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Monitoring Report

„Dr. Gheorghe Marinescu" Municipal Hospital Psychiatry Department

Târnăveni, Mureș County

Project conducted by:
THE CENTER FOR LEGAL RESOURSCES

In partnership with
THE PUBLIC MINISTER

General Considerations

The monitoring visit took place within the "Advocacy for Dignity" Program initiated in 2003 by the Center for Legal Resources. No activity conducted by the Center for Legal Resources aimed at monitoring and ensuring access to justice for residents with disabilities in public or private residential social care homes, protected housing, family-type homes, placement care homes, or psychiatric hospitals is funded by the Ministry of Labor and Social Solidarity or by any other central or local public authority.

General Context of the Visit:

The unannounced visit to the "Dr. Gheorghe Marinescu" Municipal Hospital in Târnăveni occurred on October 3, 2023, between 10:50 AM and 4:00 PM. Access to the hospital unit was granted based on a collaboration agreement signed by the Center for Legal Resources with the Monitoring Council for the implementation of the UN Convention on the Rights of Persons with Disabilities (an autonomous entity, under parliamentary control, established by Law No. 8 of January 18, 2016). The monitoring team consisted of Georgiana Pascu (program manager "Advocacy for Dignity"); Milena Enescu (legal expert); Alina Barbu (legal expert, psychologist); Roxana Mărcoiu (clinical psychologist); Mugur Frățilă (psychologist); Dan Partig (legal expert).

The "Dr. Gheorghe Marinescu" Municipal Hospital in Târnăveni includes several departments and wards (internal medicine, general surgery, neurology, psychiatry, etc.) and is located in Târnăveni, Mureș County. The variety of medical services available within the hospital can be considered an advantage when dealing with a specific issue that requires prompt attention. It should also be noted that the hospital has a polyclinic through which it provides outpatient psychiatric treatment.

The pavilion-type hospital has a generous courtyard with ample vegetation, where the buildings housing the various medical specialties' departments/wards are located. The buildings reflect the architectural style of the first half of the 20th century and bear visible signs of wear over time, although signs of successive renovations are also visible.

The building housing the psychiatric departments is no exception: walls from which plaster has fallen off and signs of repairs are noticeable. Additionally, at the time of the monitoring visit, one of the wings of the municipal hospital (a vast basement) was undergoing modernization, and once rehabilitated, the space will be used by hospital staff (for changing rooms for medical staff, various administrative spaces, etc.).

During the monitoring visit, we were informed by the hospital's management that many of the renovations and refurbishments of the departments were made possible through sponsorships and private donations obtained as a result of direct efforts undertaken by the lady manager.

Preliminary Considerations of the Visit:

The hospital management generally showed total openness and supported the Legal Resources Centre (CLR) team in visiting the psychiatric wards of the "Dr. Gheorghe Marinescu" Municipal Hospital, without any restrictions as long as the hospital's rules and regulations were respected. They also provided relevant documents and information upon request or spontaneously.

The visit began with a discussion with Ms. Manager Z.M. and Medical Director Dr. A.V. At the start of these discussions, the issue of "social" admissions was raised; whether and how many cases of such patients are hospitalized for very long periods as a solution to the lack of social alternatives.

The manager admitted that in some wards there are people who have been hospitalized for decades, some even since they were minors (mentioning even two individuals who are now 60 years old. She also specified that this situation is justified by the fact that these individuals have no income and would have nowhere else to go. Hypothetically, if they were relocated, the hospital would, in her opinion, be left without patients.

It does not seem to have been realized at the hospital management level that its role is not a social mission but to provide medical services. Moreover, external information to the visit revealed that admissions to this hospital are quite difficult, with a long waiting list. From the preliminary dialogue with the manager, it emerged that, in terms of bed occupancy rates, the hospital's wards cannot be reported as overcrowded. However, the CLR monitoring team's findings showed that although statistically, there is no "overcrowding," the actual organization of the wards reflects a significant overcrowding of beds/people, causing increased discomfort for the patients.

We mention in this context that, following the CLR visit, information was received regarding the social cases; according to the hospital management, the number of patients fitting into this category is 18. However, in the monitoring team's opinion, some of the patients with a very long duration of hospitalization are also considered social cases. Thus, according to the same information provided after the visit, the average duration of hospitalization for the permanent chronic psychiatry ward for men in 2022 was 270.3 days, and for women, it was 219.06 days.

Additionally, general discussions were held about the pathologies of the patients – these being, as a rule, dementia, schizophrenia, intellectual disability. According to the manager, the hospital has agreements with some social care homes and receives patients from these in emergency situations or when it is necessary to adjust the treatment scheme.

For example, among the social care homes with which the hospital has agreements, entities from Luduș, Sighișoara, Căpușu de Câmpie, Brâncovenești, and Mediaș were mentioned. However, no information was received regarding all the social care homes with which such agreements were concluded, nor the basis and criteria for these agreements.

Finally, during the general discussions, the hospital management requested advice from the CLR team regarding the management of funds (especially pensions) that some patients receive. In this regard, some suggestions were made, and as an example, we attach a regulation that addresses a relatively similar issue, namely the management of money belonging to inmates by the staff of the National Administration of Penitentiaries (see Annex No.2).

The Actual Conduct of the Visit. Findings of the Monitoring Team:

The preliminary discussion was followed by the actual visit to the four psychiatric wards of the hospital. The monitoring involved, among other things, discussions with patients and staff present in the wards (doctors, nurses, nursing assistants).

Additionally, the team went down to the basement of the building and visited a part of the hospital courtyard, specifically the area where the occupational therapy department is located, serving the psychiatric wards. The hospital's kitchen, located in another building, was also visited.

The extended monitoring team split into three mobile teams and proceeded with the visit. Monitors were accompanied through the hospital premises, as appropriate, by the manager, the medical director, or other staff members.

Upon the express request of the monitors, direct discussions with some of the patients were allowed in the absence of hospital staff members.

Organization of the Psychiatric Wards. Living Conditions of the Patients:

According to the statements of the unit's management, the structure includes 220 beds for permanent chronic psychiatry (110 women, 110 men), 50 beds for temporary chronic psychiatry (25 women, 25 men), and 50 beds for acute psychiatry (25 women, 25 men). The psychiatric wards of the "Dr. Gheorghe Marinescu" Municipal Hospital in Târnăveni are organized into a male sector and a female sector. The male sector (ground floor), as well as the female sector (first floor and part of the ground floor), is organized into 3 sub-departments: *permanent chronic psychiatry, temporary chronic psychiatry, and acute psychiatry*. The male and female sectors are separated by locked doors.

It was communicated that the temporary chronic ward emerged as a necessity because, according to applicable reimbursement standards, the duration of hospitalization for a person admitted to the acute ward, sometimes through emergency, is 10 days. This period is insufficient to remedy/stabilize the clinical picture with which patients are admitted to the hospital. Thus, a "bridge" was created, and the temporary chronic ward was established, where the duration of hospitalization is 58 days. Also, as mentioned before, the hospital has an occupational therapy department, located in the hospital courtyard, serving the psychiatric wards.

