**. The centre keeps a special record of special incidents that affect the physical and mental integrity of the beneficiary (illness, accidents, aggression, etc.) or other incidents in which he was involved (unauthorized departure from the centre, theft, immoral behaviour, etc.). The register shall record the date of the incident, its nature, the consequences on the beneficiary identified by name, surname and age, the date of notification of the family and / or the competent institutions to be informed according to law, and measures taken.*

M.V.-Im1S4.1: The register of records of special incidents is available, on paper, at the headquarters of the centre.

M.V.-Im2S4.1: These are recorded in the Register of special incidents.

M.V.-S4.2 the Centre informs the family / legal representative of the beneficiary about the special incidents that affect or involve the beneficiary.

The Centre shall notify the beneficiary's family / legal representative by telephone, in writing or by e-mail of any special incidents which have affected the beneficiary or in which he has been involved. In case of serious illness of the beneficiary, the notification shall be communicated / transmitted immediately. For other types of incidents and if the intervention or support of the beneficiary's family / legal representative is required, the notification shall be made within a maximum of 24 hours from the occurrence of the incident.

M.V.-ImS4.2: The notifications are recorded in the register of special incidents.

M.V.-S4.3 ***the Centre shall inform the competent institutions of all special incidents occurring in the Centre.***

*MV-Im1S4.3: In special situations, when there is suspicion of the death of the beneficiary, there has been a serious bodily injury or **accident**, there has been an outbreak of communicable diseases, facts have been found that may constitute contraventions or crimes, any other events that affect the quality of life of the beneficiaries, the centre informs the competent bodies provided by law (criminal investigation bodies, public health directorate, etc.).*

M.V.-Im2S4.3: ***The notification is made immediately.***
M.V.-Im3S4.3: ***The notifications sent to the public institutions are recorded in the register of special incidents."***

The medical history of Ms. G.S. also mentions a hospitalization at the Costache Nicolescu Municipal Hospital in Drăgășani at the doctor D.S., for pneumonia, from January, 31st, 2020 to February, 2nd, 2020. After the splint was removed by the centre's employees, **she was not seen by any other specialist.** We noticed that, in the medical file of the resident, through the discharge form the Rm. Vâlcea County Hospital, it was specified that "**observation** (our note – of the fracture) **at 3 and 6 months and as many times as necessary**" was recommended, therefore the CIA Zatreni doctor stated that "*we have to check it on the 10th (month)*" - that is, in October, which did not happen until the time of the CLR's visit.

At the time of the visit, Ms. G.S. was immobilized, lying in a horizontal position, on a **bed without protection against accidents (handles specific to hospital beds) and without the possibility of being able to change the position in bed (so that she could be fed), leaning her head on a pillow, dressed in a blouse and a diaper.** The resident's right limb was bent inwards, the right femur was shorter than the left leg, swollen, and **had no splint, plaster, etc. – bo form of protection**. The young woman was in clear state of degradation, cachexia (she was very weak - skin and bone), unable to move her upper or lower limbs, with very short haircut (cut with hair clipper), blunt and decayed teeth, the injured party has severe intellectual disabilities.

At **11:00 AM**, being alarmed by the serious condition and the groans of the injured person, Georgiana Pascu, CLR program manager, after asking the doctor and nurses to call specialized help for the care of the resident, called the 112 emergency services, requesting an ambulance for Ms. G.S. so that she could be hospitalized for adequate medical care.

An ambulance crew consisting of a nurse and the driver arrived in about 20 minutes. They mentioned that they cannot admit the young resident to the Emergency County Hospital in Râmnicu Vâlcea and that it is necessary for the employed doctor of the CIA Zătreni to specify that it is a medical emergency for the resident to be taken over and hospitalized. After telephone conversations carried out by the CLR program manager, with the coordinating doctor at Emergency unit (UPU) Vâlcea who wanted further clarifications why there was no attempt made to schedule her in the Outpatient Department in Vâlcea or why the doctor from CIA Zătreni does not request the hospitalization of the resident, the UPU doctor informed the ambulance crew that he approves the presentation of the resident at emergency unit within the Municipal Drăgăşani Hospital.

