Iceland Liechtenstein Norway grants

FRDS
FONDUL ROMÂN DE DEZVOLTARE SOCIALĂ

Ilfov County Monitoring Report:

"Armonia" Care and Assistance Centre for Adults with Disabilities

project conducted by:

CENTRUL DE RESURSE JURIDICE

in partnership with:

MINISTERUL PUBLIC

Preliminary remarks

1. Representatives of the Centre for Legal Resources (CLR) organized between September and November 2022 several unannounced monitoring visits in three of the private residential social care centres (NGOs and LTDs) which are also funded from public sources, for persons with intellectual and psychosocial disabilities in Ilfov county.
2. The visited centres were: the "Sfântul Gabriel cel Viteaz" Care and Assistance Centre for Adults with Disabilities, the "Casa Cora" Residential Care and Assistance Centre for Dependent Persons and the **"Armonia" Care and Assistance Centre for Adults with Disabilities.**
3. **The "Armonia" Care and Assistance Centre for Adults with Disabilities** is located in a neighbouring area, at the exit of Afumați, Ilfov County, on Bucharest-Urziceni Road no.36A. At the busy street (being a main entrance and exit artery from Bucharest), the centre is surrounded by a fence of approx. 2.5 m high on which are mounted video surveillance cameras and warehouse buildings. In the immediate vicinity, the centre is bordered by a fuel station, OMV.
4. At the first visit (September, 2022) the official capacity of the "Armonia" Centre was not communicated due to the fact that the access to the premises was very difficult and subsequently restricted by the management of the social service provider. Moreover, following the verbally and physically aggressive behaviour of the management, the CLR representatives called the 112 emergency service. On the second visit, which took place in November 2022, the nurse present in the centre informed the management of the centre, Mr Godăi, about the presence of the CLR team at the gate of the institution. The CLR representatives were informed that Mr Godăi could follow the nurse's interaction with the CLR team, as he had "live" access to the video cameras mounted on the gate of the institution. CLR again requested the help of a police team on 112, who facilitated the access to the centre after more than an hour of waiting outside the closed gates.
5. Both in September and November, immediately after CLR entered the premises, at the request of CLR, members of the team of specialists, a social worker, a psychologist, and the management of the association responsible for providing services in "Armonia" were called and invited. CLR noticed that the two specialists came in a car with a DPC number and asked the employees if they also worked for DGASPC Ilfov. They answered affirmatively, namely that they are employees of the Crisis Cell of DGASPC Ilfov. So if CLR were to call DGASPC Ilfov for an emergency intervention, the two employees would be sent to the site, being on site in a dual capacity. CLR tried to contact the management of DGASPC Ilfov to inform them about the situation of (non)respecting human rights in the "Armonia" Centre. As none of the directors were available and did not respond to phone calls and messages sent by CLR, Mr. Răzvan Țicu, head of service - adults with disabilities from DGASPC Ilfov, was sent. He was not at all surprised by what he saw and even reinforced the idea that the services in question comply with the quality standards for the provision of social services and, moreover, does not consider it inappropriate for the social worker and psychologist to be

employed at DGASPC Ilfov and at the "Armonia" Centre at the same time.

6. If in September, upon arrival in the "Armonia" Centre, only one employee was present and was busy with the cleaning of the dining room on the ground floor of the building, in November 2022, there were two female caretakers, the same male caretaker met in September and the nurse. Initially, information received indicated a total of 32 residents. However the information could not be officially confirmed in any of the visits carried out in 2022.
7. The "Armonia" Centre is established by the Sf. Gabriel cel Viteaz Association and holds the provisional operating license 1358/12.07.2022 issued by ANPDPD on 12.07.2022 with a validity of 1 year, until 11.07.2023.
8. **Accreditation of social service providers and licensing of social services**

   The procedure for the accreditation of social service providers and the licensing of social services is established by Law No 197/2012 on quality assurance in the field of social services, as well as the Implementing Rules of this law, adopted by G.D. No 118/2014. According to them, in order to be able to provide social services, a private entity must go through an **accreditation procedure**, which ends with the issuance of the accreditation certificate.

> According to Article 9, para. (2) of Law no. 197/2012, "the criteria used for the accreditation of providers mainly concern the following: a)identification data on the provider; b)information on knowledge in social services management;
> c) conditions provided for by Law No 292/2011, mandatory for the establishment, management, operation and financing of social services."

The assessment of the supplier consists of verifying the fulfilment of the criteria, on the basis of supporting documents. If these criteria are found to be met, an accreditation certificate will be issued for an indefinite period. Accreditation of the provider is granted at the request of the provider and only if, at the time of the application, the provider undertakes to have at least one licensed social service within a maximum of 3 years from the date of obtaining the accreditation certificate.

The licensing of social services can only be done by an accredited provider and consists of assessing the requested social service based on the minimum quality standards approved and elaborated according to the Law no. 197/2012, called *minimum standards*, and certifying compliance with them through an operating license.

> According to Article 16 of the Methodological Norms for the implementation of Law no.197/2012, the initial licensing of a social service is carried out in two stages, as follows:
> a) verification by the accreditation department of the supporting documents and the self-assessment form completed in accordance with Article 9, para. (5) of the Law, as well as the data and information in the application for accreditation of the social service, on the basis of which the provisional operating license, hereinafter referred to as provisional license or, where appropriate, the decision to reject its granting is issued;
> b) on-the-spot verification by social inspectors of compliance with the minimum standards on the basis of which the operating licence is issued or, where appropriate, the decision to refuse to grant it. The social inspectors are responsible for verifying that the legal operating conditions are met and that the data presented in the supporting documents and in the self-assessment form are real.

As such, the provisional licence shall be issued following a procedure carried out exclusively in writing, **without any on-the-spot verification**, and the provisional licence may be issued with a validity of up to 1 year (according to Art. 11, para. (6) of Law no.197/2012).

> According to Art. 23 et seq. of the Methodological Norms for the implementation of Law no.197/2012, the second stage of the licensing procedure shall be started within a maximum of 7 days from the date of issuance of the provisional license. The accreditation department of the Ministry of Labour and Social Security sends by e-mail to the territorial agency in whose administrative-territorial district the social service is based or operates, a copy of the provisional licence and the self-assessment form of the social service concerned. Within a maximum of 30 days from the receipt of the documents, the territorial agency plans to carry out an on-site assessment to be carried out at the premises of the social service by a team of 2 social inspectors, without giving prior notice to the social service provider of the date of the visit.

The field assessment is completed with an assessment report, which will be submitted with t h e social service licensing application.

It is worrying how, for the period of 1 year, while the centre is operating under the provisional licence, nobody actually checks the living conditions of the people in the centres.

Throughout Romania there are an impressive number of social service providers, established under the provisions of Law 197/2012, operating only under a provisional license:

- out of a total of **1002 service providers for persons with disabilities**
- **274** operate under **provisional licence**
- of which, for a number **of 43 suppliers the provisional licenses are older than 1 year** and although they are not listed with 5-year licenses, they still appear on the Ministry of Labour website as active[1] .

In this context, under the provisions of Law 197/2012 and the Methodological Rules of 19 February 2014 for the application of the provisions of Law 197/2012 on quality assurance in the field of social services, in order to obtain a 5-year license, initially a preliminary procedure is carried out, during which a provisional license can be issued for a maximum period of one year:

> Art. 11 (1) The licensing of the social service involves the following steps:[...]c) issuance of the provisional operating licence/operating licence or, where applicable, of the notification of rejection of the application for licensing;
> And (6) The initial licensing of the social service involves: a) verification of the supporting documents and the self-assessment form submitted by the provider and the granting of the provisional operating licence for a maximum period of one year;

At the same time, the legislative framework clearly states that evaluation visits must be carried out no later than 3 months before the expiry of the period of provisional operation in order to verify the conformity of the data in the accreditation documents with the information on the ground.