Food preparation. Nutrition:

The visit to the kitchen, which is located in another building, was conducted after the time meals were served to patients.

The hospital has its own kitchen, serving the entire unit, from where food is distributed to the wards. Menus are prepared according to the different categories of diseases of the patients. Each ward has a small office from where the food is portioned and then distributed in the rooms. The spaces designated for food preparation meet the imposed standards, and the food items are stored separately. From discussions with some of the patients, it was found that the food is "good"; thus, no "complaints" regarding its quality were received.

Psychiatry Ward II - Acute Female Patients:

The ward is located on the first floor of the building serving Psychiatry and consists of 5 rooms with a total of 25 beds. In the hallway of the ward, there are a few tables and chairs where patients can spend their free time whenever they wish. According to staff statements, sometimes the patients also spend time in the occupational therapy workshops. The ward does not have a dining hall or club; meals are served in the rooms.

At the time of the visit, four patients who had been admitted for about 3 days were encountered in the hallway of the ward, and they stated that they frequently come to the hospital.

In room 1, there are 6 beds with bedside tables, and each bedside table has an attached folding table. On one of the bedside tables, there was a working television (according to the patients' statements). There is no wardrobe in the room. At the time of the visit, 4 beds appeared to be occupied (4 patients were in the room). The bed linen was clean. The windows are not equipped with curtains or blinds, therefore, there is no shade in the rooms. The room has a sink and liquid soap, and in the corridor, there is a communal bathroom with 2 shower stalls, a working toilet, and a sink with hot water (the hot water takes a few minutes to come).

In room 2, there are 7 beds, each with its own bedside table, to which a folding table is attached. The bed linen was clean. Like the first room, this one also lacks curtains or blinds. At the time of the visit, 5 beds appeared to be occupied (5 patients were in the room). The room was equipped with its own sink and liquid soap. From the patients' statements, it is apparent that the rooms have functional radiators and do not have problems with the lack of heat during winter. The room is overcrowded and seems quite cramped.

Following these two rooms, there's a corridor where there's an office space where patients can heat their food. Next to this office is the office of Dr. P., the head of the psychiatry department. The bathroom on the corridor, the communal bathroom also used by the acute female ward, is equipped with a sink, a toilet, and 2 showers. The plumbing is very old, the hot water is slow to come, and there are no shower curtains.

Clearly, we are facing a case of non-compliance with the requirements regarding the privacy of life as set out in Article 8 of the European Convention on Human Rights, as well as Article 25 paragraph h) of the Mental Health Law 487/2002.

In room 3, there are 4 beds of which 2 are occupied, and in room 4, there are 2 beds, both occupied. The conditions are similar to those described in the previous rooms.

Some rooms have a refrigerator, which can also be used by patients not staying in the room where the refrigerator is located, and some have a television.

When the patients were asked by the CLR experts if they participate in the occupational therapy workshop activities, several individuals from different rooms responded negatively, appearing surprised (*"what is that?", "how did you say it's called?", "well, I don't know if they let us"*). Most patients were not aware of the existence of the occupational therapy department; two of the patients hospitalized in the acute ward thanked the experts for informing them and stated that they would go even during the day "*to pass the time faster, not just here in the room telling stories*".

Patients report that the food is good, sufficient, they have hot water all the time, they can shower whenever they wish, they do not express dissatisfaction with the staff's behavior, stating that the employees are attentive and kind. Some of the patients with whom the CLR team interacted said they prefer coming here rather than to the hospital in Târgu Mureș

because there they are "locked up," whereas here they are not.

Some of the patients hospitalized in the acute ward, according to their statements, came to the hospital because they know that one or two hospitalizations per year are necessary "so there won't be problems at the committee."

In one of the bathrooms serving three of the rooms, although employees state that there are no problems with the hot water, it still does not heat up after a few minutes of being turned on. There are 2 shower stalls here, tiles, sanitary fittings, a shower mixer, a shower hose with a head (there are no curtains at the stalls); sink, tap, towels, mirror, liquid soap, toilet with a seat and lid, toilet paper. The shower places/stalls have separators but no curtains.

Psychiatry Ward III – Permanent Chronic Female Patients:

The ward is overcrowded, housing 110 people, and functions more as a social care home than a psychiatric ward in a hospital. Here, there are residents, not patients (according to staff statements), who have been hospitalized for decades. Discussions with the ward staff reveal that in recent years, the hospital has not faced overcrowding in the sense of having more admissions than the number of beds (in the past, there were situations where patients shared beds, 2-3 per bed).

The monitoring team could not identify the criteria used for assigning individuals to rooms. The space is visibly insufficient. Even though, strictly formally, the standard regarding the provision of one bed per person (Art. 36 of Law 487/2002 and OMS No. 488/2016) is complied with, the organization of these individuals' accommodation does not meet the legal provisions concerning the environment and living conditions of mental health services (Art.42 para.2 of Law 487/2002), which should be as close as possible to the normal life of corresponding age individuals.

In the space visited by the CLR team, there is no privacy, there is no space between patients, beds are stuck together. Moving through the ward is difficult; you have to maneuver around someone each time to go and talk to other individuals in the room.

Room 9 has 24 beds, some of which are close to each other without any space in between. The room has 4 double-glazed windows, each with bars, linoleum on the floor, and 10 bedside tables, meaning not all hospitalized individuals have a place to keep their personal belongings. It's also noted that there are residents who told us that they do not have (unfortunately) personal items.

Room 8 has 25 beds, and here the majority of individuals are bedridden; there's a sharp smell of urine. One of the patients in this room had a few books from the library located in the occupational therapy department under her pillow. In the absence of storage spaces, it was the only place where she could keep her belongings. The patient states that if you want to go to occupational therapy, you need to sign up on a list, announce in advance, in the first part of the day, and thus you can go after 3:00 PM. However, if you did not announce in time, you cannot go that day.

At the time of the visit in the two previously mentioned rooms, there was a lot of noise, with almost all patients in beds. There were no televisions in the rooms, the bed linen was worn and appeared unchanged. Draperies or blinds to provide shade/darkness were not identified.

This department has a dining hall (where, incidentally, patients were about to have lunch at the time of the monitoring visit). The department also has a seclusion room (with a bed, a sink, and a shower tray). According to statements from the nursing staff, this room is used for agitated or violent individuals. It was also mentioned that the ward had 14 bedridden patients.

Among the patients/residents, many have short, "brush" haircuts (as CLR experts identified during a visit in 2009). Regarding this situation, Dr. O.D., a psychiatrist, claims that it is easier to maintain the patients' hygiene this way, insists that it does not represent an advantage for the staff, and also adds that those who have this haircut desire it, they were not forced. However, we consider that, for individuals who have been housed in this ward for many years (people who over the years have been given short haircuts without being asked whether they want it or not), it has become a habit, an accepted fact, so today we cannot consider the option for a short haircut to represent an authentic desire and the expression of a free and sincere choice.