Initially, none of the nurses of the CIA Zătreni wanted to accompany the resident at Dragasani Hospital, motivating that "*they do not have these obligations in the job description"* and that anyway the doctor from emergency unit of Dragasani Municipal Hospital knows what to do based on Ms. G.S medical file. **We highlight the fact that the resident is a person with severe intellectual disability and nonverbal and in a severe pain**. CLR insisted that one of the medical staff should be present at the **Dragasani**

Municipal Hospital to communicate to the doctor the health and care needs of the resident Ms. G.S. Finally, a nurse from CIA Zătreni went in the ambulance with the injured party.

Immediately after asking questions about Ms. G.S. condition, the employees began to show avoidance and agitation, requesting further clarifications regarding the legality of the CLR visit. In no time, they mentioned that they received countless phone calls from the general director of DGASPC Vâlcea, Mr. Badea, who asked the CIA Zătreni management to take the CLR representatives out of the residential centre. In fact, Mr. Badea, general director, knew very well the activity of CLR and the legal basis of the unannounced visits, restricting the access of CLR even after the visit to residential centres of Maciuca (CRRN) and Băbeni, both as a result of reports and criminal complaints submitted by CLR.

0A few minutes after the ambulance left, Ms. Jana Diaconu, the deputy director of DGASPC Vâlcea arrived at the centre, accompanied by a gentleman, head of Băbeni residential centre, to which the insistent request was addressed to facilitate the emergency provision of adequate investigationfor Ms. G.S, as well as treatment services to end the patient's suffering,and about the investigation of the incident that led to the occurrence of the trauma. The deputy director assured CLR team that the situation of the resident will be carefully monitored and the necessary medical care will be provided. Ms. Diaconu added that she would prefer that CLR would have previously informed the DGAPSC Valcea about the intention of visiting the residents of CIA Zatreni.

Furthermore, in the context of the restructuring CIA Zătreni, through which 50 residents were to remain in the centre, and some of the others were to be transferred to a newly built centre in Vâlcea, and others under the care of Professional Personal Assistant (in Romanian - asistent personal profesionist, APP), for Ms. G.S., who needed permanent and specialized care, DGASPC Vâlcea tried to resort to the easiest solution without any specialised support - the discharge of the resident with her relatives from the family; on April, 24th, 2021, by letter of request no. 334, DGASPC Vâlcea sent to the Town hall of Ionești commune to be informed if there are relatives or persons who want to be appointed guardian/curator of the resident Ms. G.S. or if their legal supporters want to be discharged and become a professional personal assistant.

That afternoon, after leaving the residential centre of Zatreni, CLR program manager, was informed by telephone by the deputy director that Ms. G.S., had a new splint fitted and an ultrasound was performed, and she will be scheduled as soon as possible at an orthopaedist for another opinion. The diagnosis with which she was discharged from Drăgășani Municipal Hospital on November, 25th, 2021, is **"chronically - defective calluses, with a recommendation to be scheduled for orthopaedics for surgery"**. On December 2, 2021, CLR called the deputy director for information about the health of the injured party. Ms. Diaconu, stated that she had erroneous information and that the resident was not fitted with a splint, so she tried to contact the orthopaedic specialist from the Emergency County Hospital in Rm. Vâlcea but without success. Following the insistence of CLR, the deputy director also mentioned that she will try to contact the doctor but that **"if she was not hospitalized at the Municipal Hospital of Drăgăşani, it means that it is not an emergency"**.

Until December, 2nd, 2021, Ms. G.S has not benefited from any specialized medical consultation, her health and emotional state is deteriorating at every moment due to the pain and the weakness of the body. CLR mentions that the degradation is visible through the medical analysis papers attached to the medical file of the resident.

Although **the critical case was directly presented by the whistle-blower to the general director of DGASPC Vâlcea during at least seven visits made in the last five months in CIA Zătreni,** the director did not make efforts for adequate treatment and care to reduce the suffering of Ms. G.S.

2. The legal situation

Article 33 (3) of the Convention on the Rights of Persons with Disabilities (ratified by Law no. 221/2010, hereinafter referred to as "the **Convention**") provides the involvement and full participation of civil society and non-governmental organizations in the process of monitoring the application of the provisions of the Convention.

Pursuant to the **art. 4 letter i) of Law no. 8/2016** on the establishment of the mechanisms provided by the Convention on the Rights of Persons with Disabilities in conjunction with **art. 29 and art. 34 Crim**. **Proc Code**, CLR has an active procedural capacity and is a procedural subject in the criminal process.

