

## Summary of Case № AJB-766/2017

The National Preventive Mechanism (hereinafter the “NPM”) made a visit to the Forensic Psychiatric and Mental Institution (hereinafter the “FPMI”) on February 16–18, 2016. The delegation also took into account the conclusions formulated in the CPT’s earlier reports on its visits to Hungary. The visit uncovered several deficiencies. It gives cause for concern that the number of barrier-free showers and restrooms was insufficient, and there was a “barrier-free” restroom where a wheelchair could not fit in. There were mould growths on the showers’ walls, patients had to stand in a line in front of the restrooms in the morning hours, and the hot water supply did not work properly, either.

As a result of the strict ban on smoking, there were no enclosed smoking areas meeting the statutory requirements in the Neuropsychiatric Ward, which made the detainees tense and irritable. In other Wards, the ventilation of the smoking areas was inadequate.

Rooms/cells in the FPMI are, in general, large; among those in use some were even larger than 60 square meters – even those were overcrowded.

There was a shortage of professional staff, i.e., physicians, psychologists and nurses. Due to the inadequate working conditions, staff members face the risk of burn-out. Although staff members attend various professional and internal trainings, there are no trainings on international human rights conventions (OPCAT, CRPD) that have been incorporated into domestic law.

It gives cause for concern that there was a person in misdemeanor detention in the FPMI who, under the prevailing legal regulation, should not have been held there. It caused an impropriety related to the right to human dignity, the prohibition of inhuman treatment, and the right of the child to protection and care.

Patients may receive visitors only on Fridays in the morning hours, and they may be visited by children under 14 years of age only once per month. Patients may initiate phone calls with a frequency and duration specified in the regime rules; however, the phones cannot handle incoming calls. Scheduling visits for the weekend would significantly facilitate maintaining contacts between the patients and their relatives.

The FPMI provided various programs for the patients; however, in the absence of barrier-free accessibility, they could not stay in the open. Patients live in an extremely unstimulating environment, practically no leisure activities were organized for them.

In the absence of receiving families, the issue of adaptive leaves for patients under compulsory treatment is not settled; neither is the release of those who do not need such treatment anymore. In order to improve the situation, the Commissioner for Fundamental Rights proposed the provision of residential care complying with the requirements of the CRPD.

The fact that the patients’ rights representative did not regularly visit the FPMI, and the interviewed patients did not know who the representative was, constitutes a serious deficiency of the complaints mechanism.

The visiting delegation experienced cases when the personnel demonstrated derogatory, disdainful behavior towards the patients. The term “mentally retarded”, often used by the staff and the management, is stigmatizing. The Commissioner for Fundamental Rights pointed out that comments on the personnel’s part constituting ill-treatment were unacceptable. If such comments refer to the detainees’ ethnic background or ancestry, they should have, in each and every case, the adequate consequences.

The visiting delegation got contradictory information as regards the cases of abuse and the proceedings initiated against the alleged abusers. In his report, the Commissioner for Fundamental Rights emphasized that the FPMI should do everything in its power in order to prevent torture, inhuman and degrading treatment and punishment. It should be regularly brought to the attention of the FPMI’s nursing and security staff that physically abusing the patients is unacceptable and liable to disciplinary sanctions.

The documentation of various means of restraint and restrictive measures was incomplete, and the competent authorities had not been notified thereof; it resulted in an impropriety related the requirement of legal certainty. At the time of the visit, the FPMI did not have a high security cell or section, and solitary confinement was not applied, either. The Institution did not hand over any documentation related to persons detained in isolation for reasons that are not health-related; therefore, it is not clear on what legal basis and how much time they spent in the isolation unit.

The catering practices of the FPMI were not in compliance either with the legal provisions regulating food service to be provided in inpatient institutions, or the lifestyles, health conditions of the patients. Inadequate food service increases the risk of developing certain illnesses, which jeopardizes the enforcement of the right to health.

In order to remedy the uncovered anomalies, the Commissioner for Fundamental Rights requested the organs and authorities concerned to take the appropriate measures.