The situation of Ms. G.I.:

Ms. G.I., 23 years old, from Satu Mare, spent many years in foster care before being taken over by an organization, which led her to Mureș County. She has been in the hospital for about a year, this being her second long-term hospitalization at the Târnăveni hospital. She was one of the beneficiaries of an NGO (the name of the organization was unclear to her) that supported and guided her towards an independent life. She had several jobs, the last being at a restaurant, from which she was fired (she says she had some problems with her leg – possibly a delusional element or inaccurately reported). She also had an apartment, a protected housing, but could not "manage" and was evicted. She states that a boiler broke, she saw it but didn't know what to do and did not inform anyone, thus flooding the property. This was the moment when the NGO stopped supporting her, and she was brought to the Târnăveni hospital (possibly the incident occurred during a decompensation episode). She is very eager to leave the hospital (saving money for it), but says that until the doctor is sure she has somewhere to live, until she knows exactly with whom she will live, she is not allowed to leave the hospital. This information is confirmed by the staff, who say they are in contact with the NGO representatives, but they are hesitant to take her back.

Comment: Unfortunately, this is a clear case of failed integration, mainly due to the lack of strategy, absence of sustained existential training (to prepare her for independent living), lack of vision, resources, competence, and funding for genuine integration/reintegration/inclusion programs, especially for individuals with mental health conditions, intellectual and/or psychosocial disabilities. Moreover, as will be shown later in this report, this case appears to be yet another instance where an individual is deprived of liberty in terms of international (and European) standards without a justified reason, with the hospital compensating for the lack of viable social alternatives.

Psychiatry Ward for Men – Temporary Chronic and Acute Patients:

Present during this phase of the visit were the manager, two female doctors (psychiatry), and two male nurses (who permanently accompanied the team that conducted the monitoring in the Men's Wards).

These wards are located on the ground floor of the building and were recently renovated about 3-4 years ago. Unlike the wards where women are accommodated, the men's wards are in worse condition. The manager's explanation is that men are not interested in maintaining cleanliness, in the condition of the goods, and that they constantly cause damages. The hallway of the ward has 2 tables and 5 chairs, where some of the patients eat. A refrigerator, which patients can use to store food, is also located in the corridor.

Room 5 has 4 beds, three nightstands, and one of them has a functioning television (patients say there are three or four TV channels, which they can change as they wish). The nightstands are visibly old, made of metal, rusty, but apparently functional. At the time of the visit, 3 beds

appeared to be occupied (3 patients were in the room). The bed linen is old, visibly used. There are no curtains or blinds on the windows (the room cannot be darkened/shaded at all). The windows are dirty (it is explained that the entire building was recently fumigated and that the windows have the substance used for fumigation, which cannot yet be removed - this explanation is valid for the other rooms as well). The room has a sink and liquid soap. Patients say there is always hot water and that there is heating (the radiators were working at the time of the visit).

According to the statements from the patients here, the food is good, the staff treats them "well," but they would like to be able to go outside more (into the hospital courtyard). The patients have means of communication with the "outside" (phones seen charging are visible).

We were allowed access to the room without the presence of the manager and the nurses, and we were able to freely discuss with the patients. They mentioned that they spend their time watching television, reading, and sleeping. Once a day, they are allowed to go outside, into the courtyard.

Room 6 has 6 beds, each with its own nightstand, TV, sink, soap, hot water, and functional radiators. Five of the beds were occupied (at the time of the visit). In this room as well, we encountered individuals who expressed a desire to spend more time outside. Some of them wish to go home. The main activities are watching TV programs or reading.

Room 7 has 6 beds and 3 people (at the time of the visit). The conditions are similar to those in the previously mentioned rooms. Some of the patients state that they cannot go for a walk in the hospital courtyard in the morning (waiting for the medical visit), but in the afternoon, after lunch and the midday treatment (or even after the afternoon nap), they are allowed to walk in the hospital courtyard. In the usual language of the patients, the area where there are chronic patients is called "*the closed room*" and "*herd*," and the patients living there are referred to by other patients as "those from the herd" (example: "*today we couldn't go yet, because those from the herd were taking a bath*").

On the adjacent corridor, there is a bathroom, relatively clean (it can be seen that it was sanitized recently). The toilet seat lid is missing (nurses claim that patients constantly break the lid, and for this reason, it has not been replaced). The shower is wall-mounted, according to patient statements, there are no problems with hot water. The cover for the floor drain is missing (nurses claim that patients "take it away" after it is installed). The room also contains an old, peeling chair. Next to the aforementioned bathroom, there's another room. Here, there are 4 beds and only one patient who claims to be temporarily admitted. The conditions are similar to those in rooms 5, 6, and 7. There is no television.

Men's Psychiatry Ward - Permanent Chronic Patients:

From discussions with the staff on duty at the time of the visit, there is an informal type of separation based on the dangerousness of the men, causing some bedrooms to be more crowded than others due to the inability to ensure supervision. Thus, there are some locations where permanent supervision is carried out – 2 monitoring rooms, each with 4 beds, as well as a closed area with 50 - 60 people, supervised by 2 nurses, a caretaker, and a nurse.

The ground floor, the area referred to as "*the herd*" by some of the patients in the presence of the nurses, seems to be under surveillance. The walls and floors are visibly more degraded than in the previously visited areas. Even through the surgical mask, the heavy smell in the rooms of the ward can be felt (although some of the windows are open). It's noticeable that the floor was recently washed (it's still wet on the ground). The space is visibly insufficient for the number of patients admitted to this ward. It's an obvious case of overcrowding. There is no privacy for patients.

Even the hospital employees had difficulties (they contradicted themselves) in communicating the exact number of beds, their arrangement, and the exact number of patients in the ward. Due to the large number of patients and the extremely limited space, it's very noisy. Moving through the ward is cumbersome: you always have to detour, avoid, let someone else pass. Most of the patients were in a room with a few tables around which there are benches. There is also a large-screen television in the room; the nurses say that it works occasionally.

From this "main" room, one passes into three other rooms. The beds are "cramped," and the impression of overcrowding intensifies. The furniture is old, and the bed linen visibly worn. The manager assures us that each of the patients has his bed. There is little free space among the beds. Each of the bedrooms has a sink. Only some windows have blinds. In each of the bedrooms, the number of dressers/nightstands is extremely limited (only a few in each of the three bedrooms; those that exist are made of metal and are rusted).

We reiterate what was mentioned above: even if, in strictly formal terms, the standard of providing one bed per person (Art. 36 of Law 487/2002 and OMS No. 488/2016) is respected, the organization of accommodation for these individuals does not comply with the legal provisions regarding the environment and living conditions of mental health services (Art. 42 para. 2 of Law 487/2002), which should be as close as possible to the normal life of individuals of corresponding age.

In another room, there are 4 beds; here stays (temporarily) one of the patients, who, for the moment, prefers to stay separate from his peers. The patient is not communicative.

Additionally, the ward has a more spacious bathroom than the one previously mentioned. Here there are 5 shower tubs, low (almost at ground level) with showers. One of the showerheads is broken. The walls of the room are peeling and with signs of dampness. Signs of dampness are visible on the ceiling as well. The showers are not separated from each other, there are no curtains or any other type of partition and privacy. In this bathroom, there are two large trash cans: in one, the garbage is thrown away, and in the other (empty at the time of the visit), patients say that dirty clothes are placed when taking a bath.

The food distribution office in the ward was clean, and the kitchen utensils were neatly arranged.