Art. 4 letter i), of Law no. 8/2016 provides:

§ In order to achieve its purpose, the Monitoring Council shall carry out the following tasks, with due regard for the principles of legality, respect for human dignity, non-discrimination, equal opportunities, and functional independence and of staff, impartiality and objectivity:

*Facilitates the access, announced or unexpected, of the representatives of the non-governmental organizations provided in art. 5 para. (1), in the institutions provided in art. 2 para. (2), in order to monitor the observance of their rights, i**n order to ensure that persons with disabilities are represented independently** before a court or any other independent body, those **non-governmental organizations have active procedural capacity in defending the rights and legitimate interests of such persons.***

§ Article 5 paragraph (1) of Law no. 8/2016 provides the following: *The Council of Monitoring is chaired by a President and a Vice President, appointed by the Senate, with the opinion of the Senate Committee on Human Rights, Religions and Minorities, **at the proposal of non-governmental organizations conducting programs to protect the rights of persons with disabilities of non-governmental organizations representing people with disabilities.***

In view of **(i)** the nature of the above facts, **(ii)** the application of such treatment to institutionalized persons (who are unable to leave that place on their own initiative and to complain or seek assistance), **(iii)** the duration of their application **(iv)** the physical and mental health effects of the treatment; this act was committed by persons entrusted with the provision of a public service, in the exercise of a function involving the exercise of state authority, there is no doubt that the above acts constitute the constitutive content of the crime of ill-treatment, according to **art. 281 Crim. Code**. and the ECtHR case law (*torture and inhuman treatment: Selouni v. France / 1999 - practices once considered inhuman treatment must be reconsidered torture; Cobzaru v. Romania / 2007 to the contrary, to be provoked by the "agents of the institution"; Filip v. Romania / 2007 - individualized psychiatric treatment; Legal Resources on behalf of Valentin Câmpeanu v. Romania / 2013 and Silih v. Slovenia - medical negligence; Carabulea v. Romania - physical and mental violence; Cadorcea v. Romania - physical and moral damage caused by the medical act*).

We also mention that **Mental Health Law no. 487/2002** prohibits, at art. 37 para. (1), the submission to inhuman or degrading treatment and other ill-treatment o**f persons hospitalized in a psychiatric unit or admitted to recovery and rehabilitation centres**, and art. 37 para. (2) expressly provides that the violation of this obligation is punishable under criminal law. The norm of the criminal law referred to in this article can only be represented by art. 281 para (2) Crim. code, this being the only incrimination rule that refers to ill-treatment of adults. We consider that art. 281 para. (2) the Criminal Code must be interpreted in the light of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the Optional Protocol thereto. This Protocol was ratified by Law no. 109/2009 and provides, in art. 4 point 2, that by the notion of deprivation of liberty is meant ***"any form of detention or imprisonment, or the placement of a person in a public or private place of detention which he cannot leave at will, by order of any authority judicial, administrative or otherwise "***. Thus, the reference in art. 281 para. (2) The Criminal Code for "detention" should be understood as "deprivation of liberty" and **should also include the situation of the immobilized women with disabilities, which is placed in a centre that she cannot leave.**

Also, the application of torture, ill-treatment and other forms of violence against persons with disabilities is prohibited by Articles 3, 15, 16 and 17 of the CRPD, which as is ratified by Romania is fully applicable in domestic law.

Inhuman treatment is considered to be acts that cause harm or physical and moral suffering to the victim. As can be seen, this definition is quite comprehensive, due to a very wide field of application of the legal provisions on the prohibition of torture and inhuman or degrading treatment.

The jurisprudence of the ECtHR reveals the following forms of inhuman treatment (obviously the list is not and cannot be exhaustive):

● Ill-treatment (applying blows) and other forms of physical violence;
● Inadequate detention conditions (Ostrovar v. Moldova, no. 35207/03, 13 September 2005);
● **Failure to provide basic health care and lack of adequate medical care for detainees** (Paladi v. Moldova [GC], no. 39806/05, 10 March 2009). Sometimes the person's own health condition is incompatible with pre-trial detention. For example, epilepsy that occurs in frequent seizures may require special treatment but is not available in the detention facility. **Unjustified delay in transfer to a specialized institution and failure to provide specific medical care may constitute inhuman treatment** (Oprea v. Moldova, no. 38055/06, 21 December 2010);
● leaving the victim in the custody of those who previously abused her, an action that can be seen as a continuation of the abuse already applied (Levinţa v. Moldova, no. 17332/03, 16 December 2008);
● Illegal detention in a psychiatric institution and being subjected to forced psychiatric treatment, arbitrarily, in the absence of the medical necessity of administering such treatment (Gorobet v. Moldova, no. 30951/10, 11 October 2011);

Degrading treatment seriously undermines human dignity, generates feelings of fear, anxiety and inferiority in the victims, capable of humiliating and degrading the victim, devaluing him of his essence as a human being; it defeats the physical and moral resistance of the victim and causes him to act against his will or conscience.