> (b) conduct, at least three months before the expiry date of the provisional operating licence, an on-site visit/assessment visits to verify the conformity of the data submitted in the supporting documents and the self-assessment report with the reality on the ground; if the minimum standards are found to be met and the data submitted in the supporting documents are found to be in compliant with the reality on the ground, the operating licence shall be issued;

[1]Dates are processed on 05.01.2023 according to the information published on the website:
https://mmuncii.ro/j33/index.php/ro/2014-domenii/familie/politici-familiale-incluziune-si-asistenta-sociala/4848

However, in view of the situation provided for by the relevant legislation, we address to the authorities the most legitimate question: **What is happening, in this extremely long period of one year, when persons with disabilities could be living in more than precarious, even miserable conditions, in outbreaks of infection, surrounded by vermin and without adequate food...**? This question is being asked in the context of the non-compliance found on the ground in many centres for persons with disabilities.

Thus, we believe that the one-year period should be amended to a much shorter period, so that non-compliances can be detected and remedied as quickly as possible. This measure is necessary in order to protect people who are extremely vulnerable, and whose interests should be protected precisely by those responsible for verifying and accrediting centres.

In view of the above, we do not know on the basis of which documents and verifications the social services provider was accredited and subsequently those services were licensed, especially since during the monitoring visit, the CLR representatives observed a number of obvious violations of the relevant legislation, as we will present below. CLR referred the matter to the County Agency for Benefits and Social Inspection and received a reply from which it emerged that the agency's representatives, following the application of evaluation questionnaires to a sample of residents, concluded that the services were of a quality corresponding to the legal norms. Moreover, CLR also referred the matter to the Ministry of Labour - ANPDPD concerning the violation of human rights in this centre and was informed that "*an inspection action was ordered, that discussions were held with the manager, the nurse and the caretaker, as well as with several beneficiaries*".

We also draw attention to the procedure and purpose of issuing operating licenses for licensed social service providers, thus, pursuant to the relevant legal provisions (both the provisions of Law no. 197/2012 and the Methodological Norms of 19 February 2014 for the application of the provisions of Law no. 197/2012 on quality assurance in the field of social services, as presented above but also of Law no. 448/2006 on the protection and promotion of the rights of persons with disabilities - art. 51 and 53, according to which persons with intellectual and psychosocial disabilities must benefit from the guarantee of **quality services** that ensure that their **specific needs are met** and that **remove as far as possible the vulnerabilities inherent to the disabilities** in which they are classified and provide them with a **minimum of safety to lead their lives with dignity**.

Art. 51: (1) The person with disabilities can benefit from social services provided in public, public-private or private day centres and residential centres of different types. (2) Day centres and residential centres are social services provided to adults with disabilities, with qualified staff and adequate infrastructure; residential centres are social services where the person with disabilities is accommodated for at least 24 hours. (4) The capacity of residential centres for adults with disabilities may not exceed 50 places. (8) Public and private day centres and residential centres for adults with disabilities operate in compliance with specific quality standards. Art. 53: (1) In a day or residential centre social services may be provided in an integrated system with medical, education, housing, employment and other services. (2) Persons with disabilities in day or residential centres shall be provided with medical services as part of the basic medical services package, which shall be borne by the budget of the Single National Social Health Insurance Fund, in accordance with the Framework contract on the conditions for the provision of health care under the social health insurance system."

In the same sense, all centres for persons with disabilities should operate taking into account the provisions of Article 7 of Law 7/2023, in order to prepare the beneficiaries of the centres for the process of deinstitutionalization, encourage independent living and intensify social-community administration activities.

> Art.7 (1)The process of deinstitutionalisation and prevention of institutionalisation of adults with disabilities aims to ensure the exercise of the right to independent living of adults with disabilities. (2) Fulfilling the purpose provided for by para. (1) shall include:
> a) to increase the efficiency and effectiveness of policies to protect and support persons with disabilities;
> b) to promote collaboration and cooperation between local and central public administration and between local public administrations and to strengthen social-community administration activities for the benefit of adults with disabilities;
> c) strengthening the case management approach within the protection system for adults with disabilities and the role of the case manager, ensuring adequate training of the case manager, incorporating the person-centred planning approach; d) developing, diversifying and strengthening community services;
> e) the provision of quality, person-centred services that provide appropriate and integrated support for adults with disabilities to live independently and integrated into the community, through an appropriately trained workforce;
> f) promoting the employment prospects of adults with disabilities by combating prejudice;
> g) improving access of persons with disabilities in residential and community centres to education and health systems; h) diversifying and coordinating actions to raise awareness, sensitise and combat disability-related prejudices in order to increase public confidence in the potential of persons with disabilities and the value they can bring to the community.

9. How beneficiaries are admitted to centres where social services are provided (transfer of residents)

According to Article 4 of Law No 292/2011[2] , every citizen has the right to social assistance under the law, including the right to be informed about the content and modalities of social assistance measures and actions. Entitlement to social assistance is granted on request or ex officio.

The same rule can be deduced from Art. 28 et seq. of G.O. no. 68/2003, according to which the procedure for granting social services is initiated at the request of the person, his or her family or legal representative, following the reporting of a situation of social need by any other person, as well as ex officio.

Regardless of whether the social assistance service is provided at the request of the beneficiary (personally or through a legal representative) or ex officio, the service will be provided in accordance with the ***principles of social assistance***, including taking into account:

> (e) the individual approach, according to which social assistance measures must be tailored to the particular life situation of each individual; this principle takes into account the nature and cause of some emergency situations which may affect individual abilities, physical condition and mental health, as well as the person's level of social integration; the support addressed to the individual's situation of hardship includes support measures addressed to the beneficiary's family members;
> l) respect for the right to self-determination, according to which each person has the right to make his or her own choices, regardless of his or her social values, while ensuring that this does not threaten the legitimate rights or interests of others;
> v) the right to free choice of service provider, according to which the beneficiary or his/her legal representative has the right to freely choose among the accredited providers.

At the same time, according to Art. 89 para. (1) of Law No 292/2011, the admission of persons with disabilities to residential centres shall be granted only if their assistance, care, recovery or protection

[2](1) All Romanian citizens who are on the territory of Romania, have their domicile or residence in Romania, citizens of Member States of the European Union, of the European Economic Area and citizens of the Swiss Confederation, as well as foreigners and stateless persons who have their domicile or residence in Romania are entitled to social assistance, under the conditions of Romanian legislation, as well as the regulations of the European Union and the agreements and treaties to which Romania is a party.
(2) The persons referred to in paragraph 1 shall be (1) have the right to be informed about the content and modalities of social assistance measures and actions.
(3) Entitlement to social assistance is granted on request or ex officio, as the case may be, in accordance with the law.

cannot take place at home or in community day centres.

As for the people with whom the CLR representatives spoke, a considerable number of them said that they did not know why they were living in this centre, that they would like to leave, to live somewhere else, that they were not asked if they wanted to live in this centre and that they were not offered several options to choose from. Moreover, the discussions with the "Armonia" Centre's employees and with the head of the adults with disabilities service, hypothesized that most of the residents are homeless or either from closed foster homes or have become "social cases" in psychiatric hospitals (people who have been involuntarily hospitalized for years without a court order).