Basement of the building housing the psychiatry wards:

After visiting the above-mentioned ward, we descended to the basement of the building (under the psychiatry wards). The basement houses, on one hand, the hospital's workshop, and on the other hand, several storage areas. It is evident that this part of the building has not been renovated for many decades. The basement is damp, dark, filled with mold, with many objects (pieces of furniture, tools, plastic bags filled with clothes, etc.) stored in disorganized piles.

Here, in one of the rooms, the hospital staff's changing rooms have been temporarily placed; this is the only relatively more sanitized area. Upon the request of the monitoring team members, two locked rooms were opened. In each of them, in total disarray, in piles, there were dirty clothes, pajamas, duvets, old furniture pieces, basins, medical gowns (some of them new), etc. There were also medical documents, some from the years 2017-2018, which the hospital staff said had not yet been archived. Even the manager appeared surprised by the findings in the basement and requested explanations/reports from the employees, etc.

The monitoring team returned to the area where the "office" of the psychiatrists is located (the main entrance area to the psychiatry wards). The CLR team visited the office where food

is distributed in the wards; it was clean and orderly (the food is prepared in another building). In the same area, there is another bathroom which was locked (with a key) at the time of the visit. The door was opened, and a renovated, clean room with all necessary facilities was observed. The staff told us that the bathroom is a "patient processing bathroom"; here, patients are brought (according to protocol, etc.) before being allocated to wards (we can assume, however, that this bathroom is used by the unit's staff).

Next to the aforementioned bathroom, there is another room (approximately 50-60 sqm) with several tables, benches, and also, crammed beds (in the order of tens). From this room, one enters another room, where again, 20-30 crammed beds were placed. The bed linen is visibly worn. There were only a few nightstands in all rooms. There are no blinds/curtains on the windows. Here too, the staff provided contradictory information regarding the actual state of affairs at the time of the visit: the number of patients in the ward, number of beds, their arrangement, etc.

In this area, there is a seclusion room equipped with a bed, shower, toilet, sink, and chair/small table, all made of stainless steel, robust, simple, and firmly fixed to the floor (they cannot be pulled out or moved). The room is small, approximately 6-7 sqm, and has a secured window, covered with a perforated plate that lets in very little natural light. The sink did not have a faucet (the staff stated that it had been pulled off and was to be replaced). The shower button and shower show signs of deposits and rust. In an attempt to demonstrate the functioning of the shower, a unit employee managed to start the shower, which began to spray water uncontrollably. Moreover, there is a distance of a few tens of centimeters between the shower and the bed, making it impossible for the bedding not to get wet when the shower is used. The unit staff could not indicate the last time the seclusion room was used (when a patient was brought into seclusion as a result of the isolation measure being imposed).

The Occupational Therapy Department:

The department is located in the hospital courtyard, near the fenced area where the permanent chronic male patients go outside. It consists of a restricted outdoor area (for recreation with various ornaments, figurines, floral arrangements, etc.), to which access is not easy, and an indoor area (a building at the basement level with several rooms). Patients are allowed to walk in this relatively generous space, with grass and trees, fenced off, but there is no specific activity for them to engage in; indeed, many patients were literally lying on the grass in the sun (see Annex No.1 to this report).

The interior area has several designated spaces:

- A room with a ping-pong table (functional, with paddles and balls), where there are also about 8 stationary bikes (for indoor use) and a treadmill (for walking/running);
- A room equipped like a kitchen, with a table, chairs, sofa, etc.;
- A room with a library (books), an aquarium with fish;
- A larger room with tables and chairs for various activities.

The entrance to the occupational therapy department, as previously mentioned, is right next to the courtyard (fenced) where the permanent chronic male patients go outside. When asked, a few of them reported that from what they have seen, the spaces are rarely used. One of them stated that the space is frequently used for hospital staff meetings. At the time of the visit, no one was present (patient or staff member), and the spaces did not seem to be frequently used for their intended purpose (although there are photos on the walls of patients

involved in various recreational/educational activities, etc.).

It must be emphasized that in the psychiatry wards, there are no club rooms (rooms for spending leisure time) because, according to the staff, everything needed for leisure time is located at the occupational therapy department, which has officially existed for 5 years. However, as already shown, during the monitoring visit, we found that many patients are not aware of the existence of the occupational therapy department, and on the other hand, patients are not truly encouraged, attracted, or convinced to participate in these activities.

According to the staff, the occupational therapy department is "not really" intended for patients from the acute wards, the reason being that their admission is of short duration. Additionally, the staff assumes that those admitted to acute do not wish "to mix" with those from permanent chronic (however, this assumption has not been clearly verified over time, nor have steps been taken to prevent such a stance from the patients in the acute wards).

Towards the end of the visit in this area, 4-5 female patients appeared, accompanied by a staff member, and began to engage in various activities.

Restraint and Seclusion Measures:

The hospital has 2 seclusion rooms, specific restraint instruments, and also utilizes a *Registry of Isolation and Restraint Measures, Incident Registry, and Nursing Shift Handover/Reception Registers compiled by nurses and nursing assistants.*

Registry of Isolation and Restraint Measures:

For the men's wards, we analyzed the registries of isolation and restraint measures for the three departments: acute psychiatry, temporary chronic psychiatry, and permanent chronic psychiatry. All three consulted registries contain elements of erasure/correction, incomplete entries, partially completed or confusing entries. Many of the records do not have the date when the restraint/isolation measure was instituted.

From the analysis of the **Registry of Isolation and Restraint Measures - acute psychiatry ward, for the period 2022 - 2023 (until September 2023),** the following results were found:

- Approximately 80 recorded situations (79) up to the date of the CLR visit;
- Surprisingly, the first 30 recorded situations (the first 10 pages of the register) do not specify the date when the isolation/restraint measure was instituted. Thus, the first recorded date appears after the first 10 pages – August 2, 2022; the last entry in the register with a date is from September 28, 2023, followed by two more entries, also without a date;
- Generally, the reasons justifying the institution of isolation and/or restraint measures are: psychomotor agitation, delirious (or delirious-hallucinatory) behavior, verbal hetero-aggressiveness towards medical staff, impulsivity, unpredictability, threat of homicide, complex visual hallucinations, imbalance, "irritable, irascible, uncooperative", verbal aggression, disorganized behavior, delirium tremens, state of unrest. Of all these, the state of psychomotor agitation (either alone or in combination with other symptoms) justifies approximately 80% - 90% of the instituted isolation and/or restraint measures;
- Out of the total measures: 33 are total restraints, approximately 45 are partial restraints, a few entries do not specify the measure, and no isolation measures are specified.

From the analysis of the **Registry of Isolation and Restraint Measures - temporary chronic psychiatry ward, for the period 2022 - 2023**, the following results were found:

- Although the register refers to the period 2022 - 2023, there is only one recorded measure from 2022: dated January 5, 2022; the other records refer to the year 2023. The last entry with a legible date is from June 7, 2023, followed by an entry without a name and without a precise date (just June 2023), with elements erased with correction fluid;
- 28 measures of isolation/restraint are recorded: 12 are partial restraints, 8 are total restraints, in 3 entries, under the column "Degree of restriction (partial or total)" is written "Yes", in 4 recorded situations the degree of restriction is not written, and 1 measure is of isolation. One of the entries, as mentioned above, is without the name of the patient on whom the restraint measure was instituted.