The public nature of the treatment may be an important element in assessing it as degrading, or humiliating the victim in the presence of others (Raninen v. Finland, 16 December 1997, Reports of Judgments and Decisions 1997-VIII). However, the public

nature of the treatment is not mandatory, the ECtHR stated that t**reatment will remain degrading even if the public element is missing, being "sufficient for the victim to feel humiliated in his own eyes"** (Tyrer v. The United Kingdom, April 25, 1978, Series A No. 26).

Similarly, the **intentional nature of the treatment will be taken into account**, **but it is not absolutely necessary for a treatment to be placed in the category of degrading ones**. In the case of Peers v. Greece, referred to above, the ECtHR was convinced that the authorities did not intend to humiliate the applicant, **but their failure to take steps to improve the applicant's detention conditions was still described as degrading treatment.**

Finally, it is important to note that the prohibition of torture, inhuman and degrading treatment, is not limited to acts committed by persons exercising state functions. **The human personality benefits from the protection of these provisions also in the cases when the third (private) persons threaten his physical and mental integrity. In these cases, the state has a positive obligation to take the necessary measures to identify and punish those who have abused the victim.**

In addition to the offenses indicated and detailed above, the centre's staffs have the responsibility to take care of Ms. G.S. but have failed to exercise it, leading to a lack of adequate care that led to irreversible deterioration of physical and mental health.

The leadership of DGASPC Vâlcea, as well the medical and social-working staff, are also guilty of crime - abuse of public duties – since they are civil servants (employees of DGASPC Vâlcea, a state authority, decentralized at local level) due to failure to perform a service duty (violating the provisions of **Mental Health Law 487/2002**), injuring the physical and mental health of Ms G.S, a resident with severe disabilities.

Also, the staff of the centre, who was aware of these crimes, but failed to notify the criminal prosecution bodies, is guilty of the offense of omission of notification (art. **267 Crim. code**), being civil servants who became aware of the commission of certain acts, provided by the criminal law, but failed to immediately notify the judicial bodies. The active subjects of this crime will be established following the investigation of the competent bodies, but from the available information it appears that the general director of DGASPC Vâlcea, Mr. Badea was aware of the situation of the injured person, the incident being registered in the Incident Register, but ignored.

JURISPRUDENCE

In the case of "CLR on behalf of Mr. Valentin Câmpeanu vs. Romania", the Grand Chamber decided that art. 2 (right to life) of the Convention was violated, both on the merits and in procedural terms. The Court found in particular: that Mr. Câmpeanu had been placed in medical institutions which **were not equipped to provide him with adequate treatment for his state of health**; that he was transferred from one unit to another without a correct diagnosis; and that the authorities did not provide him with adequate treatment with antiretroviral medication. Given that the authorities were aware of the difficult situation - lack of staff, insufficient food and lack of heating - in the psychiatric hospital where he had been placed, they unreasonably endangered his life.

Arutyunyan case against Russia
The applicant was in a wheelchair and had a number of health problems, including kidney failure requiring transplantation, poor eyesight, diabetes and severe obesity. His cell was on

*the fourth floor of a **building with no elevator**; the medical and administrative units were on the ground floor. As there was no lift, the applicant had to go up and down the stairs periodically to benefit from haemodialysis and other necessary medical treatments.*
The court ruled that art. 3 (prohibition of inhuman or degrading treatment) of the Convention, finding that the domestic authorities had not provided the applicant with safe and appropriate treatment compatible with his disability and deprived him of effective access to medical facilities, outdoor movement and fresh air. . In particular, the Court observed that for almost 15 months the applicant - who had a disability and was dependent on a wheelchair - had to go down and up four floors at least four times a week. , on his way to and from complicated and tedious medical procedures, which were vital to his health. This effort certainly caused him unnecessary suffering and exposed him to the unreasonable risk of seriously endangering his health. It is therefore not surprising that he refused to go downstairs to move around in the courtyard and was therefore isolated inside the detention centre 24 hours a day. In fact, due to stress and frustration. he repeatedly refused to leave the cell in order to benefit from the vital haemodialysis for him.