According to the information received, the procedure by which the beneficiaries arrived in the respective centres was non-transparent and involved either: (i) moving patients admitted to psychiatric hospitals to the respective care and assistance centres or (ii) moving beneficiaries from other centres to the respective care and assistance centres visited, for various reasons - reorganisation, closure, etc.

We have not identified in Law No 96/2006 or Law No 487/2002 any procedure allowing the transfer of patients from psychiatric hospitals to centres providing social services. We do not know the procedure by which these patients ended up being transferred to the centres we visited and how the responsible persons determined the centres to which transfer is appropriate.

However, what we found from discussions with some residents was that their admission to those centres was made in disregard of the principles listed above, according to which:

- admission to such centres is only possible if assistance and care cannot be provided at home or in community day centres;
- the provision of social services is done taking into account the principle of self-determination;
- the delivery of social services is based on an individual approach, meaning that the measures taken must be tailored to the particular life situation of each individual;
- the provision of social services shall respect the right to free choice of the service provider.

Specifically, residents were only told that they would be moved (either from other centres or from psychiatric hospitals, depending on where they were at the time), being told where they were going and being transported to their allocated centre, without involving them in any way in the choice of where they would live.

Moreover, we do not know the procedure by which the responsible authorities came to purchase the social services provided by the provider in question, nor the contracts concluded by the social service providers with the responsible authorities, although such contracts should have been concluded in accordance with the provisions of Law No 98/2016 and the procedures should have been public on the Electronic Public Procurement System.

As such, given that we did not identify the incidental procurement procedures underlying the admission of beneficiaries to the three centres visited and did not have access to the tender documentation which

formed the basis of the purchase of these services, we were also unable to identify the reasons why the authorities responsible for the care and protection of these beneficiaries considered that they needed social services provided in care and assistance centres.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	MINISTERUL MUNCII ŞI SOLIDARITĂŢII SOCIALE																	
2	© DIRECŢIA POLITICI SERVICII SOCIALE																	
3	SERVICII SOCIALE LICENŢIATE ÎN BAZA LEGII 197/2012 - 09 decembrie 2022																	
4	Nr. crt.	Publi c/ Priva	CUI furnizor	Tip furni zor	Denumire Furnizor	Judeţ furniz or	Denumire serviciu social	Cod serviciu social	Tip serviciu social	Adresa serviciu social	Cod Siruta	Localita te /sector	Judeţ serviciu	Mediu de rezidenţă	Capacit ate/ nr. benef.	Data licenţă provizorie	Data licenţa de funcţionare pe termen de	Numar si se licenţa de funcţionare /ra
3332	3.328	Privat	35088499	4	Asociaţia Pentru Evoluţie - Rotas	Ilfov	Centrul de zi Rotas	8891 CZ-C-II	Centre de zi pentru copii: copii în familie, copii aşezaţi sau în stare de urgenţă de plasaj	str. 1 Decembrie, nr. 1	105570	Tunari	Ilfov	Rural	30	25.03.2020	19.03.2021	000805/L
3333	3.329	Privat	33569810	4	Asociaţia Pentru Îngrijirea şi Recuperarea Vârstnicilor Ariminia	Ilfov	Cămin vârstnici Ariminia - casa Clinceni	8730 CR-V-I	Centre rezidenţiale de îngrijire şi asistenţă pentru persoane vârstnice	sat Clinceni str. Monumentul eroilor	102035	Clinceni	Ilfov	Rural	35	14.02.2020	10.11.2020	LF/000913
3334	3.330	Privat	8724211	4	Asociaţia Prietenia	Ilfov	Locuinţă Maxim Protejată pentru Persoane Adulte cu Dizabilităţi Casa	8790 CR-D-VII	Centre rezidenţiale pentru persoane adulte cu dizabilităţi	str.Sf.Gheorghe, nr.46	179515	Panteli mon	Ilfov	Urban	10	24.11.2021	06.09.2022	LF/000014
3335	3.331	Privat	8724211	4	Asociaţia Prietenia	Ilfov	Centrul de Zi pentru Persoane Adulte cu Dizabilităţi Prietenia Pantelimon	8899 CZ-D-I	Centre de zi pentru persoane adulte cu dizabilităţi	str.Sf.Gheorghe, nr.46	179515	Panteli mon	Ilfov	Urban	18	05.02.2016	16.12.2016	LF/000519
3336	3.332	Privat	32683874	4	Asociaţia Printre Oameni	Ilfov	Centrul Venus	8730 CR-V-I	Centre rezidenţiale de îngrijire şi asistenţă pentru persoane vârstnice	str. Răscoala din 1907, nr. 39	179515	Panteli mon	Ilfov	Urban	14	16.10.2020	02.11.2021	LF/001017
3337	3.333	Privat	43637547	4	Asociaţia Sf. Gabriel cel Viteaz	Ilfov	Centrul de Îngrijire şi Asistenţă "Sfântul Gabriel cel Viteaz"	8790 CR-D-I	Centre rezidenţiale pentru persoane adulte cu dizabilităţi	str.Ştefan cel Mare, nr.38	179551	Volunta ri	Ilfov	Urban	30	14.07.2021	07.07.2022	LF/000009
3338	3.334	Privat	43637547	4	Asociaţia Sf. Gabriel cel Viteaz	Ilfov	Centrul de Îngrijire şi Asistenţă pentru Persoane Adulte cu Dizabilităţi "Armonia"	8790 CR-D-I	Centre rezidenţiale pentru persoane adulte cu dizabilităţi	Şoseaua Bucureşti-Urziceni nr.36A	100834	Afumaţi	Ilfov	Rural	50	12.07.2022		
3339	3.335	Privat	34618384	4	Asociaţia Sfântul Irineu	Ilfov	Căminul de bătrâni Sfântul Irineu	8730 CR-V-I	Centre rezidenţiale de îngrijire şi asistenţă pentru persoane vârstnice	str. Răscoalei, nr. 5	179515	Panteli mon	Ilfov	Urban	49	28.11.2016	05.09.2017	LF/000820
3340	3.336	Privat	29937417	4	Asociaţia Sora Med	Ilfov	Centrul rezidenţial de îngrijire şi asistenţă persoane dependente Sfântul	8790 CR-PD-I	Centre rezidenţiale de îngrijire şi asistenţă pentru alte categorii de persoane în situaţii de dependenţă	str. Drumul Becheanului, nr. 65	179551	Volunta ri	Ilfov	Urban	30	07.03.2022		
3341	3.337	Privat	41747411	4	Asociaţia Spune Da Vieţii	Ilfov	Centrul Autism Steb by Step	8891 CZ-C-III	Centre de zi pentru copii: copii în familie, copii aşezaţi sau în stare de urgenţă de plasaj	Şos. Olteniţei, nr. 40-44	179178	Sector 4	Bucureş ti	Urban	20	09.02.2022		
3342	3.338	Privat	28901016	4	Asociaţia Şansa Ta	Ilfov	Cantina socială	8899 CPDH-I	Centre de programare şi distribuire a hranei pentru persoane în stare de nevoie	Calea Griviţei, nr. 355 - 357	179141	Sector 1	Bucureş ti	Urban	450	05.01.2021	11.03.2021	LF/001019
3343	3.339	Privat	28901016	4	Asociaţia Şansa Ta	Ilfov	Centrul de zi pentru copii "Şansa ta"	8891 CZ-C-II	Centre de zi pentru copii: copii în familie, copii aşezaţi sau în stare de urgenţă de plasaj	str. Datinilor, nr. 212, sat Bilciuresti	66401	Bilciureş	Dâmbo vita	Rural	25	06.11.2019	09.11.2021	0001357/L
3344	3.340	Privat	45164542	4	Asociaţia Tibes Îngrijiri la Domiciliu	Ilfov	Unitate de îngrijire la domiciliu a persoanelor vârstnice	8810 ID-I	Servicii de îngrijire la domiciliu pentru persoane vârstnice, persoane cu dizabilităţi, persoane aflate în	str. Mr. Ion Racoţeanu, nr. 6,	179169	Sector 3	Bucureş ti	Urban	25/zi	23.02.2022		
3345	3.341	Privat	45164542	4	Asociaţia Tibes Îngrijiri la Domiciliu	Ilfov	Serviciul Social de Îngrijiri la domiciliu pentru persoane adulte cu dizabilităţi	8810 ID-III	Servicii de îngrijire la domiciliu pentru persoane vârstnice, persoane cu dizabilităţi, persoane aflate în	str.Mr.Ion Racoţeanu, nr.6, et.1,	179169	Sector 3	Bucureş ti	Urban	25	31.03.2022		
3346	3.342	Privat	37166992	8	Balkan Medchim S.R.L.	Ilfov	Căminul pentru persoane vârstnice Raiul Bunicilor	8730 CR-V-I	Centre rezidenţiale de îngrijire şi asistenţă pentru persoane vârstnice	str. Câmpului nr. 23	105570	Tunari	Ilfov	Rural	38	12.12.2019	18.06.2020	LF/000911