From the analysis of the **Registry of Isolation and Restraint Measures – the permanent chronic psychiatry ward, for the period of 2022**, the following results were found:

- The recording period is from June 6, 2022, to February 17, 2023;
- There is a total of 7 entries, 5 from the year 2022 and 2 from the year 2023;
- 4 measures with partial restriction and 3 measures with total restriction are recorded.

It was also found that patients (restrained) men are housed together with their roommates. This situation is unethical, psychologically risky, and physically hazardous.

Some specific conclusions regarding restraint and isolation measures:

- Considering that in the registries of isolation and restraint measures we did not encounter mixed restraint-isolation measures, it is reasonable to assume that partial or total restraint measures are applied (and or only) in the rooms where patients are housed. Given the architecture and organization of the men's ward with sub-departments for acute, temporary chronic, and permanent chronic patients, as well as the very diverse hours at which partial or total restraint measures are applied, it is legitimate to assume that restraint measures are applied in rooms where other patients are also present.

- This practice is contrary to the recommendation (as a principle) of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT); excerpt from the 16th General Report published in 2006 (CPT/Inf (2006) 35). According to paragraph 48:

  "*Generally, the place where a patient is subjected to physical restraint must be specially designed for this purpose. It must be safe, (e.g., without broken windows or other types of shards), and have adequate light and warmth, thus constituting a calming environment for the patient. In addition, the restrained patient must be appropriately dressed and not exposed to contact with other patients, unless he himself prefers otherwise, and when his preference for company is known. It must be guaranteed, under any conditions, that patients subjected to physical restraint are not harmed by other patients. And of course, staff must not be assisted by other patients when applying means of physical restraint.*"

- The information regarding the restraint of some of the patients is not sufficiently clearly rendered/explained/circumstantiated, even succinctly (related to the applicable normative provisions; including methodological norms, etc.) the concrete reason

(described in a manner that can be objectively verified later) for which the measure was ordered is not evident: what happened, how it happened, who was present, what exactly did the patient do, why exactly a certain medical conduct was adopted, etc.

Besides the legal norms previously referenced, international standards are clear in this regard. The principle of detailed, clear, and circumstantial recording of the restraint measure (reasons for taking the measure, circumstances of the case, etc.) is also found, for example, at paragraph 50 of the Recommendation of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT); excerpt from the 8th General Report (CPT/Inf. (98) 12).

- It is not clearly and explicitly evident (starting from the factual situation) the urgency of the measure, the imminence of danger (to oneself/others) that necessitated the measure. This practice is contrary to the principle stated in Article 39 (1) of Law No. 487 on mental health and Article 27 of Recommendation Rec (2004)10, from September 22, 2004, of the Committee of Ministers of the Council of Europe (to member states) on the protection of human rights and dignity of persons with mental disorders.

- There is no indication that other measures to calm the patient were attempted (according to the principle that restrictive measures – of freedom, etc. – should be taken progressively, only if previous, milder measures did not have an effect, etc.). This practice is contrary to Article 39 (3), second thesis, of Law 487/2002 on mental health.

- Relevant information is missing (for example, employees could not present certain parts of the event register, the shift handover/reception register);

- Information does not seem to be correlated (for example, an event that required restraint – and which involved acts of violence – summarily recorded in the Restraint Register, is not correspondingly, eloquently recorded in the Incident Register.

We reiterate schematically that, according to the law, the information recorded in registers and any other documents must be coherent, retrospectively analyzable, clearly express certain contexts, and explain and justify certain actions and measures, especially when it involves measures that entail as significant psychological and legal consequences as isolation and restraint do.

Isolation and restraint measures are extreme measures that should be instituted exclusively if there is an imminent and extremely high danger and if other measures have not been successful in adequately managing a situation.

In the same context, we mention that, from the dialogue with the medical staff, the necessity for training in the application of measures in crisis situations emerged. In this regard, an operational procedure regarding the management of patients with aggressive behavior was adopted in May of the current year (which was made available to the CLR team). It was mentioned that the medical staff (it was not clear whether only nurses or all staff) was trained based on this procedure, with a representative of the public order authority also being invited to the training session.

Regarding the procedure, beyond the commendable initiative, which reflects a real need and is necessary, in our opinion, a standard national-level procedure regarding this issue is required, we believe that it could still be improved.

The language used in this procedure, such as – the conflict of interest between the autonomy of the patient and the safety of others, can be adapted – the phrase "conflict of interest" is not

specific to the field. The application of colored bracelets to patients at risk of aggression can entail discussions from the perspective of non-discrimination and their difficult integration into the patient community. Finally, notifying the attending or on-call physician within 30 minutes of initiating techniques to restrict patients' freedom of movement may violate Article 9 (9) of the Rules of 15.04.2016, implementing the Mental Health Law (verification by medical staff of the condition of the restrained patient, every 15 minutes, etc.).

The situation of involuntary admissions within the psychiatry wards:

- ***Admissions conducted under Law No. 487/2002:***

Regarding involuntary admissions, the CLR team was informed that committees are established according to the law (2 psychiatrists and another doctor of a different specialty), operating exclusively during the week. Their number is relatively low – 3 this year. At the time of the visit, there was no clear record of the individuals, nor of the registers they manage.

After the visit, information was received that the total number of involuntary admissions during 2022-2023 was 7 individuals. There are some procedures in front of the courts regarding involuntary admission, which have been carried out in conditions where the court came to the hospital, with the court session usually taking place in the emergency room, but also others in which the procedures were completed through audio-video means (however, the hospital's infrastructure was not used, but a personal phone, and the hearing took place via WhatsApp). There were also situations where the patient was transported to the court for participation in the trial.

The CLR team considers the court's approach of coming to the hospital to fulfill the procedures encouraging and encourages the hospital management to provide all necessary conditions for such an approach. At the same time, it considers that hearing through audio-video means is a procedure meant to reduce much of the institutional and budgetary efforts required to fulfill judicial procedures, but emphasizes that these must be rigorously applied - the audio-video means used could be those from the video-conferencing system with which the hospital was equipped during the pandemic, for example, in a room that allows separate consultation, under confidentiality conditions, between the patient and his lawyer who comes to represent his interests in court.

A particular case is that of ***patient V.C.***, for whom the legal measure of admission was terminated by right in August 2021, but who, at her request, continued to stay in Târnăveni hospital. A similar situation seems to be that of ***patient K.S***., released in July 2021, who was admitted to this hospital at the time of the visit. The legal situation of such individuals is important, and the CLR team requests additional information (the names of the patients are included in Annex No. 3, Part I, non-public, of this report). It's noted that the situations seem to be similar to the one in the condemnation of Romania at the ECHR – the case of N.v.Romania[1], where the European court stated that it is the state's responsibility to identify solutions for community integration and that fundamental rights and freedoms are violated by deprivation of liberty, even if it is done at the person's request[2].

[1] N. v. ROMANIA (coe.int).

