Summary of Case № AJB-4320/2016

On November 10, 2015, the National Preventive Mechanism (NPM) conducted an on-the-spot inspection in the Assisted Living Center for the Elderly in Pécel (the Living Center). The Commissioner for Fundamental Rights had already investigated the Living Center[1], so the conclusions of the earlier report were kept in mind.

The earlier investigation concluded that the Living Center was not suitable for the placement of 75 persons – under the given circumstances, statutory living space could have been provided only for 45 inhabitants. This caused an anomaly related to the patients' right to human dignity. The Commissioner for Fundamental Rights was concerned that neither the director of the institution, nor the patients knew who the patients' rights representative was and how he/she could be reached. The absence of a patients' rights representative and any information on his/her reachability caused an impropriety related to legal certainty and the patients' right to human dignity.

The Ombudsman requested the Head of the General Directorate of Social Affairs and Child Protection (GDSACP) to take the necessary measures to ensure proper placement conditions. He requested the head of the institution to obtain information on the patients' rights representative's reachability.

Between September 7 and 10, 2015, the GDSACP held a supervisory inspection in the Living Center, since it had received complaints from the staff in connection with the management and operation of the Living Center. The supervisory authority's report established that the material conditions of the Living Center (e.g., crowdedness, the dilapidated state of the building) do not meet the statutory requirements. The supervisory authority pointed out that the working environment was tense, which had an adverse effect on the staff's performance and also on the care provided to the patients. The supervisory authority specified the tasks and the deadlines in an action plan.

The Social and Guardianship Authority of the Pest county Government Office (the Guardianship Authority) reduced the Living Center's capacity to 45 patients.

At the time of the NPM's visit, there were 48 patients residing in the Living Center; even so, the living space rate of six square meters per patient could not be ensured. However, as a result of the reduced capacity, the anomaly pointed out by the Commissioner for Fundamental Rights was partially remedied.

The NPM concluded that inaccessibility-related restricted mobility within the Living Center is not the result of the patients' health or physical state, it results from the building's structural features and the failure to perform the necessary maintenance and renovation works – it causes an anomaly related to the right to human dignity.

A community room could not be created in the Living Center, either. According to the Guardianship Authority, the gathering places created in the corridors were not suitable for community activities. The Living Center did not have a room that would be suitable for accepting visitors.

The facts that per capita living space in the rooms is often less than six square meters, that there are more than four inhabitants in the rooms and that there are no special rooms suitable for community activities and receiving visitors in the Living Center constitute an impropriety related to the requirement of legal certainty, deriving from the principle of the rule of law, and to the prohibition of inhuman and degrading treatment.

The supervisory authority's report pointed out that the nurses did not pay due attention to preventing people opening the bathroom's door from having a direct view of the patient being bathed. There were only female nurses working in the Living Center, male patients were also bathed by them. Such bathing practice is prone to induce embarrassment in the patients. The fact that male patients are being bathed by female staff members and the fact that opening the bathroom door gives sight of other patients being in there violate those patients' privacy, thus constitute an impropriety related to the prohibition of degrading treatment.

A sanitary unit had to be closed in the Living Center because it had flooded the rooms beneath. The fact that the statutory number of toilets was not ensured caused an anomaly in connection with the prohibition of degrading treatment.

Patients have to buy themselves toilet paper and diapers. When they run out of toilet paper, the nurses provide them with some. A residential institution shall provide full board services to the

[1] Case № AJB-2015/2014

patients. It does include the provision of appropriate quantities of toilet paper and diapers to the patients. The NPM concluded that the institution's failure to provide the patients with appropriate quantities of toilet paper and diapers as part of the full board service caused an impropriety related to degrading treatment.

The possibility to wash or disinfect one's hands was not ensured in many living rooms, in the dining room and at the nurses' station, which caused an impropriety related to the right to physical and mental health.

There was not a single room in the Living Center that could be used by married couples or life partners. The absence of a conjugal room caused an impropriety related to human dignity.

Several patients thought that the nurses were very busy, that's why they had no time for the patients. There was a case when a patient was punished. Another patient complained of having been locked up at one time. Other patients said that they felt good in the Living Center. According to them, the members of the staff are very nice to them; however, sometimes they get irritated. According to one of the nurses, the patients sometimes quarrel with one another, but relations between the patients and the staff are generally good. The NPM established that the staff's behavior towards the patients was often objectionable, patients did not always receive proper care, corresponding to their condition and needs. The Living Center could not develop a receptive atmosphere, which presented the danger of an impropriety related to the right to human dignity and the right to physical and mental health.

Most of the patients were bored because no programs were organized for them. During the day they watch television, read, smoke and drink coffee. Those who are able go and take a walk in the courtyard. The responsible staff member can engage 2-3 patient at a time. He leads discussions, organizes film screenings and arts and crafts activities. He tries to organize programs outside the Center on a weekly basis. According to the patients, they may leave the Center only infrequently, which makes shopping very difficult. The Living Center cannot always provide an attendant who would accompany the patients to the nearby shop or to take a walk. The lack of assistance to leaving the Living Center caused an impropriety related to the right to freedom of movement and residence.

The NPM concluded that the small number of activities and the lack of cultural and physical activities caused an anomaly in connection with physical and mental health.

The NPM did not find any signs indicative of fundamental-rights-related anomalies in connection with catering. However, he suggested that the energy content of foods should be indicated on the menu.

The name and coordinates of the patients' rights representative were displayed in an easily visible place, thus remedying the impropriety pointed out in an earlier report by the Ombudsman. However, there was no complaint box enabling the patients to lodge their complaints anonymously with the institution's management. Many patients were not familiar with the existence and operation of the interest representation forum. If the interest representation forum operates randomly or the patients are not familiar with its operation, and the complaint mechanism does not have any other efficient means, it jeopardizes the enforcement of the prohibition of inhuman and degrading treatment and carries the risk of an impropriety related to the right to complain.

The employees of the Living Center mentioned that there had been many conflicts between the management and the staff prior to the change on the post of the head of the institution. The previous management had treated the staff rudely, making them feel continuously threatened. The members of the staff concurred that the change on the post of the head of the institution had slightly improved the situation. According to the staff, labor turnover had been high due to the working conditions. Even at the time of the NPM's investigation there were staff members performing their tasks on a temporary basis. The NPM concluded that the bad workplace atmosphere, the contradictory decisions by the management and the resulting uneven performance of the tasks by the staff vis-à-vis the patients caused the imminent danger of an impropriety related to the prohibition of degrading treatment.