"Armonia" Care and Assistance Centre for Adults with Disabilities and "Sfântul Gabriel cel Viteaz" Care and Assistance Centre for Adults with Disabilities apparently have the same management. As mentioned in the report of the "Sfântul Gabriel cel Viteaz" Centre, on leaving the centre, CLR spoke on the phone with the management of the centre, Mr Godei Ștefan Cristian. The CLR representative provided him with information regarding the legal framework for conducting unannounced monitoring visits and the main observations and recommendations resulting from the visit. The discussion was conducted on amicable terms. Subsequently, in the afternoon of the same day, after entering the courtyard of the "Armonia" Centre, the same gentleman came in showing aggressive and intimidating behaviour, using a raised tone to ask CLR to leave the premises on the grounds that "there is no legal protocol in force". Therefore, the same person who in the morning understood what the activity of CLR consists of, after arriving in the "Armonia" Centre was disturbed by the activity, threatening that he is in direct contact with the legal department of the Ministry of Labour and Social Solidarity and that he is advised by "*the best social worker in the field, award winner of the National College of Social Workers*", Mr. George Pleșa, coordinator of a private care company.

CLR explained and presented the documents in force and requested a discussion with Mr George Pleșa. He used a suburban language, mentioning his contacts in the ministry and that he is an advisor in the field of accreditation and licensing of social services for persons with disabilities or for home care.

Following the discussions with Mr Godei and Mr Pleșa, CLR requested the assistance of a police team on 112. The police crew present on the spot indicated that the situation was not new and that several requests had been sent regarding the treatment and living conditions that the residents of the Armonia Centre complained were inadequate.

On 01.11.2022 the second visit of the "Armonia" Centre took place, since on the visit of 07.09.2022 the CLR representatives were not allowed access to the premises and were not able to carry out the monitoring visit in accordance with the law. On the occasion of this visit too, on 01.11.2022, police support was needed to

enter the space. When the CLR representatives arrived at the gate of the "Armonia" Centre, they were met by Mrs. Claudia Costescu, who is the medical assistant of the centre and who told us that she is not allowed to receive anyone in the centre, except the legal guardians of the residents, if they can prove with documents their quality. In the presence of the CLR representatives, she spoke by phone with the head of the centre who told her that it is not possible for the CLR to visit the centre. This was the reason why one of the CLR representatives requested the help of a police crew on 112. After the arrival of the police crew and after explaining the quality in which CLR has the right to carry out monitoring visits including in the "Armonia" Centre, the social worker and the psychologist arrived, we were allowed to enter the centre and we were given some of the requested documents, in the form in which they were found.

10. In the **"Armonia" Care and Assistance Centre for Adults with Disabilities,** complaints were received that the head of the centre is holding them sequestered against their will. Although on our first visit, on 07.09.2022, we were not able to visit the institution carefully, as we were prevented by the management of the association accredited to provide the relevant social service, from the information received from the people in the yard of the centre, some of them did not want to live in the centre, they were not given consent to be brought to the said centre, nor were they given further information about their stay. Although - at the first visit, the CLR representatives communicated that the monitoring is carried out in accordance with art. 4, letter i) of the Law no. 8/2016, they were denied access to the centre, remaining in the courtyard of the centre until the arrival of the police team that intervened following the referrals made by both the CLR representative and the representative of the association (social service provider). Even after the arrival of the police team it was not possible to carry out the monitoring visit, but the police officers recorded the complaints of the residents who stated that they did not want to live in the centre and that they wanted to leave the centre but were not allowed to do so.

On the occasion of the second visit, on 01.11.2022, the CLR representatives were able to observe the living conditions of the residents and to talk to some of them. There was a strong smell of faeces and urine throughout the centre. **We met a resident who was sleeping on a metal bed on which there was only a mattress, no linen, no pillow, covered only with a blanket. The clothes she was dressed in were dirty and looked worn. Both the mattress and the blanket were dirty, having including small, brownish stains (possibly blood stains from bedbug bites, the whole centre being infested with these parasites).** From the discussion with this resident, since she was brought to the centre, she has been subjected to methods of restraint that were not ordered in accordance with legal procedures.

As we will detail in the next chapter, the living conditions in the "Armonia" Centre are degrading, since the residents live in unsanitized, vermin-infested spaces, with only two bathrooms available in the two floors of the centre, which were extremely dirty and did not appear to have functioning sanitary facilities (a shower tub with a hose coming out of the wall) and in which all residents were supposed to wash themselves, with no personal hygiene products available to each resident (such as toilet paper, towels, soap, shampoo, etc.).

Noting the living conditions of the residents of the "Armonia" Centre, one of the CLR representatives contacted DGASPC Ilfov, requesting that the person responsible for the residents of the "Armonia" Centre come on site to verify their situation. On this occasion, Mr. Răzvan Țicu, Head of Service - Adults with Disabilities, case manager for the whole Ilfov county, came around noon and after visiting the centre, he told us that he does not consider that the things we have reported are serious violations of the rights of the residents, while he appreciates that the situation in this centre is preferable to living on the street, especially since the beneficiaries have mental disorders and have no other options. We do not know the institution's official view on this issue. Mr. Țicu also told us that although he is officially in charge of the situation of the persons in question, he does not know what the procedure is for allocating the persons to the centres, whether it is a public procurement procedure or the method of concluding the service contract between DGASPC Ilfov and "Armonia" Centre.

In **"Armonia" Care and Assistance Centre for Adults with Disabilities** it seems that there have been several deaths, but we were not given a clear number of deaths and a record of the causes that led to those deaths. The existence of these deaths resulted from the discussion with the nurse, Mrs. Claudia Costescu, who told us that she has been working in this centre for about 1 year, and only in this period there have been about 8 deaths as far as she can remember, the most recent being that of a 37 years old young man (who died on 24.10.2022). On asking for further information about this case and the procedure initiated following the death, we were told that it had been taken over by the family for burial and that the representatives of the centre did not consider it necessary to refer the matter to the competent authorities although the causes of

the death of this young man are not certain. When we asked the social worker for the centre's death register, we found that the death had not been registered at that time, although about a week had passed. On this occasion we asked for information about the other deaths and were told that they had not taken place at the "Armonia" Centre, but at the "Casa Bunicilor" Nursing Home for Elderly. Thus, from the information received, it would appear that two different social services were operating or are still operating on the same premises. With regard to the "Casa Bunicilor" Nursing Home for Elderly, it is mentioned in the register "Nursing Homes for Elderly licensed on 26.07.2021 (social service code 8730 CR-V-I)"[3] , as having an operating licence from 2021, valid for 5 years[4] , but we do not know whether this social service provider is still operating in this premises or not. However, the essential point is the considerable number of deaths that have occurred in this centre and the fact that, from the information received, it does not appear that the competent authorities have been notified, even though the causes of the deaths required notification.