Semikhvostov v. Russia, February 6, 2014
Suffering from lower limb paraplegia and being immobilized in a wheelchair, the applicant alleged that the correctional facility in which he had been detained for almost three years was inadequate for his condition. He also complained that he did not have an effective national remedy for these claims.
The court ruled that art. 3 (prohibition of inhuman or degrading treatment) in the Convention, finding that the conditions of the applicant's detention and in particular his inability to gain independent access to certain areas of the institution, including the canteen and sanitary facilities, and the lack of travel assistance, they certainly caused the applicant unnecessary and unavoidable physical and mental suffering, thus constituting inhuman and degrading treatment. The Court also found that, in the present case, art. 13 (right to an effective remedy) of the Convention.

Stanev v. Bulgaria (see also sections below, "Right to liberty and security" and "Right to a fair trial")

The case concerned a man who claimed that he had been placed against his will for many years in a psychiatric institution located in a remote mountain area in degrading conditions. The Court noted that art. Article 3 of the Convention prohibits inhuman or degrading treatment or punishment of any person in the custody of the authorities, whether in detention in the context of criminal proceedings or in detention in an institution intended to protect the life or health of the person concerned. The Grand Chamber also emphasized that, according to the conclusions of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) after visiting the centre, the living conditions there could be considered as constituting an inhuman and degrading treatment. In the present case, although there is no indication that the Bulgarian authorities intended to treat the applicant in a degrading manner, taken as a whole, his living conditions (food was inadequate and of poor quality; the building was inadequately heated and, in winter, the applicant had to sleep in his clothes, he could only take a shower once a week in an unhygienic bath, which was in a deplorable state, the toilets were in a deplorable condition, etc.) for a period of about seven years, they represented a degrading treatment and, therefore, a violation of art. 3 of the Convention.

L.R. v. Northern Macedonia (No 38067/15) 23 January 2020
The case involved an eight-year-old child who had been left in the care of state institutions since he was three months old, and allegations of inadequate care and ill-treatment. His situation came to the attention of an NGO when the Ombudsman visited the child in the

centre where he was in 2013 and found him tied to the bed. The applicant alleged that he had been misdiagnosed as suffering from a physical disability, which led to his being placed in an institution which was unable to meet his needs and where he had received inadequate care and treatment, which was negligent. He also complained that the investigation into his allegations was ineffective.

The court ruled that art. 3 (prohibition of inhuman or degrading treatment) in the Convention, finding that the authorities were responsible for placing the applicant in an institution which could not meet his needs, as he had not provided him with the necessary care and was subjected to it, and that art. 3 (procedural aspect) due to the failure of the authorities to carry out an appropriate investigation in this case. It was particularly worrying that a person as vulnerable as the complainant, an eight-year-old child with a mental disability, who was deaf and dumb, was frequently bedridden during his stay of about one year and nine months, in a which was clearly unsuitable for him, as it was intended for the physically handicapped, despite the fact that the institution had informed the authorities from the outset that he could not receive the the skills needed to take care of him. In addition, instead of focusing on the general failure of the system to meet the applicant's needs, the investigation focused on the individual criminal liability of the institution's employees, which led the prosecutor's office to find no intent to harm the child and dismiss his case.

H.L. v. the United Kingdom (No 45508/99) of 5 October 2004
The applicant is autistic, unable to speak and has a limited level of understanding. In July 1997, when he was in a day centre, he started injuring himself. He was later transferred to the intensive care unit for behavioural disorders in a hospital, as an "unofficial patient". The applicant alleged in particular that the treatment applied as an unofficial patient in a psychiatric institution constituted detention and that it had been illegal and that the procedures available to him to verify the lawfulness of his detention did not meet the requirements of Art. 5 (right to liberty and security) of the Convention.

The Court noted in particular that, due to a lack of procedural rules and procedural limitations, specialized medical staff took full control of the freedom and treatment of a vulnerable and incapacitated person, solely on the basis of their own clinical assessments, and at the time deemed appropriate by him. The Court found that the absence of procedural guarantees did not protect the applicant against arbitrary deprivation of liberty on the ground that it was necessary, and consequently did not comply with the essential purpose of Art. 5 § 1 (right to liberty and security) of the Convention, this provision being violated. The court also ruled that art. 5 § 4 (the right of a court to rule on the lawfulness of detention in a short time) of the Convention, finding that it had not been established that the applicant had a procedure in place for a court to verify the lawfulness of his detention.

