Summary of Case Report No. AJB-3772/2017

On November 8-9, 2016, the OPCAT National Preventive Mechanism (hereinafter the "NPM") made an unannounced follow-up visit to the (hereinafter the “institution”) Platán Integrated Social Institution of Bács-Kiskun County.

The objective of the follow-up visit was to examine how the recommendations of the Report No. AJB-1686/2015 (hereinafter the “2015 Report”) had been implemented by the institution and its new supervisory authority, the General Directorate of Social Affairs and Child Protection.

At the time of the visit, the institution with the capacity of 100 provided care to 94 persons living with disabilities. The residents have practically no hope to move out of the institution and start an independent life. Two residents died, and one was transferred to another institution in 2016. Up to the date of the visit n 2017, three residents died.

There were one interim head of the institution and one head of the nursing section, four developmental pedagogues, two social and mental health workers, two activity-organizers, one leisure-time organizer, 22 caretakers, eight nurses, one material manager, and one laundry worker employed in the institution.

In the 2015 Report, the NPM requested the head and the supervisory authority of the institution to ensure the statutory minimum living space (at least six square meters per resident). The follow-up visit established that this requirement was not met even after moving back to the permanent premises. The NPM requested the new supervisory authority, the General Directorate of Social Affairs and Child Protection to ensure at least six square meters of living space per resident in the residential rooms. The institution had fewer bathtubs and showers than specified by the relevant legal regulation. The statutory minimum number of toilets was not ensured to the male residents, either. The NPM requested the institution’s supervisory authority to renovate the sanitary unit in order to ensure the statutory number of bathtubs, showers, and toilets for both sexes.

The daily menus did not indicate either the calorie values of the meals or the list of macronutrients; the menus were not displayed so that the residents could see them. The asked the head of the institution to ensure that calories and nutrients were taken into account when preparing the menu (including the menu for residents on special diet) and that the menu was displayed in a visible place.

Several of the residents were on special diet, some of them received, in addition, formula. There was a resident who accepted only a few spoonsful of food; he was skinny and weak. One of the residents with diabetes would have hypoglycemic attacks if he did not eat enough. The NPM pointed out that special attention must be paid to the nutrient content of the special diets of diabetic, emaciated, and formulafed residents. The NPM asked the head of the institution to ensure that the raw material chart was updated in order to guarantee that residents on special diet received the necessary nutrients. Since neither the taste nor the consistency of the dishes tried by the members of the visiting delegation was acceptable, the NPM asked the head of the institution to take the necessary measures to have both the consistency and the taste of meals improved.

The 2015 Report recommended the regular health checks of the residents, with special attention to the residents with psycho-social disability. The follow-up visit established that the general practitioner did not see all residents on a regular basis and the psychiatrist did not check regularly the condition of the residents taking antipsychotics or antidepressants. The NPM reiterated its request to the head of the institution to ensure that the GP and the psychiatrist regularly examined all residents, and to monitor the documentation of their state of health and medication. As the majority of residents had bad teeth, the NPM also asked the head of the institution to ensure the immediate provision of dental check-ups and dental care.

The 2015 visit did not find anything "unusual" as regards the frequency of the ad hoc administration of psychiatric drugs. The expert physician participating in the follow-up inspection established that the administration of drugs in the institution, "prescribing medication in quantities for specific sets of symptoms was unacceptable." The residents sleeping during the day regularly received "Mixtura chloralo-bromata," a preparation that had not been in use by the modern psychiatric profession for decades. As a result of the simultaneous application of strong drugs, some of the residents were strongly sedated, slept through the day, could not be woken. The NPM requested the head of the institution to immediately revise the administration of drugs (simultaneous application of drugs with similar effect) and to stop using the bromide, long abandoned by modern psychiatry. The interviews with the residents suggest that they did not know what drugs they had been taking.

There was no conjugal room in the institution; therefore, the NPM asked the head of the institution to designate a room that could be used by the residents, even if not in conjugal community, to get intimate with one another.

Since 2015, the outside programs, joint field trips had become less frequent; the residents had not taken part in such activities for more than six months. Therefore, the NPM requested the head of the institution to organize various programs, field trips for the residents.

There was no complaint box in the institution. The NPM requested the head of the institution to have a complaint box installed to provide the residents and their relatives with the opportunity to lodge their complaints about the circumstances in the institution anonymously.