CLR reiterates its view that, as with other institutions where persons may be deprived of their liberty by a public authority, when a resident of a social care centre dies unexpectedly, an autopsy should be performed, unless a medical authority independent of the institution indicates that an autopsy is not necessary. Moreover, when a resident of a social care centre dies after being hospitalized in an external medical facility, the clinical causes of death (and, if an autopsy is performed, its findings) should be systematically reported to the social care residential centre.

CLR requests ANPDPD to take the necessary steps - including at legislative level - to ensure that whenever a resident dies in a social care unit or, following a transfer from a social care unit, in a hospital:

- death is promptly certified by a physician based on the patient's medical history, the circumstances of death and a physical examination;
- an autopsy is performed, unless a physician has established a clear diagnosis of illness prior to death and if the illness resulted in death. To prevent any potential conflict of interest, this assessment should be carried out by a medical authority independent of the social care institution;
- each time an autopsy is carried out, its findings are systematically communicated to the management of the social care unit to determine whether there are any lessons to be learned in terms of operational procedures;
- a record of the clinical causes of death of residents is kept at the social care unit.

In addition, when a resident dies in suspicious circumstances or as a result of injury, the relevant investigating institutions must always be informed (public prosecutor's office, police).

[3] Available at URL: http://mmuncii.ro/j33/images/Documente/Familie/26072021_Camine_persoane_varstnice.pdf
[4] Licence No LF/0009143 of 01.02.2021;

As regards the many deaths that were not recorded in writing, but which occurred in the centres for persons with disabilities, from discussions with the staff, the CLR representatives found that they not only did not follow the procedure[5] , but were not even aware of it.

"(2) A forensic autopsy of the corpse shall be carried out at the request of the judicial authorities, only by the forensic pathologist, and shall be mandatory in the following cases:
1. violent death, even when there is a certain period between the causative events and death;
2. the cause of death is unknown;
3. the cause of death is suspicious. A death is considered suspicious in the following situations: [...]
d) death occurring in custody, such as deaths of persons in detention or deprived of their liberty, deaths in psychiatric hospitals, deaths in prison hospitals, in prison or in police custody, deaths associated with police or military activities where the death occurs during public demonstrations, or any death raising suspicion of a failure to respect human rights, such as suspicion of torture or any other form of violent or inhuman treatment;
e) multiple serial or concurrent deaths; [...]
(3) Autopsy of the corpse or parts of the corpse or skeletal parts shall be carried out only if the forensic authorities provide the forensic pathologist:
a) the prosecutor's order or the court's conclusion to carry out the autopsy, containing the objectives of the autopsy;
b) the on-the-spot investigation report;
c) a copy of the complete clinical observation sheet in the case of persons who died during hospitalization."

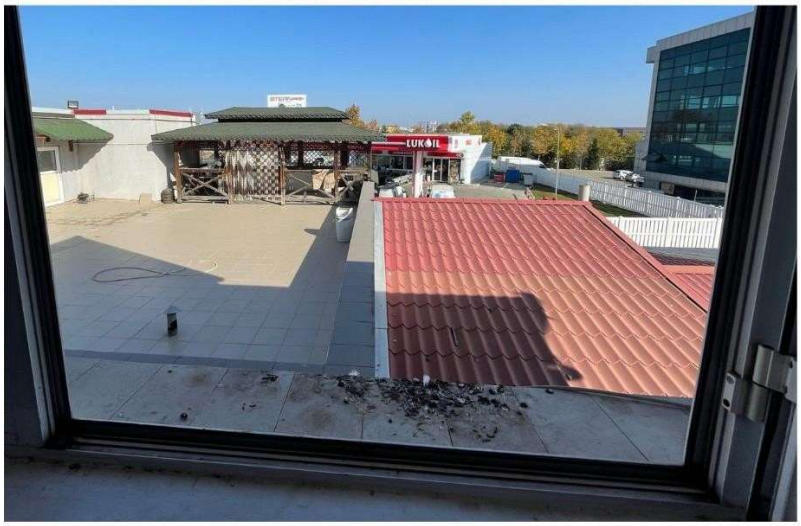
In the context, it was found that although there were several residents who died in the centres for people with intellectual and psychosocial disabilities, the registers had no records, the criminal investigation authorities were not notified and, as a consequence, no investigation was carried out because, according to those "responsible", there was no case of "suspicious death".

A similar situation was in the ECHR case "CLR on behalf of Mr V. Câmpeanu v. Romania", a case in which the Centre for Legal Resources was recognized as an active party in the representation of vulnerable persons without a representative, Romania being condemned in 2014 by the judges of the Grand Chamber of the ECHR for violation of Articles 2, 3 and 13 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, namely: the right to life (Art. 2), the fact that no one cannot be subjected to torture or to inhuman or degrading treatment or punishment (art. 3) and that everyone [...] has the right to an effective remedy before a national court, even when the violation is allegedly committed by persons acting in an official capacity (art. 13).

11. Living conditions in the "Armonia" Centre.

The building in which the centre operates consists of a ground floor and two upper floors; the access to the upper floors is via a narrow staircase on the outside of the building; the specialist staff office can only be accessed via the courtyard at the back of the house if the gate leading to it is not locked. Apparently, the building "hidden" behind 2.5m-high fences and storage rooms looks like an unfinished construction, located somewhere on the edge of a dirt road outside Afumați, Ilfov. A heavily trafficked and polluted area. There is no indication that in the courtyard next to the petrol station, at the exit of Afumați commune, more than 30 people are locked up.

[5] governed by the provisions of Article 34 of the Procedural Rules of 25 May 2000 on the performance of expert opinions, findings and other forensic work to Order No 1134/C of 25 May 2000 approving the Procedural Rules on carrying out expert opinions, findings and other forensic work



1. Yard
2. View from the centre
3. Storage space in the front yard
4. Two residents in the front yard

The courtyard behind the centre, a former orchard, was unkempt, dirty, with dirty mattresses and various debris thrown on the ground. We did not meet any residents in that yard. Most were sitting on old pieces of furniture (leather sofas) in the cement-lined courtyard at the entrance to the building.

At the entrance to the premises, on the ground floor, on the left is the kitchen, on the right is a doctor's office, in front is a large hallway of approx. 150 sqm, where meals are served. In the same space, on the day of the November visit, an elderly and apparently immobilized resident was lying on a leather sofa. CLR asked the staff why she was not admitted to the hospital, and the staff's response was "*the family doesn't want this and brought her here*". Also on the ground floor were other elderly people who were immobilized. The entire ground floor area is under video surveillance. At the back of this hallway are further bedrooms, two bathrooms and a storeroom with food (on the day of the visit there were two bags of onions and potatoes).