[2] "165. The court considered that, although the complainant agreed to remain confined until the social services found a suitable solution for his situation (...), this agreement was supported by the corresponding letter written by his legal representative (...), adequate guarantees should be provided for his protection, which should, in particular, lead to his release without unjustified delays. The truth is that the complainant was never actually released. It appears that to date, a detailed assessment of the complainant's practical needs and appropriate social protection measures has not been conducted. Moreover, the actions taken by the national authorities have been unproductive due to the lack of reception facilities. This situation reflects the realities in Romania that have already been described by international organizations (...). These factors are sufficient for the Court to conclude that the continuation of the complainant's detention after the Buzău Tribunal's decision of August 29, 2016, was arbitrary under Article 5 § 1 (e) of the Convention. – Case of N. vs. Romania, 28.11.2017

- ***Admissions as a form of implementing security measures:***

Although not listed among the hospitals where individuals subjected to security measures within criminal procedures can be admitted, there were such patients admitted to Târnăveni, following express orders received from the courts, as claimed by the medical staff, on the grounds that these individuals had not committed serious acts. The legal situation of such individuals is important, and the CLR team requests additional information (the names of the patients are included in Annex No. 3, Part II, non-public, of this report). Preliminarily, the CLR notes, however, the non-compliance with provisions regarding the admission of such patients considering the hospital is not on the list adopted for this purpose by order of the Minister of Health, but understands that the approach is taken, if documents confirm it, following orders from judicial bodies.

Beyond the issues arising from the decision to execute this measure in a framework other than the one formally approved by order of the Minister of Health, it should be noted that the admission of these individuals together with other patients reflects the medical system's ability to manage such cases, without the need for additional security or treatment measures. This fact, thus proven in practice, is likely to encourage broader initiatives to extend the number of hospitals where the execution of security measures ordered within judicial procedures can be ensured, consequently reducing the massive overcrowding of those currently on this list, an aspect that has also been highlighted in the most recent CPT report on Romania[33].

Status of deaths in the Psychiatry Wards:

Regarding the deaths that occurred within the hospital, the staff informed the CLR team that, following recent legislative changes, these no longer need to be reported. They received clarifications on this matter from both the National Institute of Legal Medicine (INML) and the local police authorities. After the visit, the hospital provided the CLR team with a letter from the Institute of Forensic Medicine Târgu Mureș, indicating that, due to new legislative changes, deaths occurring in psychiatric hospitals are no longer considered suspicious deaths, hence *the mere fact of a death occurring in a Psychiatry ward does not require notifying the authorities and declaring the case as medicolegal*.

Currently, deaths are internally analyzed, and the police are notified only in certain situations, namely those that occur without any known medical history that could have led to death. According to the clarifications received, it is the medical director or the hospital manager who decides whether the police should be notified in the event of a death.

In fact, the CLR team notes an aspect that has also been highlighted in other monitoring missions, namely that, following legislative intervention this year (Joint Order of the Minister of Health and the Minister of Justice No. 1434/2023), significant changes were made to Article 34, especially in terms of limiting the situations in which forensic autopsies are mandatory.

Beyond narrowing the definition of violent death and eliminating situations when the cause of death is unknown, a provision that expressly required the autopsy of individuals whose deaths occurred in custody or who were detained or deprived of liberty, deceased in psychiatric hospitals, prison hospitals, in prison, or in police custody, alongside those whose deaths could have been associated with the activities of the police or the military - during public demonstrations or any deaths that raised suspicions of human rights violations, such as suspicion of torture or any other form of violent or inhuman treatment, was removed.

[3] Council of Europe anti-torture committee (CPT) publishes report on Romania - CPT (coe.int)

Instead, the new regulation stipulates autopsies in cases where death occurs in individuals under care within specialized institutions for care if they are not known with documented lethal potential diseases.

Following these changes, not only is it no longer mandatory to notify any death of individuals deprived, in any form, of liberty, but also deaths that occur to other individuals, except insofar as those individuals were not known with documented potentially lethal diseases.

The CLR will undertake formal actions regarding this aspect, requesting specific information from the Ministry of Justice and the Ministry of Health. Regardless, however, of the responses to be received, the CLR emphasizes that **there remains an obligation to notify the Monitoring Council of deaths, as well as regarding the text, even newly regulated by the mentioned amendment, which still maintains valid scenarios for reporting, such as: when serial or concurrent deaths occur, when they occur in isolated places, when death occurs suddenly, abruptly, rapidly, and unexpectedly, there is a reasonable suspicion that death was caused directly or indirectly through a crime or in connection with the commission of a crime.**

The situation of the 7 individuals from the " Căsuța lui Min " social care home, who were admitted to the psychiatric wards in Târnăveni:

Given that some individuals identified at the " **Căsuța lui Min**" social care home during the monitoring visit in July were also admitted to this hospital, discussions were held regarding the admission procedures and the situation created at that time. In this context, the hospital management clarified that, due to a lack of human resources, they rely on external doctors who exclusively work shifts. However, these doctors do not know the patients, do not interact with them afterward, and have minimal dialogue with the rest of the hospital staff. This was also the case in July when a female psychiatrist employed under a collaboration contract admitted 7 patients from " Căsuța lui Min " social care home during her shift, without rigorously complying with the required documents and procedures. The admission took place on a Friday evening, and the procedural irregularities were only noticed on Monday morning by the hospital manager.

These patients did not have referral slips, and there were no medical emergencies. They were allocated to wards and remained hospitalized for approximately one week. Subsequent discussions and document analysis revealed that only medical services were provided to these patients without conducting an analysis of how they came to be hospitalized, the authenticity of their consent on various documents filed in their medical records, or the completion of the mandatory anatomical record sheet to assess any injuries or document obvious elements regarding previous treatments they had undergone (e.g., cachexia in the case of one patient, fear of dark environments and aggressive reaction to darkness in another patient during an X-ray, the fact that many of them presented with scabies).

It is noteworthy that the admission of a group of individuals to a ward with such specificity is atypical; none of the psychiatric hospital staff questioned the novelty of the situation (7 people admitted at the same time): who are these people? where did they come from? why were they admitted in this manner? etc.

Possibility for patients to file complaints:

When asked by CLR experts whether patients can file complaints, the hospital manager seemed genuinely surprised, stating that no complaints have been recorded. Patients can be visited at any time, and there are many people who want to be admitted there.

Near the main entrance to the psychiatric wards (next to the psychiatrists' office), there is a "complaints" box. When asked, staff members mentioned that the box is empty because nobody files complaints this way; if there are potential grievances, they are communicated verbally to the hospital staff.

The Patient/Family Satisfaction Report for 2022 was requested and communicated after the visit. According to this report, the satisfaction rate of patients reflected an average of 93.14%. CLR team observes that out of 1645 admitted patients (1241 discharged) in 2022, questionnaires were completed by only 363 individuals, a percentage too small to draw a conclusion regarding the true satisfaction level of patients. This report also notes that complaints were responded to in a manner considered very good (139 respondents), good (110), excellent (64), adequate (12), and inadequate (6).