International standards present several options for triggering domestic mechanisms. Detainees may simultaneously or selectively:
Benefit from basic legal guarantees and inform relatives, lawyer or doctor about ill-treatment;
to complain when they are brought before the prosecutor or judge, who are obliged to take firm action in response to allegations or other indications of ill-treatment;
insist on the immediate transfer to another prison and alert the prison administration or medical services, who are obliged to record allegations of ill-treatment and bodily harm, if any, and report it to the competent authorities;
Register and send complaints or any written declarations to the designated competent authorities and bodies, and request in accordance with the right to respect for correspondence provided for in Article 8 of the ECHR, its transmission without delay in a sealed envelope, or otherwise, excluding any kind of censorship.

At the same time, it is important to obtain evidence by requesting a forensic medical examination or insisting on a detailed description of the injuries or other medical consequences of ill-treatment by the institution's doctors or other doctors involved.

Therefore, we would like to inform you about the situation of non-compliance to the rights of residents from CIA Zătreni, requesting you to investigate and provide us the documents that resulted from your control, Report of the Control Body and any other relevant information:

1. Please urgent access to medical and palliative care for resident Ms. G.S. and inform us promptly about the measures taken, as well as about the lawfulness of her institutionalization in a residential centre that has proven not to provide adequate health care services.
2. Please check the reasons why the health condition of the resident Ms. G.S. has visibly deteriorated and what are the reasons why a person in obvious pain and state of suffering has not received and does not receive adequate medical care.

3. Please analyse and inform us about the reason and period of institutionalization of each of CIA Zătreni residents, living in centre at the date of CLR's visit. Also, please provide us in electronic format - anonymized , of the documents attesting the daily activities and participation of each resident, indicators and means of monitoring their achievements (evolution of their situation), in the context in which many of those institutionalized people could be supported for an independent life, in the community, and from the discussions with the residents it emerged that Mr. P.I. has no disability, but is diagnosed with an ulcer.

4. When was the last on-site assessment conducted by a representative of ANDPDCA and ANPIS and what was the date of the last visit of an authority representative in CIA Zătreni? Please share your findings and recommendations of your former evaluation.

5. Please consider, for each resident, whether the established medical treatments, especially those based on neuroleptics, remain relevant, if they receive visits from the psychiatrist (when was the last visit and who is the attending doctor), what are the individual therapies, and those in groups, in which each resident participates (if he/she participates), if he/she receives support and specialized medical/ therapeutic assistance, according to their needs.

6. For residents who have a court decision appointing a legal guardianship, please check if each person has a guardian, if the accountability (use of their money and goods) reports have been made, and if the guardians of these residents can actually check the conditions under which they are institutionalised and whether they can request access to independent living services in the community.

7. What other alternatives do currently institutionalized residents have - apart from being hosted in CIA Zătreni, and how they could go outside the centre and interact with the community, given that they are vaccinated with the 3 doses against COVID-19, and the centre does not offer many options for activities.

8. What are the alternatives for their deinstitutionalization - specifically for each resident?

9. Under what conditions do all residents have access to the means of adressing requests and reporting abuses and the bad conditions in the centre, which was the last complaint requested by a resident, what is the history entered in the register of special events.

10. What are the initial and long-term training courses that each employee of the centre benefited from - the period in which they took place, who completed and contracted them, as well as any other supporting documents related to them.

11. For residents that came from placement centres (meaning that they were institutionalised since childhood), who was the legal guardian appointed by law at the time of transfer from child protection system to adult-care centres and what were the steps taken to prevent their (re)institutionalization?

Also, based on Ruling no. 27/2002 on the regulation of the activity of resolving petitions, we request to be constantly informed about the measures taken during the settlement of the request, as well as its purpose, including the provision of the requested data, even more that at national level we are in a context of analysis of plans for restructuring and reorganization of residential centres for people with disabilities.

We are at your disposal for the necessary clarifications in order to urgently resolve the notified situation.

Thank you.

Sincerely,

Georgiana Pascu
Program Manager

Centre for Legal Resource