Initially, despite CLR's insistence, the door to the room where the kitchen was located was not opened. The reason given was that the key was missing. We insisted to see the room also because the CLR received information that food is prepared there for the "Armonia" Centre, but also for the „Sf. Gabriel cel Viteaz" Centre. Although the mealtime had passed, the residents were not getting food because the CLR team was present in front of that premises. Immediately after the CLR entered the social worker's office, two pots with at least 40 litres of soup "appeared" on the floor in the hallway. The employees reasoned that this had been brought by the catering company with which they have a contract. According to the contract, the food had to be delivered by 12.30 pm. Yet, several people in the centre confirmed that food was being prepared in that kitchen, but that because of the mess and unkempt space, CLR's access was restricted.

However, there was food in the fridge (frankfurters, eggs), packages of meat in the freezer and bags of potatoes and onions in the pantry. Asking who all the food in the kitchen and pantry was for, the CLR representatives received equivocal answers - either that it belonged to the employees, who were cooking just for themselves in the centre, or that it belonged to one of them and they just stored it there.

The kitchen was unsanitary, with grease stains, mould and a strong smell of rotten food. On the two floors there were several bedrooms with 3-5 metal-framed beds, dirty and old mattresses, some rooms poorly lit, beds close together, no storage space, toilets in the hallway not working, beds covered with dirty sheets. Residents did not have their own storage space for personal belongings. Hallways and rooms were tiled.

On the walls of the rooms, the sheets on the beds, mattresses and pillows - there were traces of blood and bedbugs. CLR indicated this infestation directly to the representative of the DGASPC Ilfov and the employees of the "Armonia" Centre. They admitted that the situation was known but pointed out that DGASPC Ilfov was aware of the lack of financial funds to pay for the services.

At the back of the building there is a small undeveloped garden and the office for the administrative staff. This area is separated from the front courtyard by a metal gate, so residents do not have easy access to the administrative staff offices.

Both in the courtyard and inside the centre a disgusting smell of urine was prevalent and permeated everywhere inside, smelling of food as well, the kitchen being located immediately to the left of the main entrance, the rest of the ground floor being occupied by a large dining room and an area (on the right side of the room) where there were sofas and a TV.

Two toilets are open to access on the 1st floor and 2 disused bathrooms on the 2nd floor. Actually, all residents could only use the 2 existing bathrooms on the 1st floor, one of which had a bathtub and the other a shower (which was actually a hose coming out of the wall), both bathrooms being in an advanced state of disrepair, showing damp, mould, plumbing unfit for use and insufficient for the number of residents they were supposed to serve. On the ground floor, next to the dining room, there was also a service toilet, but it was not working properly, so that it could not be cleaned after each use, the staff brought a container of water from the hallway for sanitation.

In the hallway on the first floor there was a closet with clothes that looked dirty hanging out of the closet. Regarding the lack of hygiene products, the centre's employees told us that they are available on request. Beyond the fact that access to such things should be unrestricted, as long as they concern basic needs, however, we have not identified a place where they exist and are sufficient for each resident. Although most of the residents presented an unkempt posture, dress and appearance, in the files presented by the social worker who came later to the centre, it appears that almost weekly the residents received sanitation procedures such as haircuts, nail trimming, even dyeing (although on the spot, only one of the residents was dyed - although with a manly haircut - being in fact the resident who complained about non-compliance, abuse and forced internment in that centre).

All the rooms were contaminated with bedbugs, and considering the degree of infestation, it could be concluded that the problem was an old and unresolved one. The existence of this contamination was also confirmed by the nurse, but also by the head of the centre, who justified himself using the lack of funds, namely that DGASPC Ilfov, with which the centre has a contract for the provision of social services, has not paid the bills for about 6 months.

All the residents looked unkempt, sad and those who could communicate told the CLR team that they wanted to leave the "Armonia" Centre as soon as possible. CLR informed the management of the DGASPC Ilfov that since September 2022 it had written to them that one of the residents wanted to be let out of the "Armonia" Centre. The young woman filed a complaint both with the DGASPC Ilfov and the police. The DGASPC Ilfov representative replied that she could not be allowed to leave and that they did not reply because "she will stay there anyway".

12. Staff and resident care

According to the provisions of Annex No. 1 to Order No. 82/2019, the social service provider must draw up the Annual Training and Education Plan for the staff employed and also keep the Register of Continuous Staff Development in which staff training sessions will be recorded. According to the above-mentioned Annex, depending on the activities in which the beneficiaries should be involved, the social service provider should have employed and trained staff who are responsible for the following activities:

- psychological counselling - the staff involved may be psychologists/psychotherapists;
- information and social counselling activities - the staff involved may be social workers;
- habilitation and rehabilitation activities - staff involved may be speech therapist, physiotherapist, physiotherapist, masseur, rehabilitation teacher, occupational therapist, technician for assessment, referral, provision and adaptation of wheelchairs, occupational therapy instructor, education instructor, social worker, nurse, other therapists;
- care and support activities - staff involved may be social workers, nurses, social pedagogues, rehabilitation pedagogues, occupational therapy instructors, other therapists;
- cognitive skills development/maintenance activities - staff involved may be psychologist, psychotherapist, speech therapist, occupational therapist, rehabilitation teacher, social teacher, education instructor, occupational therapy instructor, other therapists;
- activities to maintain/develop daily living skills - staff involved may be psychologist, psychotherapist, occupational therapist, rehabilitation teacher, social teacher, social worker, occupational therapy instructor, education instructor, other therapists;
- activities to maintain/develop communication skills - staff involved may be psychologist, psychotherapist, speech therapist, occupational therapist, rehabilitation teacher, social worker, education instructor, occupational therapy instructor, social worker, other therapists;
- activities to maintain/develop mobility skills - staff involved may be a doctor, occupational therapist, physiotherapist, physiokinetic therapist, masseur, rehabilitation teacher, occupational therapy instructor, social teacher, social worker, other therapists;
- activities to maintain/develop self-care skills - staff involved may be occupational therapists, physiotherapists, physiokinetic therapists, rehabilitation teachers, occupational therapy instructors, nurses, social workers, social pedagogues, other therapists;
- activities to maintain/develop skills for caring of own health - staff involved may be a doctor, nurse, psychologist, psychotherapist, occupational therapist, social worker, social teacher, occupational therapy instructor, other therapists;
- activities to develop/strengthen self-management skills - staff involved may be psychologist, psychotherapist, occupational therapist, rehabilitation teacher, social teacher, social worker, nurse, education instructor, occupational therapy instructor, other therapists;
- activities to develop/strengthen interaction skills - staff involved may be psychologist, psychotherapist, speech therapist, occupational therapist, rehabilitation teacher, social worker, education trainer, other therapists.
- activities to improve work education/readiness - staff involved may be psychologist, psychotherapist, occupational therapist, social worker, vocational guidance counsellor, supported employment specialist, vocational assessment specialist, vocational counsellor, social worker, rehabilitation teacher, social teacher, education instructor, occupational therapy instructor, other therapists;
- actions related to decision support can be - the staff involved can be a legal adviser, a lawyer, a social worker, a psychologist, a vocational counsellor, a psychiatric doctor, other specialists as appropriate;
- social and civic integration and participation activities - the staff involved can be social worker, social work technician, social worker, psychologist, psychotherapist, occupational therapist, physiotherapist, physiokinetic therapist, rehabilitation teacher, social teacher, occupational therapy instructor, education instructor, art therapist, educational animator, other therapists.

As can be seen, in the centres visited there should have been staff responsible for at least all the above activities. However:

- In the **"Armonia" Centre** we have identified only **3 caregivers or nurses and 1 medical assistant, these people are responsible for the 32 residents;**
- Moreover, as we have previously indicated, taking into account that this centre institutionalised elderly and persons with disabilities, we consider that this centre should have complied with all the requirements of Annex No. 1 of Order No. 82/2019 and should have been properly licensed in order to properly care for and assist beneficiaries with disabilities.