Six respondents specified that they were asked for money or favors by medical staff and wished to report this. It is not stated in the report how this response was analyzed. Patient recommendations aimed at improving the quality of food, sanitary conditions in bathrooms, and equipping the rooms with television sets and refrigerators.

The situation of patients placed under interdiction:

It is mentioned that there are patients placed under interdiction; it is stated that there are cases where patients do not yet have legal representatives. Information presented subsequently to the CLR team indicates that 31 such individuals without legal representatives are hospitalized.

The lack of a legal representative for these individuals presents a particularly serious issue from the perspective of the rights of patients placed under interdiction.

We remind that according to legal provisions (Civil Code, Mental Health Law, etc.), representation in such cases is mandatory. Consequently, **we recommend the urgent remedy of this situation.**

The staff in the Psychiatry wards:

The hospital has, at the level of the psychiatry departments, 3 psychologists, 7 psychiatrists (working from 08:00 to 15:00), and one social worker with medium-level education. According to the statements of the manager, a request was sent to the Ministry of Health to unblock positions for psychiatrists, psychologists, and nursing assistants, but they were informed that the request for unblocking positions should be addressed to the Ministry of Development.

One of the issues the hospital faces is covering the shifts by psychiatrists. According to the job description, each doctor is required to do one shift per month, and the chief psychiatrists of the departments are not required to do any shifts. A few months ago, shifts were not problematic because there were many young doctors from Târgu Mureș who came to work shifts at the hospital because they were unemployed. Thus, all shifts were covered by doctors from outside, but for some time now, even they are not willing to come. Nursing assistants work in shifts: 07:00 - 15:00; 15:00 - 23:00; 23:00 - 07:00. There are approximately 5 people on the night shift.

It is mentioned that the hospital does not have a legal advisor, but there is an ongoing recruitment procedure for such a position. The lack of a specialist in the field also affects the patients hospitalized in the psychiatry departments (for example, the situation of patients placed under interdiction, who do not have legal representatives).

Psychology, recovery activities, psycho-social activities, leisure time:

For patients in the chronic care departments, the main psychological activity consists of assessment or reassessment, psycho-diagnosis (necessary for the *Evaluation Commission of Adults with Disabilities*), with few patients having counseling sessions upon their request, and occasional events during holidays (called socialization events). Most of the time, patients approach the psychologist to complain about various conflicts and they "come to find solutions and be guided". The most common conflicts arise from territory invasion and the use of personal material goods (e.g., *"someone sat on my bed", "they took my spoon", "they took or touched my shower gel"*). If patients do not explicitly request the psychologist's services, then the psychologist approaches certain patients exclusively to conduct the mandatory annual psychological assessment.

According to the statements of the psychologists we spoke with, socialization activities are extremely important (*"due to the conditions the patients suffer from, they cannot create friendship relationships"*); for this reason, the "Miss Psychiatry" event was organized on March 8th. For this event, a jury was formed from the staff, 9 women participated, there were general knowledge tests, a dance test, and evening dresses. The female patients did not want the participation of colleagues from the men's wards. The event took place in the closed ward. Additionally, psychologists attempted to form discussion groups to identify what interests the patients, and among the first topics/groups chosen was the self-awareness group. However, this was not successful, with the psychologists concluding that patients *"neither want to know themselves, nor to know others,"* so they abandoned these groups. According to the statement of the psychologist, they did not attempt other themes or activities with the chronic care patients "*due to cognitive deterioration"*; there are 2-3 patients who want to talk and come to the office, but otherwise, patients do not want this and have no interest. They also *"conduct groups with those with neuroses, anger management"* (the psychologist, together with the doctor, has established certain relaxation techniques).

It is mentioned that only a limited number of patients are allowed to take walks freely (without supervision) in the hospital courtyard (the hospital and its outbuildings were built on approximately 10 hectares of land). Typically, patients do not leave the hospital premises. If outings are approved, they can only do so under the supervision of a hospital employee, and this happens rarely. During discussions, it emerged that a small chapel-sized church has been built in the hospital courtyard (which is not yet completed and functional).

According to the statements of the manager, patients go on trips, to restaurants, or other activities outside the hospital. In the last outing, there were 60 patients (30 women, 30 men). Not all patients get to go on outings, for various reasons: medical, mood, etc.

CONCLUSIONS of the monitoring visit:

- Operating a psychiatry unit with 320 beds with only 3 psychologists and without a wide and complex spectrum of professional psychological programs/interventions represents a challenge that, objectively and regardless of the punctual efforts of the staff, cannot be adequately addressed. **The inadequate infrastructure and severe understaffing constitute a grave violation of the right to health and the best treatments, as established in national and international standards, for the patients of this hospital.**

- **The living conditions of patients housed in certain departments and wards of the men's psychiatry sector are dehumanizing, depersonalizing, pathogenic,**

and violate fundamental rights, especially the right to privacy: old mosaic cracked cement floors, walls painted with oil paint, broken bathroom doors, PVC doors or worn-out thermoplastic doors, bent, broken, with signs of impact, dampness, mold, and dampness, broken locks, old locks with broken and repaired padlocks, broken taps, cracks in walls, discrimination based on diagnosis, etc.

- **The most difficult living conditions are experienced by individuals with severe conditions who do not sufficiently realize their living situation, who cannot react or are afraid to react, who do not know their rights,** etc.: overcrowded wards with dozens of beds stuck together, without spaces between them, torn linens, old cast iron radiators, very high rooms with minimal artificial lighting (one or two fluorescent bulbs/light fixtures), shower cabins without curtains, side by side, toilet cabins without doors, toilet bowls without toilet seats, floor drains without grates/covers, an unsanitary basement with some of the psychiatry ward documents thrown into dust and dampness (beyond the fact that such a basement can become a focus of infections and accidents for staff and patients, the condition in which we found documents, new inventory materials, etc., indicates a lack of responsibility and concern for optimal document archiving, lack of professional and cultural respect, lack of concern for the unit's movable and immovable property, etc.).
- **Managerial deficiency in prioritizing the institution's investment plan** (the renovation of employee locker rooms starkly contrasts with the deplorable living conditions of patients with severe conditions, who reside temporarily or permanently in unrenovated wards, without the possibility or option to leave the degraded spaces they inhabit. The only plausible reason for this unnatural prioritization seems to be the severe diagnosis of the patients, their lack of credibility, and reduced human value in the eyes of authorities, as well as their inability to have a voice, express credible revolt, and react to the abuses they endure every moment of their existence in the degraded and unsanitary wards, in the dehumanizing living conditions (described above) in some psychiatry departments of Târnăveni Municipal Hospital, where they reside, temporarily or permanently;
- **Lack of diversified and adapted recreational/educational activities to meet the needs of patients;**
- **Improper completion of registers** (restraint registers, shift registers, incident registers, etc.) **or missing wards for certain periods,** etc.;
- Existence of **individuals under interdiction without legal representation,** etc., medical internments conducted without strict adherence to the procedures prescribed by law;
- **Acceptance in psychiatry departments of social cases, residents from certain social care homes with which the hospital has agreements, those patients for whom the provision of medical services by the state is not justified, their needs being rather social.** Possible cases of illegal deprivation of liberty are not excluded, in cases where hospitalization was done without legal support, etc.