- Although, as mentioned above, at the time of our first visit to the "Armonia" Care and Assistance Centre for Adults with Disabilities we were not able to obtain sufficient information, we would like to point out that at the time of our visit there was only one person in the centre, responsible for all the approximately 32 beneficiaries, who was also in charge of cleaning the dining room (we did not identify the position held).
- At the second visit, on 01.11.2022, when the CLR representatives arrived, only the nurse, a female caregiver and the same male person from the first visit were present (we still do not know the position he held or his duties). After the arrival of the police team, the second nurse, the social worker, the psychologist and a male person who seemed to have administrative duties, but who also brought lunch for the residents and who also had keys to the locked premises, arrived (we do not know his position or duties - but from the information gathered on the spot, he seems to be related to the centre's administrator, i.e. his brother). After lunch, the administrator of the association, Mr. Stefan Godei, also came and explained to us that the situation we found is due to the fact that for more than 6 months, DGASPC Ilfov has not paid the invoices representing the allowances due for each beneficiary for which this institution is responsible.

From what was found, it did not appear that there would be sufficient staff or that they would be adequately trained to manage the needs of beneficiaries.

With regard to the social worker, we would like to point out that based on the information gathered on the spot, it turned out that Mrs. Ramona Nicolae works both as a social worker in the "Armonia" Centre and as a social worker in the Centre for Emergency Intervention in the field of social assistance, situations of abuse, neglect, trafficking, migration, repatriation, domestic violence and the DGASPC Ilfov social helpline[6] , information confirmed by her during the visit. However, she told us that she does not consider herself to be in any situation of incompatibility or conflict of interest, although the Code of Conduct of the DGAPSC Ilfov institution indicates the contrary[7] . Moreover, during the visit we also found out that, although the door to the administrative space intended for staff "offices" said that the program is daily from 16 to 18, the residents of the centre and the nurse confirmed that the social worker does not come every day to the centre, and even "if she arrives, this happens more on weekends". Regarding the care of the residents, it was also noted that with only one nurse, on days when the nurse is on leave, or after she finishes working there is no other nurse or medical staff to take her place or to provide medical services for the residents. In the event that one of them needs medical assistance, in the absence of the medical staff in the centre, "they call the ambulance and we take them to Bălăceanca".

Regarding care services, in all the centres visited, despite the insistence of the CLR representatives to receive adequate information, the only data were those recorded in writing, in the "Armonia" centre each resident having a detailed sheet with the services they receive, namely personal hygiene,

[6] URL: https://protectiacopilului.ro/wp-content/uploads/2016/01/Rezultatul-selectiei-dosarelor-concurs-30.07.2019.pdf
[7] URL: https://protectiacopilului.ro/wp-content/uploads/2016/01/COD-ETICA-2020-D.G.A.S.P.C.-ILFOV.pdf

clothing hygiene, haircuts, hair dyeing, nail trimming, although it was clear from the on-site findings that these services were only provided to residents in writing.

In terms of the **daily regime**, there was no evidence of a range of occupational and recreational activities offered to residents. The staff submitted several reports which showed that residents had carried out activities such as going to the market to buy seasonal fruit and vegetables, although in fact residents complained that they were forbidden to leave the centre.

CLR observed that residents were not encouraged to participate in activities, there was nothing structured, and any activities did not follow any resocialisation plan. Indeed, the main part of the activity seemed to be sitting in the yard or in bed.

Also in this centre run by the same provider, the main focus seemed to be on isolation, maintaining order and trying to meet only the basic needs of the residents at a minimum level. The situation had been aggravated by the fact that, although there were no restrictions on daily outdoor exercise within the premises, there were no opportunities to go out to the market, the shop, the street, parks or recreational trips outside the centres. In the two centres, the majority of residents spent much of their days subject to a rigid regime that made them sit on old furniture in the courtyard (Afumați), crowded, noisy, watching a television mounted high on the wall, close to the ceiling, rather than engaging in any meaningful activity.

In the centres visited, there were no multidisciplinary teams that had drawn up an individual needs assessment and individual support plans for each resident. Apparently, these assessments and individual plans were generally updated annually and in a 'copy and paste' manner by the DGAPSC case manager.

Existing arrangements for contact with the outside world were generally unsatisfactory in this centre. Residents are unable to keep in touch with people outside, most of them being unable to access mobile phones or the internet.

Mechanisms for complaints and the provision of information on residents' rights were lacking also in this centre. Residents told us that they did not have access to internet, telephone, paper and writing tools to make claims/complaints, we did not identify any registers in which complaints made by residents were documented. They also told us that they are not provided with a telephone to use as needed.

As we have already mentioned, during the first visit to the "Armonia" Centre, one of the residents made a request to DGASPC Ilfov stating that she no longer wished to live there, that she had been brought to Armonia without being consulted beforehand and that she would like to receive other social services adapted to her needs. At the second visit we asked the social worker for information about the status of the complaint, whether it had been resolved and how, and we were told that it had been forwarded to DGASPC Ilfov and that it was *in progress*.

In view of the above, during the second visit to the "Armonia" Centre, the CLR representatives witnessed the complainant *being warned by* the nurse that she was responsible for the visit carried out by CLR and that "all this is happening because of you", with the result that the residents were encouraged not to make any complaints or complain about the situation they were in, about the violation of their rights, and in this way their rights were once again clearly violated. Despite the provisions of Subsection 5: Module V - Protection and Rights (Standards 1 - 8) of Order No. 82/2019, not only are residents not informed of their rights and there are no procedures for reporting violations of their rights, but they are discouraged from doing so, a situation that indicates blatant abuse on the part of those responsible for the care of residents.

During the same visit to the "Armonia" centre, another resident asked the CLR representatives for assistance in order to receive the necessary support to return home, since "he arrived and is kept in the CIAPD Armonia against his will". In this regard, the CLR representatives took up the request of the resident in question and forwarded it to the competent institutions, namely: the Ministry of Labour[8] , the National Authority for Persons with Disabilities[9] and the National Agency for Payments and Social Inspection[10] . As a result of the communications made, the Ministry of Labour informed us that the submission address together with the resident's request had been forwarded to the National Authority for Persons with Disabilities for competent resolution, the latter informed us[11] that the guardian's position on the petitioner's request was that "he does not have sufficient income to support himself" - consequently, as the petitioner is placed under interdiction, his guardian would be the only one who could decide on his deinstitutionalisation. On the other hand, the National Agency for Payments and Social Inspection through the Ilfov County Agency for Payments and Social Inspection, by the answer no. 24542 of 17.11.2022, communicated that although a control action was carried out at the "Armonia" Centre, only "a sample of eligible beneficiaries" was selected and satisfaction questionnaires were applied to them. Extremely important is the fact that from this "sample" were excluded "beneficiaries who have a guardian" without being explained to us or understanding a real reason for their exclusion (in concrete terms we do not understand the reason why these residents could not express their level of satisfaction, or, moreover, "the forms of abuse or exploitation to which they may be subjected" could not be identified). With regard to the petition of the resident in question, ANPIS representatives through AJPIS Ilfov "ascertained" that he was "placed under interdiction", which is why he could not be part of the sample of eligible persons. We stress that such an approach cannot be accepted under any circumstances, in this sense, the authority responsible for respecting the rights of persons with disabilities, doing nothing but restricting any kind of access to their control bodies, fuelling abuses and forms of exploitation. At the same time, the reply in question also referred to an earlier petition from the resident to whom the nurse had drawn attention. Thus, the representatives of AJPIS Ilfov, noting that the resident "promises not to jump again the fence of the centre where she was" and that "the beneficiary oscillates in her statements" without understanding, however, in concrete terms, the

[8]Registered as received 24929/RG/07.11.2022
[9] Registered as received 221107-019184
[10] Registered as received 10583/07.11.2022
[11]By address not registration number 17419/ANPDPD/SJCLA/23.11.2022

relevance of these findings to the resident's express request, or whether or not she received an answer - but only that "it was ordered that they be informed of the resolution of the beneficiary's request".

In this context, by reference to the provisions of Art. 6 para. (3) letters c)-h) of GEO 113/2011 of 21 December 2011 on the organization and functioning of the National Agency for Social Payments and Inspection, the institution in question should have been in charge of everything that means carrying out controls and checks so that the rights of persons with disabilities are respected, to be actively involved in campaigns to prevent abuses against them and to sanction any deviation, instead of encouraging inappropriate behaviour of the centres where these persons are interned.

> **c)** *c) propose to the inspected institutions to take legal measures to* ***remedy the shortcomings*** *found as a result of the inspection activity, to* ***establish the legal liability of the persons responsible*** *and* ***refers the matter to the competent prosecution authorities****. [...]*
>
> *d)* ***finds that acts which violate the legal provisions*** *laid down in all the normative acts governing the national social assistance system* ***have been committed*** *and applies the contraventional sanctions provided for therein;*
>
> *e)* ***exercises control in order to prevent, discover and combat any acts and facts in the national social assistance system that have led to the violation of the citizen's social rights****;*
>
> *e^1) carries out* ***social investigation*** *activities on the* ***provision of social services****, the granting of social assistance benefits, the way of compliance with the legal provisions on the classification of the degree and type of disability, degree of invalidity or degree of dependency, in order to identify possible situations of error, fraud, abuse and negligence in the social protection system and transmits to the competent bodies the evidence and information resulting from the checks carried out, for the purpose of criminal investigation, if necessary; [...]*
>
> *g) controls, evaluates and monitors compliance with the legal provisions regarding the* ***fulfilment of the conditions for the accreditation/licensing of social service providers and the services they provide****;*
>
> ***h) controls the way in which the legal provisions on combating social marginalisation are respected and implemented;*** Consequently, by combining the legal provisions on the protection of the rights of persons with disabilities, those on quality assurance of services provided by social service providers and those on evaluation and control authorities, we can clearly see that the best interests of vulnerable persons, their safety and dignity are in fact placed in last place, following (probably) the satisfaction of the material interests of certain people in key positions.

CLR reiterates its view that although some residents have difficulties in understanding and communicating, whenever possible they should be informed of their rights, if necessary, using repeated, simplified and individualised verbal forms. There should also be accessible and understandable complaints systems.

13. Means of containment - restraint and seclusion

One of the residents of the "Armonia" Centre told the CLR team that her arms and legs were tied when she arrived at the centre. The person was visibly affected by the restraint and seclusion measures applied. The person's appearance was unkempt, her hair was cut by a machine (a haircut that all residents had - they were cut by staff with a haircutter - whether they were female or male and without obtaining consent) and she was frightened of what would happen to her if staff found out she was dissatisfied with the "treatment" she receives in this centre.

Most of the residents also complained about the inhuman conditions in which they were accommodated in the psychiatric hospital and in the home in Bălăceanca. DGASPC Ilfov Representatives said that they were aware of these conditions, but that they had not taken steps to report them to the relevant institutions.

Many of the people met by CLR during this visit said that they prefer to live on the street rather than to be locked up in the "Armonia" Centre. CLR referred to the DGASPC Ilfov about the persons' right to choose where, how and with whom they live and that the legislation in force obliges public authorities to support them in the necessary steps and not to lock them up in unhealthy and unworthy conditions.

On the basis of the findings of the CLR representatives on the spot, it can be concluded that what is happening in the "Armonia" Centre is nothing more than a concrete translation of the material element of the objective side of the offence provided for and punished by the provisions of Article 205 of the Criminal Code which regulates "*unlawful deprivation of liberty*", all the more so as we can also discuss punctually about "persons unable to express their will or to defend themselves". The provisions of the Criminal Code in force must be interpreted in accordance with Article 23 of the Romanian Constitution, which guarantees the inviolability of a person's freedom.

14. Placing under restraint, sequestration

The employees did not provide concrete information on the number of people who have a court order of restraint, nor data on guardians or legal representatives. However, whenever CLR referred to the deprivation of liberty of these persons, the employees replied that " the guardians do not let them".

Another general position found in the monitored centres is particularly important (also fed by the position of AJPIS Ilfov - according to the answer no. 24542 of 17.11.2022) according to which even more than half a year after the entry into force of Law 140/2022, representatives of public authorities and private entities do nothing more than claim that "certain beneficiaries are placed under restraint" and therefore they cannot discuss with anyone, they cannot be subject to "eligible interview batches" or any other communicational anomalies that suggest that these persons are nothing but objects, without life, feelings or suffering.

In this context, we would like to inform (even by these means) those who still easily use the notion of "person under restraint by a court order" that **the Constitutional Court's decision of 16 July 2020 declared unconstitutional Article 164 of the Civil Code, which regulated the measure of placing a person under restraint**. The situation of persons who have had their legal capacity (totally or partially) restricted was regulated by Law 140/2022. Thus, within 3 years of the entry into force of the above-mentioned law, all persons who have been placed under restraint will go through the review procedure ex officio or upon request. Consequently, the representatives of the entities in question should once again realise that they are responsible for the lives of citizens with rights.

Requests to the institutions with competence in this area:

1. We request the President of ANPDPD and the Director of ANPIS to verify the legality of the transfer procedures and the presence of persons with intellectual/psychosocial disabilities in the **"Armonia" Care and Assistance Centre for Adults with Disabilities**;

2. We request the Minister of Health to check whether the procedure for maintaining non-voluntary admissions for persons admitted to Bălăceanca Hospital is respected;

3. We request the Director of DGASPC Ilfov to verify the way in which the residents of the **"Armonia" Care and Assistance Centre for Adults with Disabilities** are institutionalized - in view of the suspicions of arbitrary institutionalization and taking into account the Romanian conviction in the case N. v. Romania;

4. We request the Public Ministry to investigate the fact that there are cases of "suspicious deaths" in the Romanian centres, that are not properly recorded and investigated – taking into account Romania's conviction in the case of CLR on behalf of Mr V. Câmpeanu v. Romania;

5. We request the Ministry of Labour and the ANPDPD to make public and transparent the procedures for transferring beneficiaries from one centre to another, the number of beneficiaries in each centre (including centres operating under provisional licence), where the beneficiaries come from and who is responsible for the services provided. We also ask the Ministry of Labour and the Monitoring Board to provide the Public Ministry with data on deaths registered in publicly and/or privately funded private centres (number, causes) as well as data on the number of persons with disabilities institutionalized in centres for the elderly.

Material developed in the framework of the AdaptJust - Accessible Justice for Persons with Disabilities project, implemented by the Centre for Legal Resources in partnership with the Public Prosecutor's Office attached to the High Court of Cassation and Justice, a project that benefits from a grant of € 1,324,994, offered by Iceland, Liechtenstein and Norway through EEA Grants 2014-2021, within the Local Development Programme. The material is made available free of charge and may be distributed with acknowledgement of source. Modification in any way, sale or use of the content for commercial purposes is strictly prohibited. The content does not reflect the official opinion of the Programme Operator, the National Contact Point or the Financial Mechanism Office. The information and opinions expressed are the sole responsibility of the author(s). Working together for an inclusive Europe.