Recommendations following the visit (see the contextual ones, inside the report):

- Urgent reprioritization of investment plans to guarantee humane living conditions for all hospital patients;

- Avoidance of any discriminatory practices based on diagnosis in the allocation of patients to wards and rooms;

- Reevaluation of agreements between the hospital and certain social care homes (based on applicable legal norms);

- **Reevaluation of all social cases and those with prolonged hospitalizations and firm request to competent authorities to identify measures for their community reintegration;**

- Reconsideration of the importance of psychological and psycho-social intervention programs, as well as alternative/complementary programs in managing and improving the symptoms of mental illnesses;

- Demonstration of **increased managerial, administrative, methodological, and professional responsibility in the utilization of documents** referring to certain critical situations and measures such as isolation and restraint measures, recording incidents, involuntary hospitalization measures, etc.

- **Revision of the methodology and personnel policy to ensure that special measures of isolation and restraint are used exclusively as extreme medical measures** necessary in situations of extreme danger, and not as a substitute for lack of staff, resources, alternative solutions, expertise, and competence;

- **Strengthening the management practices of episodes of psychomotor agitation with progressive methods and alternatives to isolation and restraint measures;**

- **Strengthening all procedures and efforts necessary to ensure patients' access to community activities,** contact with the community, etc.;

- **Urgent evaluation of the legal situations of individuals, especially those who are or have been interned in this hospital under security measures, and immediate discharge of those against whom the courts have ordered release.** This will put an end to the illegal deprivations of liberty to which these individuals are subjected, in violation of national and European standards (see, in particular, the similar case of N. c. Romania);

- **Training of staff** on: mandatory admission procedures; obligations regarding recording of any injuries or harm; standards regarding restraint; strict maintenance and proper completion of records; obtaining genuine informed consent from patients upon admission; standards for obtaining treatment consent and implementing controls to ensure compliance with them.

Additionally, regarding the legislative changes regarding **the reporting of deaths, CLR will formally and publicly request from the two initiating ministries (the Ministry of Health and the Ministry of Justice) the reasons and documentation behind such a major legislative regression with significant impact on the guarantee of fundamental rights and freedoms.** Moreover, since the adoption procedure itself does not seem to have been transparent, as the joint order project was not identified on any of the ministries' websites, clarification is needed.

Furthermore, **CLR requests a statement from the Ministry of Internal Affairs (MAI) regarding how it will interpret these provisions from now on. Additionally, clarification is sought from the National Institute of Legal Medicine (INML) regarding the clarifications they seem to have formulated regarding documented/important potentially lethal diseases**.

ANNEX NUMBER 1

ANNEX NUMBER 2

Here are excerpts from the Regulation for the Implementation of Law no. 254/2013 regarding the execution of penalties and measures of deprivation of liberty ordered by judicial authorities in the course of criminal proceedings (Government Decision no. 157/2016

For example, Article 87[44], which is implemented through the Decision of the General Director of the National Prison Administration no. 521/2017, establishes the form, content, and archiving method of documents provided by Law no. 254/2013 regarding the execution of penalties and measures of deprivation of liberty ordered by judicial authorities in the course of criminal proceedings and the Regulation for the Implementation of Law no. 254/2013, approved by Government Decision no. 157/2016, dated 21.03.2017. Similarly, Article 100[55], which has been implemented by the Norms regarding the methods of keeping goods, valuable objects, and sums of money, in lei or foreign currency, declared and collected from detainees, as well as the management of sums of money, in lei or foreign currency, undeclared and held under conditions other than those legal by detainees (Ministerial Order no. 1416/2017).

[4] (4) Inmates in open regime are allowed to keep and manage sums of money from their personal account or electronic payment means necessary for minimal expenses related to personal hygiene, transportation, supplementing food, and purchasing clothing and footwear, while they are outside the prison, engaged in activities provided for in Article 86 paragraph (2). Upon returning to the prison, they are obligated to justify the amounts of money spent. Inmates in open regime can purchase clothing items, in the number specified in Annex 1, only with the prior approval of the prison director. After purchase, the goods will be recorded in the receipts for safekeeping.
(8) Mobile phones, remaining sums of money upon return to the prison, as well as electronic payment means, are kept in a specially arranged space, in boxes equipped with secure locks, placed at the entrance to the detention area, and are nominally recorded in a register by the prison administration staff, indicating the time they were handed over and returned to the inmates.

[5] Article 100 (2) Goods, valuables, and sums of money, in lei or foreign currency, declared and collected from detainees are inventoried, recorded in receipts for safekeeping, and kept under the care of the place of detention administration or, at their written request, handed over to the family or deposited with institutions authorized to keep them. Sums of money in lei or foreign currency declared and collected from detainees upon receipt are recorded in a nominal accounting record and may be used in accordance with Article 70(4) of the Law.
(**3**) After the search, goods, valuables, and sums of money, in lei or foreign currency, not declared and held under conditions other than those legal and regulatory, are confiscated according to the law.
(**4**) The methods of storing goods and valuables provided for in paragraph (2), as well as the management of sums of money in lei and foreign currency provided for in paragraph (3), are established by order of the Minister of Justice.

An example of a register of evidence can be as follows:

ANEXA Nr. 22

MINISTERUL JUSTIȚIEI

Administrația Națională a Penitenciarelor

Locul de deținere . . . . . .

Nr. indicativului din nomenclator: . . . . . .

REGISTRU

de evidența a telefoanelor mobile, sumelor de bani și a mijloacelor electronice de plată aparținând persoanelor private de libertate clasificate în regim deschis, care se deplasează în afara locului de deținere

Nr. crt.	Nume și prenume persoanei private de libertate	Data și ora primirii	Locul unde se deplasează	Bunuri și sume de bani primite de persoana privată de libertate[1]	Semnătura de primire a bunurilor (la plecare)	Data și ora returnării	Bunuri și sume de bani returnate de către persoana privată de libertate[2]	Sume de bani cheltuite și scopul în care au fost folosite	Semnătura de returnare a bunurilor (la sosire)	Semnătura de primire de către personalul desemnat

[1] Sunt consemnate datele de identificare a fiecărei categorii de bunuri aparținând persoanelor private de libertate care se deplasează în afara locului de deținere (marca/tip, serie, număr pentru telefoane mobile si mijloace electronice de plată), precum si suma de bani

MINISTRY OF JUSTICE
National Administration of Penitentiaries
Place of detention …….
Index number in the nomenclator ……

REGISTER

mobile phones, cash amounts, and electronic payment means belonging to persons deprived of liberty classified in open regime, who move outside the detention facility

Crt. No.	Surname and name of the person deprived of liberty	Date and time of receipt	Place of destination	Goods and sums of money received by the person deprived of liberty[1]	Signature of receipt of the goods (at departure)	Date and time of return	Goods and sums of money returned by the person deprived of liberty[2]	Sums of money spent for the purpose of use	Signature of return of the goods (at arrival)	Signature of receipt by the appointed staff

[1] The identification details of each category of property belonging to individuals deprived of their liberty who are moving outside the place of detention are recorded (brand/type, serial number, number for mobile phones and electronic payment means), as well as the amount of money.